‘WOUNDED HEALERS’

A Collaborative Exploration of Trauma Exposure With The Kerry Travellers Health and Community Development Project

Anne Marie Quilligan

CARL Research Project

in collaboration with

Kerry Travellers Health Community Development Project

Name of student (s):	Anne Marie Quilligan
Name of civil society organisation / community group:	Kerry Travellers Health Community Development Project
Name of community liaison person:	Andy Walker
Academic supervisor (s)	Sara Kelleher
Name and year of course:	Master of Social Work (MSW2)
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- provide their services on an affordable basis;
- promote and support public access to and influence on science and technology;
- create equitable and supportive partnerships with civil society organisations;
- enhance understanding among policymakers and education and research institutions of the research and education needs of civil society, and
- enhance the transferrable skills and knowledge of students, community representatives and researchers (www.livingknowledge.org).

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Author (year) Dissertation/Project Title, [online], Community-Academic Research Links/University College Cork, Ireland, Available from: http://www.ucc.ie/en/scishop/completed/ [Accessed on : date].

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Lastly, my beautiful parents, Paddy and Norann, your sacrifices have not gone unnoticed. I could never repay you for all that you do but my life's work will be a testament to making you proud.

Declaration

‘WOUNDED HEALERS’

A Collaborative Exploration of Trauma Exposure With The Kerry Travellers Health and Community Development Project

Student Number: 122107024

Student Name: Anne Marie Quilligan

I declare that this dissertation is based on my own work. Where others' work has been used to support my research, it has been cited accordingly.

Signed: Anne Marie Quilligan Date: 22nd April 2024

Abbreviations

AITHS	All Ireland Traveller Health Study
CARL	Community Action Research Links
CSO	Central Statistics Office
ESRI	Economic Social Research Institute
KTHCDP	Kerry Travellers Health Community Development Project
NGO	Non-Governmental Organisation
NTRIS	National Traveller and Roma Inclusion Strategy
UCC	University College Cork
CBPR	Community-Based Participatory Research

Definitions

The terms advocate, practitioner and helping professionals are used interchangeably throughout the study.

Table of Contents

Abstract

This study, conducted in collaboration with the Kerry Travellers Health Community Development Project (KTHCDP), explores the trauma exposure among Irish Traveller staff within their professional roles, focusing on its impact on their personal and professional lives. Employing a phenomenological approach through Community-Based Participatory Research (CBPR), the research involved conducting six semi-structured interviews to gather in-depth insights. The findings reveal significant exposure to both primary and secondary trauma among the participants, characterised by direct interactions with distressed individuals and emotional burdens from community-based crises, notably including high incidences of suicide. The study highlights a complex interplay of resilience and vicarious trauma within the community, illustrating how personal experiences with trauma influence professional engagements and advocacy efforts. The results underscore the need for tailored support systems for Traveller staff, emphasising professional recognition and the integration of trauma-informed care. Recommendations for enhancing organisational support and developing targeted interventions to mitigate the impact of trauma exposure are discussed, aiming to contribute to better mental health outcomes and sustained advocacy efforts within the Traveller community.

Chapter One: Introduction

1.1 Introduction

The following chapter will provide an overview of the research topic by outlining the background and rationale along with the aims and objectives of the study. This research project was conducted in partnership with the Kerry Travellers Health Community Development Project (KTHCDP) as part of the Community-Academic Research Links (CARL) initiative. The chapter will also highlight the research questions that guided the thesis. Lastly, a chapter overview of the thesis structure will also be provided.

1.2 Research Title

Wounded Healers: *A Collaborative Exploration of Trauma Exposure with The Kerry Travellers' Health & Community Development Project*

1.3 Kerry Traveller Health Community Development Project

Images Sourced: Kerry Traveller Health and Community Development Project

The Kerry Traveller Health and Community Development Project (KTHCDP)[1] was established in 1996. KTHCDP is a Traveller-led initiative that reflects community development principles, including equality, participation, empowerment, and self-determination. The project has a diverse team of 12 staff members and eight project volunteers, united by a shared value system of equality, human rights, and anti-racism. Irish Traveller and non-Traveller staff at KTHCDP have developed a strong, trusting partnership dedicated to empowering one another and the community to achieve positive change.

[1] https://kerrytravellersproject.wordpress.com/wp-content/uploads/2012/03/2014-annual-report.pdf

Under the leadership of Dr. Brigid Quilligan, KTHCDP has been working diligently for almost two decades to address the multifaceted issues faced by the Traveller community in a local and national capacity. The organisation's portfolio of work includes vital areas such as health, family support, education, enterprise, culture and identity, accommodation, horse ownership, gender-based violence, and youth development.

While the CSO (2016) recorded 998 Irish Travellers in Kerry, KTHCDP believes this to be conservative, estimating the "figure to be 50% higher"[2]. To date, KTHCDP has been successful in forging strong partnerships with Kerry's HSE Healthy Community Development, mental health and addiction services, Tusla and the regional Traveller Health Unit. Adopting a social determinants model of health, KTHCDP has identified the significant health implications stemming from the poor living conditions, discrimination, and exclusion that Travellers often face. To combat the mental health and suicide epidemic within the Traveller community, KTHCDP is facilitating access to mental health services and addressing the underlying causes of these crises. As noted by Dr Quilligan, the Traveller community in Kerry is resilient and strong, but it is currently confronting a severe mental health crisis. The pervasive national unconscious bias against Travellers in Ireland further exacerbates the situation. Nonetheless, KTHCDP's unwavering commitment to promoting the human rights of Travellers, including their identity, access to justice, economic barriers, accommodation, education, and health, is commendable.

1.4 Community Partnership

Community-based initiatives involving Higher Education Institutions (HEIs) were first introduced in the Republic of Ireland in the mid-2000s (Bates & Burns, 2012). The Community-Based Participatory Research (CBPR) model focuses on collaborating with community groups, charities, and Non-Governmental Organisations to support communities in need (Bates & Burns, 2012). According to Tremblay et al. (2018), three core principles of CBR are:

(1) Power sharing and the reciprocal transfer of expertise between the researcher(s) and the researched.

[2] https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/joint_committee_on_key_issues_affecting_the_traveller_community/submissions/2019/2019-09-24_opening-statement-brigid-quilligan-kerry-traveller-health-community-development-project_en.pdf

(2) Validating knowledge based on lived experience as a legitimate source of understanding.
(3) Mutual ownership and dissemination of research findings to improve policy and practice outcomes.

A key strength of the CBPR approach is its effectiveness in addressing health and social justice inequality through shared decision-making among partners (Coughlin et al., 2017).

1.5 Research Rationale

The emotional challenges faced by Irish Traveller human rights advocates have received limited attention in academic research. To date, there is a notable absence of literature focusing on the experiences of human rights activists in general, particularly in relation to Irish Traveller advocates. This research project has a twofold aim: firstly, to raise awareness, and secondly, to highlight the importance of such awareness for my fellow Irish Traveller advocates, including those involved in managing organisations within the sector. The research question, 'A Collaborative Exploration of Trauma Exposure With The Kerry Travellers Health and Community Development Project,' aims to bridge this gap in the literature. It seeks to examine, from a phenomenological perspective, how work-related trauma impacts the personal and professional lives of Irish Traveller staff in KTHCDP.

1.6 Researcher Positionality

Drawing from my professional background as an Irish Traveller actively engaged in my community, I have gained first-hand insight into the repeated exposure to work-related trauma experienced by my fellow colleagues. As a Master of Social Work student, I am attuned to the risks associated with assisting individuals who have endured traumatic events including how work-related trauma can permeate helping professionals' personal and professional lives. Research undertaken by Mathieu (2012) indicates that over 60% of helping professionals have encountered traumatic events in their personal lives (p.13). Between 40% and 85% of these professionals are susceptible to developing vicarious trauma or compassion fatigue. This has encouraged me to conduct this research.

1.7 Research Aims and Objectives

Primary Aim: This study collaborated with the Kerry Traveller Health Community Development Project (KTHCDP) to investigate the extent and nature of trauma experienced by Irish Traveller staff within their professional roles.

Objective 1: Conduct a comprehensive literature review to understand the existing research on trauma among helping professionals and identify best practices for reducing trauma exposure.

Objective 2: To examine the specific experiences of trauma exposure among Irish Traveller staff through conducting six one-to-one semi-structured interviews.

Objective 3: To use thematic analysis to code and interpret the data from the interviews, focusing on identifying and understanding the emerging core themes.

Objective 4: Present the research findings and provide recommendations based on the research outcomes.

1.8 Research Questions

This research will address three questions:

1) How does exposure to trauma manifest among Irish Traveller staff who work with distressed individuals?
2) What impact does trauma exposure have on Irish Traveller staff's well-being?
3) What factors challenge or contribute to Irish Traveller staff's perseverance, and what resources or support are instrumental in this process?

1.8 Research Chapter Outlines

Chapter Two: Literature Review

2.1 Introduction

Research Title: '*Trauma Exposure and Professional Advocacy: A Collaborative Exploration With The Kerry Travellers' Health & Community Development Project*'

The Key objectives of this participatory research study were to explore the following:

- Discuss the most common types of trauma exposures experienced by the Traveller staff at Kerry Traveller Health and Community Development Project.
- What impact does trauma exposure have on Irish Traveller staff's well-being?
- What factors challenge or contribute to Irish Traveller staff's perseverance, and what resources or support are instrumental in this process?

2.2 Irish Travellers

Irish Travellers are an ethnic minority indigenous to the island of Ireland. According to the 2016 Central Statistics Office[3], Irish Travellers represent less than 1% of the population (an estimated 30,987 individuals). Section 2 (1) of The Equal Status Act 2000[4] defines Irish Travellers as "a community of people who are commonly called Travellers and who are identified (both by themselves and by others) as people with a shared history, culture, and traditions including, historically, a nomadic way of life on the island of Ireland". Following five decades of "resolute lobbying, strategic alliance-building and sustained agitation for change" (Kavanagh & Dupont, 2021, p.553), including several recommendations from Human Rights and UN treat-monitoring bodies[5], on the 1st of March 2017, the State formally recognised Irish Travellers as a distinct ethnic minority.

Extensive research reveals that Irish Travellers face significant challenges across all indicators used to measure disadvantage such as unemployment, poverty, social exclusion, health status, infant mortality, life expectancy, education and training levels, access to decision-making and political representation, access to credit, accommodation and living conditions (O'Connell, 2002; AITHS, 2010; Harvey, 2013; Watson et al., 2017; Cush et al., 2020; McKey et al., 2022; Kennedy et al, 2023; Friel, 2023).

[3] https://www.cso.ie/en/releasesandpublications/ep/p-cp8iter/p8iter/p8itd/
[4] https://www.irishstatutebook.ie/eli/2000/act/8/enacted/en/print#sec2
[5] https://www.ihrec.ie/ihrec-designate-welcomes-call-for-recognition-of-traveller-ethnicity-by-joint-oireachtas-committee-on-justice-defence-and-equality/

In 2010, the All-Ireland Traveller Health Study conducted a comprehensive census of 7,042 Traveller families, which revealed significant health disparities compared to the general population (AITHS, 2010). Daly (2011) likened the mortality rates for Travellers to that of the general population in Ireland during the 1940s. Figure (1) illustrates the mortality rates of Traveller and non-Travellers in Ireland. Less than 3% of Travellers live beyond the age of 65 compared to 13.3% of the general population (CSO, 2016)[6]. Traveller infant mortality rates are 3.6 times higher than the general population, with 10% of Traveller children dying before their second birthday (O'Reilly et al., 2018). Traveller women are five times more likely, and Traveller men are six times more likely than their settled counterparts to die by suicide (AITHS, 2010). Recent data revealed that Traveller men account for 10% of the national young male suicide statistics (Mckey et al., 2020, p.223). Overall, an estimated 11% of Traveller deaths are caused by suicide (Villiani & Barry, 2021). O'Mahoney (2017) states that 70% of completed suicides among Irish Travellers are first attempts, which would suggest little or poor engagement with services at the early stages of mental distress. Similarly, Van Hout & Hearne (2017) noted that although there was an increase of 291% of Travellers accessing addiction services between 2007 and 2010, they tend to wait until their "pathologies are chronic and increasingly difficult to treat" (p.4).

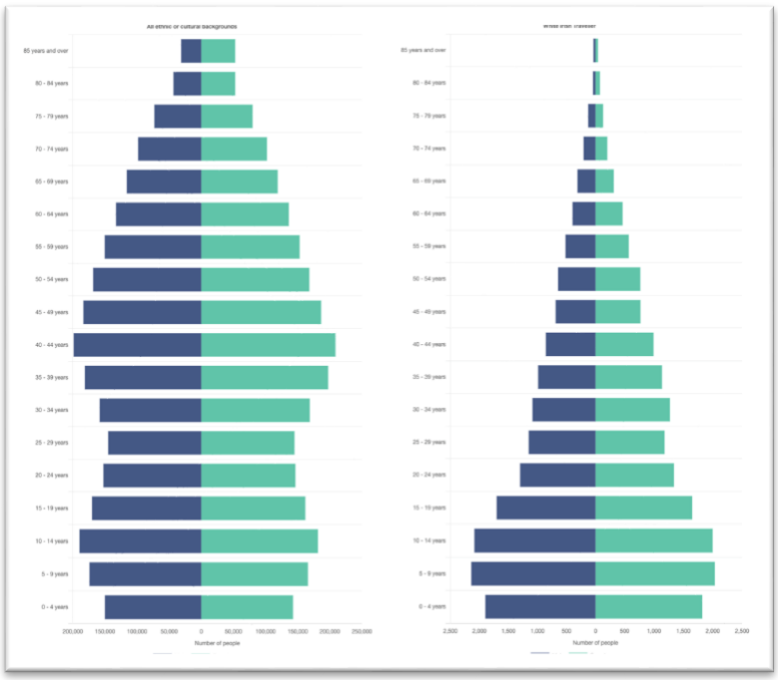

Figure 1: Irish population pyramid by sex and age group (2016)

[6] https://www.cso.ie/en/releasesandpublications/ep/p-cp8iter/p8iter/p8itd/

Villani et al. (2023) highlight the need for comprehensive action to address the mental health crisis experienced by Travellers. They suggest that adopting a social determinants approach to Traveller mental health requires action across all sectors and across "the life course to address the range of risk and protective factors that operate at multiple levels, including the individual, family, community, structural and societal level" (p.20). To reduce inequities in Traveller's mental health, "a whole- of government and whole- of society" approach should be taken. This approach underscores the shared responsibility and collective commitment to improve everyday living conditions and enhance the potential for good mental health, starting before birth and progressing into early childhood, adolescence, adulthood and old age (Villani et al., 2023, p.21).

2.3 Wounded Healers

Jung (1951) coined the term 'Wounded Healer' to describe how practitioners who have had a painful experience in the past can use that experience to foster empathy and compassion when supporting others. In their study, Conti O'Hare (1998) delves into the archetype of the Wounded Healer to explore the use of personal experiences among nurses in providing therapeutic support to clients recovering from addiction (p.71). The research revealed that when nurses acknowledge their personal wounds (past sufferings), it fosters compassion and empathy, which aids inner healing among patients (Conti O'Hare, 1998). In a similar vein, Woods (2020) conducted a study that delved into the experiences of peer support workers who had lived through imprisonment and were assisting women affected by the same. The research revealed that support workers had an overwhelmingly positive experience, with many reporting a boost in their self-esteem and self-worth. Authentic collaboration and the ability to give back were cited as the primary reasons for this, with many peer-support workers feeling that helping others allowed them to help themselves (Woods, 2020, p.202). The research also found that due to their lived experiences, the peer support workers were often able to provide "deeper insights and understandings" concerning the client's experience (Woods, 2020, p.193).

A substantial body of literature shows that helping professionals can suffer adverse effects from exposure to other people's trauma (McCann & Pearlman, 1990; Figley, 1995; Danieli, 1998; Cummings et al., 2021; Pellegrini et al., 2022). Due to their close work with clients, these professionals are more likely to experience "negative psychological responses including vicarious trauma (VT), secondary traumatic stress (STS), and burnout" (Cummings et al.,

2018, p.1). Trauma expert Mathieu (2012) states that 60% of helping professionals have a personal history of trauma (p.13). Mathieu also notes that it can prove challenging for professionals with a trauma history to practice safely if they have not engaged in their own trauma work. These professionals may not be aware of how their personal trauma history can negatively affect their practice. Mathieu (2012), notes that between 40% and 85% of helping professionals are prone to developing vicarious trauma or compassion fatigue.

A study involving 282 social workers found that 15.2% met Post Traumatic Stress Disorder (PTSD) criteria due to secondary (indirect) trauma exposure (Bride, 2007, p.67). Satterthwaite et al. (2019) conducted a study among 110 human rights advocates from 35 countries and revealed that exposure to direct and indirect trauma through work had a significant impact on the well-being of advocates. Advocates discussed significant concerns regarding their mental health, feelings of anxiety, suicidal ideation, physical health, disrupted sleep, detachment from friends and family, PTSD symptoms, substance misuse, compassion fatigue, and burnout (Satterthwaite et al., 2019, p.448).

Satterthwaite et al (2019) state that advocates experiencing burnout, depression, and anxiety are likely to be less successful in their individual and collective work, which presents a challenge to the longevity of advocacy. According to Satterthwaite's (2019) observations, a considerable number of human rights defenders are not advocates by choice but are rather compelled to do so due to the injustices prevalent in their communities. This aspect of their work can make them more susceptible to occupational hazards such as burnout and STS, given their previous experiences of intergenerational trauma. Advocates who are not from the community may not fully understand the challenges faced by its members, which can lead to different professional needs and experiences.

2.4 Trauma

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2012) defines trauma as the result of a singular significant event or a series of events or distressing circumstances that are perceived by the individual to be physically or emotionally harmful or threatening, with ongoing adverse effects on the individual's social and emotional functioning,

including their mental health and overall well-being (p.2). Inherent in SAMHSA's definition of trauma are the three E's: **E**vent, **E**xperience and **E**ffect[7].

The Diagnostic and Statistical Manual of Mental Disorders (DSM-V) defines trauma as when a person is exposed to "actual or threatened death, serious injury, or sexual violence" (American Psychiatric Association, 2013, p.271). Trauma may occur through one of the following situations:

(1) Direct involvement in the traumatic event.
(2) Bearing witness to the traumatic event.
(3) Learning that a loved one or a close friend experienced a traumatic event.
(4) Repeated first-hand experience or exposure to details regarding a traumatic event.

According to renowned trauma expert Bessel van der Kolk, trauma is not merely the retelling of a past event but rather the lasting impact of the pain, fear, and horror that still reside within the person's mind and body. Van der Kolk (1994) describes being traumatised as continuing to live as if the traumatic event is still happening, with each new experience tainted by the past. According to Pearlman & Saakvitne, (1995), psychological trauma encompasses the distinct, personal experience of an event or ongoing circumstances where an individual's capacity to process their emotional response is overwhelmed. This can occur if "the individual experiences (subjectively) a threat to life, bodily integrity, or sanity" (Pearlman & Saakvitne, 1995, p.60). The threshold for trauma can vary for each individual, contingent on various factors. These include the nature and intensity of the traumatic experience, the individual's history of trauma, their physical and emotional proximity to the traumatic event, as well as their access to resources or social support networks (Herman, 1992; Brenner et al., 2010, Lynch, 2017).

2.5 Race-based Traumatic Stress

Traumatic stress resulting from a racist encounter is known as race-based traumatic stress. According to a study by Carter and Reynolds (2011), individuals who face cultural racism, including condemnation and belittling of their racial group, are more susceptible to experiencing negative emotions such as depression, anger, confusion, fatigue, and tension (p.160). The cumulative affects of real or perceived experiences of discrimination can result in

[7] SAMHSA'S concept of Trauma and Guidance For Trauma-Informed Approach in Youth Settings: https://www.pathwaysrtc.pdx.edu/pdf/fpS1510.pdf

chronic stress levels, and not only can this have a psychological impact on individuals, but it can also result in physical ailments such as headaches, hypertension and respiratory illness. Kirkins et al. (2018) conducted a systemic review of recent literature within the previous six years examining the relationship between experiences of racial discrimination and trauma. The study found a significant statistical link between incidents of racial discrimination and "70% of the trauma symptomology outcomes" (Kirkins et al., 2018, p.1).

2.6 Primary Trauma and Secondary Trauma

Primary trauma — also known as direct or first-hand trauma — arises from significant, potentially life-altering events that leave an individual feeling fearful and overwhelmed (Mathieu, 2011). This can include directly experiencing traumatic events or witnessing a traumatic event. These events can be acute, like a single occurrence such as a vehicle accident, or they can be chronic, like ongoing situations such as domestic violence, racism or child neglect (Mathieu, 2011). Primary victims are those directly impacted by the trauma, while secondary victims are individuals who provide support to the primary victim (Avary & Uhlemann, 1996; Mathieu, 2011). Secondary trauma can arise from bearing witness to traumatic events through indirect exposure. This can take the form of hearing other people's accounts of abuse, extreme loss or suffering, reviewing distressing case notes, or engaging in graphic debriefings with colleagues (Bride, 2007; Mathieu, 2011; Lambert, 2018).

Individuals exposed to other people's traumas are at significant risk of physiological and psychological harm (Newell & McNeill, 2010). These occupational harms are known as Vicarious Trauma (VT), Secondary Traumatic Stress (STS), Compassion Fatigue (CF), and Burnout. Newell & MacNeil (2010) state that occupational harms are interconnected and can follow a specific progression from VT to STS, then to CF, and finally to burnout. These terms are often used interchangeably which can often cause confusion. However, they each possess subtle yet distinct characteristics that set them apart (Rauvola et al., 2019; Cummings et al., 2021). Therefore, the literature review will explore and clarify each one further.

2.7 Vicarious Trauma (VT)

McCann & Pearlman (1990) coined the term vicarious trauma to describe how individuals working with survivors of traumatic life events may themselves experience indirect trauma.

Prolonged exposure to distressing narratives can lead to harmful changes in an advocate's cognitive schemas, affecting their "feelings, relationships, and life" (McCann & Pearlman, 1990, p.136). This profound change is known as "vicarious traumatisation" (Pearlman & Saakvitne, 1995, p.279). When reflecting on her work at the Trauma Stewardship Institute, Dr. Van Dernoot Lipsky eloquently described her personal experience of vicarious trauma as follows: "I finally came to understand that my exposure to other people's trauma had changed me on a fundamental level. There had been an osmosis. I had absorbed and accumulated trauma to the point that it had become part of me, and my view of the world had changed'' (Lipsky & Burk, 2007., p.3).

Vicarious Trauma can lead to "decreased motivation and empathy" among professional helpers (Lambert, 2018, p.33). They may also begin to perceive "their world as more unsafe than the actual statistical risk" (Lambert, 2018, p.33). Ravola et al. (2019) provide the following example of vicarious traumatisation: A professional working in a disadvantaged area may experience VT over time due to their interaction with marginalised or vulnerable youths (p.303). This could be a result of hearing stories of violence, extreme poverty, or crime, and witnessing or observing signs of abuse. As a consequence of this experience, the teacher may start to view the world as less just and lose hope for their work and for society (Ravola et al., 2019, p.303).

A person experiencing VT may also begin to adopt symptoms similar to those they are supporting, such as intrusive thoughts, emotional numbing and hyperarousal (Pearlman & Saakvitne, 1995). VT develops over a prolonged period and is due to repeated exposure to other people's trauma. VT centres on the cognitive effects (thinking & reasoning) associated with indirect exposure to trauma (Pearlman, 1996).

2.8 Secondary Traumatic Stress

In contrast to Vicarious Trauma, STS can occur relatively quickly and be linked to just one specific event (Jimenez et al., 2021). These nuanced differences highlight the unique characteristics between the two phenomena. Figley (1995) defines STS as follows, *"The natural, consequent behaviours and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to*

help a traumatized person" (p.7). STS typically does not shift an individual's fundamental worldview and is often referred to as "the cost of caring" (Figley, 1995, p.9).

STS can occur following an isolated or repeated trauma exposure, it can also be "sudden and acute in nature" (Rauvola et al., 2019, p.304). Symptoms of STS can often mirror those experienced by traumatised clients, such as "intrusive imagery related to clients' traumatic disclosure" (Bride, 2007, p.64). Additional symptoms can include distressing emotions, avoidance behaviours and heightened psychological arousal.

Practitioners experiencing increased levels of STS are susceptible to countertransference reactions with their clients (van der Merwe & Hunt, 2019). Countertransference occurs when a practitioner projects their unresolved trauma or conflict onto the client. Corey (1991) describes countertransference as the process wherein a practitioner may overidentify with a client or try to meet their personal needs through the therapeutic/working relationship. While it is not imperative to eliminate countertransference, acknowledging it in professional supervision is crucial. If issues regarding countertransference remain unresolved, the practitioner "may need to engage in their own therapeutic process" (van der Merwe & Hunt, 2019, p.11).

2.9 Compassion Fatigue

Compassion Fatigue is more specific to helping professionals who work directly with other peoples' suffering or distress. CF was primarily identified by Joinson (1992) in a study examining the levels of burnout among nurses routinely exposed to the trauma of others. Joinson (1992) observed symptoms such as chronic fatigue, fear of going to work and high levels of irritability, which diminished the nurses' capacity to provide compassionate care. Joinson (1992) refers to CF as the "loss of ability to nurture" due to multiple environmental stressors (p.74). Mathieu (2011), describes CF as a "gradual erosion" of the things that once kept people connected to others in their caregiver role (Mathieu, 2011, p.14). According to Mathieu (2011), compassion fatigue is a precursor to burnout.

Figley (1995) notes 32 triggers that contribute to CF, the majority of which are work-related, such as excessive workloads, a lack of resources and poor organisational structure. However, the most recurrent personal trigger identified was a lack of professional boundaries

(countertransference), often leading to workers becoming overly emotionally involved with their clients' situations. This highlights the importance of maintaining clear boundaries to help reduce the risk of CF.

2.10 Burnout

Research regarding burnout initially aimed to assess the negative effects of work-related stress on advocates supporting trauma-experienced individuals such as mental health care providers (Cummings et al., 2018). Cheun and Chow (2011) note that burnout among healthcare providers can leave them feeling worn down, thus significantly impacting their overall well-being and the quality of care to service users. Burnout can result in "physical, emotional, psychological, and spiritual exhaustion" (Cummings et al., 2018, p.4).

Burnout is primarily associated with the chronic exposure of workplace stressors, such as a lack of resources, job insecurity and excessive caseloads (Mathieu, 2011). These factors can lead to low motivation, diminished job satisfaction and increased feelings of helplessness (Mathieu, 2011). Kou and Kantas (2003) suggest that burnout-related exhaustion may cause individuals to disengage from work or adopt a negative attitude towards job-related tasks or goals. The symptoms associated with burnout usually have a gradual onset and progressively intensify. Workplace interventions to address burnout often involve re-assessing caseload management and regular supervision support (Mathieu, 2011). Fig 2 illustrates the continuum of burnout.

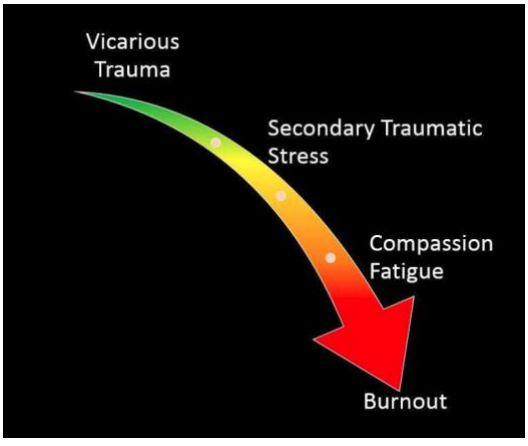

Figure 2: Continuum of burnout

2.11 Vicarious Resilience and Post-traumatic Growth

As outlined in the literature, several risk factors are associated with working in the area of trauma. However, many practitioners also report positive effects such as post-traumatic growth (Tedeschi & Calhoun) and Vicarious Resilience (Hernandes et al., 2007). These experiences can lead to increased job satisfaction, a deeper sense of meaning and purpose, and high levels of professional effectiveness in the role.

Hernandez et al. (2007) define Vicarious Resilience (VR) as the "transformation in the therapist's inner experience resulting from empathetic engagement with the client's trauma material" (p.237). VR is not simply the positive experiences that the therapist remembers from working with clients; rather, it is the sense of empowerment they experience after witnessing and reflecting on a client's profound capacity to heal. VR can also encourage the therapist to reflect on their own position regarding power and privilege in relation to the client, developing a deeper sense of empathy and patience if feeling frustrated when working with the client. VR empowers practitioners to practice from a place of compassion and self-awareness, develop knowledge, and therefore, enchance self-efficacy (Hernandez et al., 2007).

The term Post-traumatic Growth (PTG) was coined by Tedeschi and Calhoun (2004) who described it as "the experience of positive change that occurs as a result of the struggle with highly challenging life crises" (p.1). While the definition refers to crises, the authors state that it also includes stressful events and traumas. It is important to note that PTG does not occur because a person has experienced trauma; rather, it occurs in the aftermath and is determined by how the person adapts to their new reality (Tedeschi & Calhoun, 2004, p.5).

When supporting people who have experienced trauma, Tedeschi & Calhoun (2015), use the term "expert companions" to describe their roles as "facilitators" of growth, working in collaboration with clients. Tedeschi & Calhoun (2015) "chose these words carefully" as PTG cannot be prescribed (p.510). Instead, it is a process of psychological healing through repeated listening and mentoring to help the individual explore or make sense of the traumatic event, in such a way that it can be tailored into a more positive narrative. By doing this, the client can learn to re-evaluate their core beliefs, finding strength in what was once a vulnerability,

resulting in a new way of living in the aftermath of the trauma and ultimately achieving PTG (Tedeschi & Calhoun, 2015, p.510).

The positive changes experienced in PTG encompass changes in three areas: (1) self-perception, (2) interpersonal relationships, and (3) worldview/philosophy of life. While PTG can be experienced by direct victims of trauma, it can also be experienced by the professionals who support them. The unique characteristics of PTG among professionals are increased levels of job satisfaction and confidence in their skills due to witnessing their client's PTG (Guhan & Lievling-Kalifani, 2011).

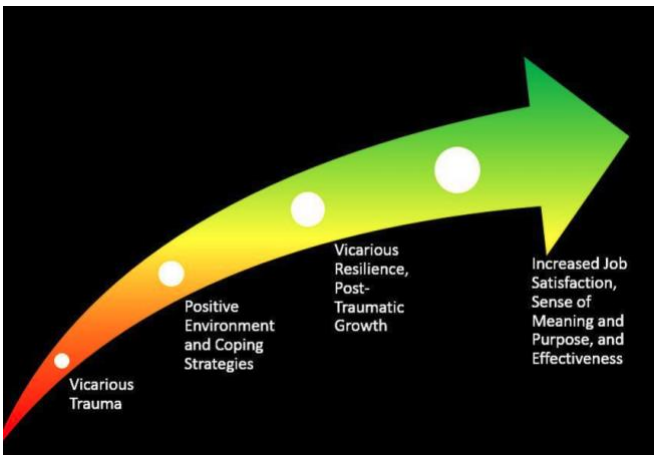

Figure 3: Continuum of vicarious resilience and post-traumatic growth

2.12 Trauma Informed Care

According to Lambert et al. (2017), a trauma-informed service has a comprehensive understanding of the widespread effects of trauma, particularly on an individual's physical and emotional well-being. To achieve this, it is important to have a deep understanding of the complexity of trauma, be able to recognise the signs and respond accordingly. The physical setting in which services and systems operate can potentially trigger trauma. Therefore, it is essential for a trauma-informed service to prioritise safety by actively reducing the likelihood of re-traumatisation for both service users and all staff members. It is important to note that a trauma-informed service may not necessarily provide trauma-specific interventions, but it should have "trauma awareness as its focus" (Lambert et al., 2017, p.5).

According to SAMHSA (2014), The Key Principles of a Trauma-Informed Approach are:

Menschner & Maul (2016) note that supervision, along with continuous professional development (CPD) and training, is crucial for the well-being and, often, the healing of staff, particularly those who may have a past history of trauma. Van Dernoot Lipsky & Burk (2007) emphasise that supervision is not therapy. However, it is widely recognised that many practitioners may also be survivors of trauma. Therefore, there is an increased risk of secondary trauma, particularly when a client's experiences are similar to those of the supervisee. Staff may need support from their supervisor to handle boundaries in current or future cases.

According to Walsh (2017), trauma-informed supervision should be structured in a way for staff to (1) access support, (2) have a safe space to reflect upon their work without fear of judgment or reprisal, (3) explore new opportunities to develop their skills and knowledge and (4) discuss self-care strategies. Trauma-informed supervision can foster meaningful and often difficult dialogue, which can help reduce the risk of vicarious trauma and burnout. According to Varghese (2018), trauma-informed supervisors should be "accessible, consistent, direct, deliberate, and affirming, as well as self-reflective" (p.138). Additionally, organisations can enhance trauma-informed practices by providing "trauma-specific training, effectively allocating caseloads, and providing opportunities for respite and self-care" (p.138).

According to Morrison (2007), self-care strategies can help mitigate occupational harms that can occur through working with trauma. Self-care techniques that can enhance well-being are:

1. **Cognitive techniques:** Re-evaluating how one thinks such as acknowledging that you made a difference or accepting that you have done all that can be done.
2. **Physical techniques:** This can be going to the gym, walking in nature, running or listening to music.
3. **Spiritual techniques:** Practicing spirituality and prayer for support and solace.
4. **Verbal techniques:** Journaling, writing poetry or talking about your emotions to someone else.

2.13 Conclusion

This chapter provides a brief overview of the challenges faced by Irish Travellers. This context helps to understand the advocacy work undertaken by staff within this community. Given the limited research on Irish Traveller advocates and their exposure to trauma, this chapter shows how various helping professions encounter work-related traumas. It explores the burnout continuum, which includes vicarious trauma (VT), secondary traumatic stress (STS), and compassion fatigue (CF). The discussion acknowledges not only the detrimental effects of working with trauma but also highlights potential benefits. Practitioners can also experience vicarious resilience and post-traumatic growth. Finally, the chapter concludes with a look at the principles of trauma-informed care and its application.

Chapter Three: Methodology

3.1 Introduction

This chapter outlines the research process for this study, beginning with the phenomenological and theoretical perspectives followed by the Community-Based Participatory Research (CBPR) methodology utilised. It will then discuss the method and design for data collection and analysis, concluding with ethical considerations, challenges, limitations, and the researchers' reflexivity.

A key principle of CBPR is to emphasise the collaborative nature of the research and prioritise the participants' voices. This extends not only to the body of the text but also to the title and can be achieved by referencing characteristics of the research population or using terms such

as “partnership,” “collaboration,” or “engagement” (Grieb et al., 2015, p.278). Therefore, the title for this research study is as follows:

‘Wounded Healers’

Trauma Exposure and Advocacy: A Collaborative Exploration With The Kerry Travellers’ Health & Community Development Project

The Key objectives of this CBPR study were to explore the following:

1) Discuss the most common types of trauma exposures experienced by the Traveller staff at Kerry Traveller Health and Community Development Project.
2) What impact does trauma exposure have on Irish Traveller staff’s well-being?
3) What factors challenge or contribute to Irish Traveller staff’s perseverance, and what resources or support are instrumental in this process?

3.2 Phenomenology

Although not explicitly defined, phenomenology is grounded in philosophy. The idea became prominent in research in the late 1900s due to philosopher Edmund Husserl’s unique contributions (Moran, 2005). Moran (2005) defines a phenomenological approach as the “attempt to get to the truth of matters, to describe phenomena, in the broadest sense as whatever appears in the manner in which it appears” (p.4).

According to Polkinghorne (1989), phenomenology researchers seek to convey the lived experiences of the participants in such a way that readers “understand better now what it is like for someone to experience that” (p.46). This study used a phenomenological lens to “make meaning by discovering similarities and differences” among the research participants (Glesne, 2016, p.290). Phenomenology was chosen as it distinguishes itself from traditional Western philosophy by intentionally “returning it to the life of the human subject” (Moran, 2005, p.5). Employing a phenomenological method supported the researcher in gathering authentic, nuanced insights from the participants as they described their lived experiences of trauma exposure in their work.

3.3 Constructivism and Reflexive Positioning

According to Cobern (1993), the constructivist paradigm in social science research recognises that knowledge is fluid and influenced by social constructs (interactions). Constructivism values the co-construction of knowledge between the researcher and the participant. Unlike traditional elitist research, constructivism encourages a balanced power dynamic, treating participants as active contributors with valuable knowledge through their lived experiences. However, the constructivist paradigm emphasises that research is inevitably influenced by the beliefs and values held by the researchers themselves and cannot be independent of them (Cobern, 1993). Therefore, a "boundary" setting needs to be negotiated, which, according to Ladkin (2015), is a task that many researchers struggle with (p.113).

According to Braun & Clarke (2013), research reflexivity is "the process of critically reflecting on the knowledge we produce and our role in producing that knowledge" (p.37). As the researcher is an Irish Traveller with experience working within the community, they applied a boundary-setting technique known as epoché, the Greek translation for 'suspension of judgment' (Sokolowski, 2000). Through epoché, "we are more able to look at what we normally look through" (Sokolowski, 200, p.50). Through engaging in critical reflection via journaling (Fook, 2006), as well as supervision with their UCC supervisor, the researcher was able to reflect upon their positionality within the study. The epoché technique supported the researcher in evaluating their assumptions and maintaining an unbiased perspective on the participants' narratives and experiences (Sokolowski, 2000). Adopting a constructivist framework helped the researcher remain objective while considering multiple viewpoints and constructing knowledge collaboratively with the participants. This approach reflects the researcher's core value of learning with and from their community.

3.4 CBPR Methodology

Community-based initiatives involving Higher Education Institutions (HEIs) were first introduced in the Republic of Ireland in the mid-2000s (Bates & Burns, 2012). The Community-Based Participatory Research (CBPR) model focuses on collaborating with community groups, charities, and NGOs to support communities in need (Bates & Burns, 2012). According to Tremblay et al. (2018), three core principles of CBR are:

(1) Power sharing and the reciprocal transfer of expertise between the researcher(s) and the researched.
(2) Validating knowledge based on lived experience as a legitimate source of understanding.
(3) Mutual ownership and dissemination of research findings to improve policy and practice outcomes.

A key strength of the CBPR approach is its effectiveness in addressing health and social justice inequality through shared decision-making among partners (Coughlin et al., 2017). This collaborative model involves community members, agency representatives, and academic researchers in all research stages, from assessment and problem definition to research and design, data collection, analysis, interpretation and sharing of findings. Participatory research is the "antithesis of elitist research", which believes that all power, value and knowledge reside solely with the researcher, thereby marginalising the perspectives of the participants who may be regarded as "passive subjects in the research process" (Higginbottom & Liamputtong, 2015, p.3). Through sharing expertise and power distribution among stakeholders, CBPR ensures inclusivity and diverse perspectives (Coughlin et al., 2017).

A methodology is the underlying "strategy, plan of action, process or design behind the choice and use of particular methods" to achieve the desired outcome (Crotty, 1998, p.3). According to Coughlin et al. (2017), the CBPR framework "is a methodology rather than a set of methods" (p.23). Figure (4) illustrates the CBPR methodology framework for this study:

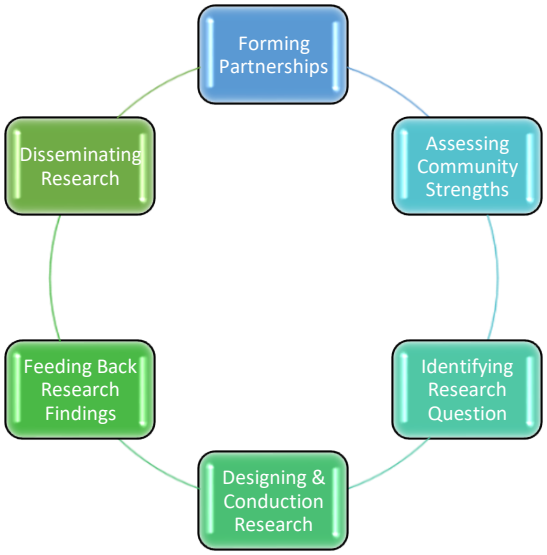

Figure 4 (adapted from Coughlin et al., 2017, p.205).

The principles of CBPR underpinned the methodology for this research study, which was conducted in partnership with the Community Academics Research Link (CARL) at University College Cork (UCC). The research question emerged organically from a pre-established relationship between the researcher and KTHCDP, who are developing a Trauma-Informed initiative with additional Traveller NGOs. The student researcher sought guidance on the proposed research question from their UCC supervising tutor, who subsequently endorsed a recommendation on their behalf as a suitable participant researcher with the CARL project. This endorsement was followed by KTHCDP's application to the CARL project department at UCC.

Once the research application was assessed, an online meeting was convened with the student researcher, UCC research supervisor, CARL supervisor, and KTHCDP management. This meeting outlined various processes, including the ethics application, research approach, available supports and resources, completion timeline, and dissemination of research findings via a report upon completion. The researcher also committed to presenting the findings to the KTHCDP team in person. All stakeholders signed an agreement formalising these details. The researcher shared completed chapters with their UCC supervisor and KTHCDP, incorporating feedback and advice at each stage. Designated liaison personnel from the CARL team supported the researcher throughout the process. These supports were instrumental in helping the researcher establish a methodological framework aligned with the principles of CBPR.

3.5 Methods

3.5.1 Purpose Sampling and Recruitment

According to Creswell (2013), it is important to have a group of participants with shared characteristics or knowledge of the research topic when conducting phenomenological research. This homogeneity is not merely desirable but essential in capturing the research topic's essence. Phenomenologists regularly use purpose sampling as it allows researchers to intentionally choose the "sample for the study for a purpose" (Alston & Bowles, 2003, p.89) and capitalise on obtaining data from those with "special knowledge" (Marshall, 1996, p.113). As noted by Lopez & Whitehead (2013), purpose sampling can provide "information-rich cases for in-depth study", particularly in research with a smaller, more focused sample size (p.123). Inclusion criteria for a research sample refer to the specific skills or characteristics a person needs to possess in order to participate in the study, such as "a specific age range or gender"

(Lopez & Whitehead, 2013, p.126). Conversely, exclusion criteria refer to characteristics that deem a participant unsuitable for inclusion and can be based on factors such as age, gender, ethnicity, or cognitive impairment (Lopez & Whitehead, 2013).

Incorporating the work of Creswell (2013), participants were selected based on factors such as their knowledge, experience, availability and willingness to reflect upon experiences related to trauma exposure. For this study, purposive sampling was employed to voluntarily recruit six Irish Traveller staff members over 18 who were engaged in direct work with clientele at KTHCDP. Research participants were identified and recruited by a dedicated liaison in KTHCDP. A preference was given to staff with a minimum of three years of employment to ensure familiarity with the organisation and the work. Research participants were diverse in gender, occupational role and years of experience. Exclusion criteria encompassed non-Traveller staff, individuals under 18, and those who worked in the organisation for less than one year. Non-Traveller staff were excluded from this study as the research findings aim to inform a regional Traveller-specific trauma awareness initiative.

3.5.2 Literature Review

Boote & Beile (2005) state that a thorough literature review is the "foundation and inspiration for substantial, useful research" (p.3). Conducting a literature review demonstrates that the researcher has developed a comprehensive understanding of the research topic (Douglas & Douglas, 2007). In exploring the nuanced issue of Traveller staff exposure to trauma in KTHCDP, the researcher utilised several resources such as Google Scholar, JSTOR, Cochrane Library, UCC Library, PsycINFO, Science Direct and ProQuest. The researcher focused on studies within the last decade, mainly in the field of psychology. The researcher conducted an extensive search for the most frequently cited papers on topics related to "compassion fatigue", "secondary trauma", "burnout", and "vicarious trauma". Additionally, the researcher reviewed the bibliographies of these papers for any relevant additional literature. As a result, all studies included in the analysis focused on assessing one or more of the constructs among helping professionals who have experienced trauma exposure through their work.

3.5.3 Semi-Structured Interviews

According to Seidman (2006), interviewing is a widely endorsed data collection method in participant-centred research. Data collection for this study was conducted through semi-

structured in-person interviews. Burgess (2002) characterises semi-structured interviews as purposeful conversations guided by an interview framework. This structured approach ensures that key topics are covered while allowing flexibility with questions to explore interesting points further. Semi-structured interviews are known for fostering in-depth discussions and often lead to discovering new insights and perspectives on the research topic (Burgess, 1984). As noted by (Lopez & Whitehead, 2012), a limitation to conducting interviews is the challenge for the researcher to temporarily put aside their own prejudice, bias and "internalised data" (p131).

Interviews began on March 19th and concluded on March 27th, 2024. The researcher conducted in-person, one-to-one interviews with participants in a private office on KTHCDP premises. The interviews ranged from 27 to 60 minutes. The researcher developed an interview guide (see Appendix 1) by incorporating insights from the literature review and theoretical framework of the study. Additionally, the researcher incorporated feedback from KTHCDP staff and reflections upon the work of peer-led research conducted by Irish Traveller academics Friel (2021) and McGinley (2021). The questions were a blend of structured and open-ended queries. Interviews were recorded via the researchers' student Microsoft Teams account at UCC, which is password-protected. Once the researcher had completed transcribing, the recordings were permanently deleted. Each research participant was assigned a generic pseudonym to ensure confidentiality, and all identifying information was removed (Clarke & Braun, 2017).

3.5.4 Thematic Analysis

Figure 5 (adapted from Clarke & Braun, 2017)

Thematic analysis (TA) offers a structured framework for "identifying, analysing, and interpreting patterns of meaning" within the data (Clarke & Braun, 2017, p.279). Drawing on

Braun and Clarke's (2017) six-phase framework illustrated in Figure 5, the researcher systematically analysed and familiarised themselves with the interview data. The researcher listened to each interview and reviewed the transcripts four times. TA involves identifying themes by grouping elements of ideas and experiences into meaningful clusters that could otherwise be meaningless when viewed in isolation (Aronson, 1994). According to Maguire & Delahunt (2017), a lack of "focus on rigorous and relevant thematic analysis" can undermine the integrity of the research study. A common error by novice researchers is to mistake research questions for themes, which shows that the data was "summarised and organised, rather than analysed" (Maguire & Delahunt, 2017, p.3353).

The data (interviews) was analysed for recurring terms. These terminology, or "codes", were then categorised into themes which reflected the participant's experiences and aligned with the research question (Clarke & Braun, 2017, p.279). The researcher reviewed these themes to ensure coherence and relevance, eliminating data that did not align with the emerging patterns (Noble and Smith, 2015). The researcher also examined the relationships between primary and sub-themes, refining the analysis to capture the nuances of the data. By adhering to Braun and Clarke's (2017) framework, the researcher could distil the interview data into meaningful insights, shedding light on key issues such as the participant's exposure to trauma.

3.6 Ethical Considerations

Walsh et al. (2001) describe ethics in research as "the standards of behaviour and the practical procedures that researchers are expected to follow" (p.70). Ethical research involves respecting the research participants by enabling them to make informed choices about their involvement and treating them with dignity throughout the research process (Becker et al., 2012). Moreover, it requires safeguarding participants from harm and minimising risks associated with the research. Privacy and confidentiality are paramount in data collection, management, and reporting. Central to ethical research are the VIP principles: Vulnerability, Informed Consent, and Privacy (Blanford, 2013, p.18).

In relation to this primary research study, obtaining ethical approval from the Master of Social Work research ethics committee was mandatory, and it was received on January 16th, 2024 (See Appendix). In light of the sensitive subject matter, the ethics committee requested a

detailed plan for participant protection and strategies for researcher self-care to mitigate the effects of psychological distress should it arise.

KTHCDP assigned a dedicated mental health support worker should any research participants, including the researcher, experience any distress during the process. The researcher provided each participant with an information sheet containing the contact information for mental health support networks, including Traveller culturally appropriate agencies. Regular check-ins and supervisory sessions with their UCC supervisor were integral throughout the study. Guided by Lopez and Whitehead (2012), the researcher provided information sheets and consent forms highlighting the voluntary nature of participation and the rationale for the research. Participants were assured of their right to withdraw consent at any stage without questioning their decision or facing any repercussions. During the study, sensitive information concerning the clients and the research participants was revealed; therefore, the researcher ensured confidentiality by using pseudonyms and destroying the transcripts and interviews once the research was completed. Because the research involved very detailed personal stories and a small group of participants, it was challenging to ensure anonymity. The participants decided who would take part in the study. As a result, the researcher has not attributed any of the quotes in this research to specific individuals.

As noted by Lopez and Whitehead (2012), "in the interview process, the participant needs to be made feel as comfortable as possible" (p.129). The researcher provided pastries, refreshments and tissues and took active steps to minimise disruption, such as disabling their phone. Interviews were capped at 1.5 hours to avoid "interview fatigue" (Lopez and Whitehead, 2012, p.129). Participants were informed that all identifying information would be anonymised and their data would only be accessible to the researcher and their supervisor, stored on a password-protected database in UCC for a maximum of 13 months.

3.7 Challenges and Limitations

The research participants highlighted their preference for face-to-face interviews. As noted by Lopez and Whitehead (2012), interviews can be "time-consuming and resource-intensive" (p.131). Coordinating participants' busy schedules with the researchers' academic commitments posed a logistical and time-resource challenge. While the research sought to include the voices of Irish Traveller staff in KTHCDP, the findings cannot purport to represent

all Traveller staff working in other NGOs. Therefore, it is advised that the findings would not be used to make broad generalisations about trauma exposure of Irish Traveller staff across different organisations. A further limitation was the lack of perspectives from non-Traveller staff as this would have enriched the research. However, the findings of this particular study are intended to inform an existing Traveller-specific trauma awareness initiative, which, coupled with the stringent research timelines, required a more focused approach.

Conclusion

This chapter outlined the phenomenological approach adopted in conducting the research study. Grounded in constructivism, the study adopted a CBPR methodology to explore the experiences of trauma exposure among Irish Traveller staff in KTHCDP. Reflexivity to address potential research bias and ethical considerations were paramount throughout the research process.

Chapter Four: Results

4.1 Introduction

This study aimed to explore the experiences of staff members from the Kerry Traveller Health and Community Development Project (KTHCDP), who work with traumatised individuals. The aim was to give a voice to those who work with the Traveller community and often bear the emotional burden of serving clients. Research shows that first responders, including social workers and therapists, are vulnerable to occupational hazards such as secondary trauma, vicarious trauma, and burnout (Figley, 1995; Woods, 2020). Consequently, measures are taken to promote protective factors among these professions, ensuring employees know warning signs and how to seek treatment. However, this level of guidance is not afforded to all helping professionals. This study aims to highlight the importance of raising awareness about trauma exposure among Irish Traveller advocates and offering information about resources promoting well-being. The following research questions were posed:

1. Discuss the most common types of trauma exposures experienced by the Traveller staff at Kerry Traveller Health and Community Development Project.
2. What impact does trauma exposure have on Irish Traveller staff's well-being?

3. What factors challenge or contribute to Irish Traveller staff's perseverance, and what resources or support are instrumental in this process?

This chapter will present the findings from interviews conducted with six Traveller staff members from KTHCDP. The interviews focused on three main aspects: (1) the types of trauma exposure that the research participants have experienced, (2) how these experiences of trauma have impacted them, and (3) the strategies that the research participants use to cope with these experiences.

4.2 Theme 1: Trauma Histories

Several recurring themes emerged among the participants during discussions about why they chose to work in this sector. The most common responses shared centred around personal experiences of trauma, which influenced their decisions to pursue careers in KTHCDP. This was articulated against a backdrop of sorrowful experiences regarding the premature or unexpected deaths of loved ones, often due to tragic circumstances. One participant powerfully reflected on a past trauma they still *"live with every day",* stating:

"We had a huge trauma… There were no services available to us. Well, they were there, but we were never offered them. So we didn't know any different, and I always have that in my head... I try to help people from my experience."

The tragic loss of loved ones served as a catalyst for some participants to seek education and become proactive within the Traveller community. The strong desire to understand and prevent such tragedies is captured in the words of another participant:

"I suppose to educate myself and to educate my community and my family. You know, there was no blame game there… Each one of us used to ask the question, how? Why, like? So that's what brought me into this role then, like."

All six participants mentioned protective instincts towards younger community members, including children, nieces, nephews and siblings, as motivating factors in their work. In the words of one participant who experienced emotional abuse in childhood, *"I know it's shame, but what can I do? I've faced it. I've been through it… I wasn't going to let my [relative] go*

through what I've been through." While another participant mentioned Traveller discrimination, *"It goes against every human right that is there, equality, inclusion… for us we are standing the fight because we are looking to the future of our children."*

While the recurring themes from the interviews reveal a prevalence of trauma histories among the participants, they also highlight a remarkable resilience and capacity for growth. Driven by their personal experiences, the participants were inspired to pursue professional advocacy roles, demonstrating a strong commitment to delivering positive change for other Travellers who may encounter similar challenges.

4.3 Theme 2: Primary and Secondary Trauma Exposure

The interviews explored the types of trauma that participants encountered in their professional capacities. Their experiences varied depending on their roles. Several primary traumas experienced by Traveller service users, which, in turn, affected the Traveller staff were identified. These included incidents of discrimination, addiction, domestic violence, premature deaths and children being placed into the care of Tusla. The recurring theme of suicide was prevalent, directly and indirectly impacting five participants. One participant poignantly stated:

"*Suicide would have been a big one, like in the community, you know, accidents and dying young. A lot of people suffering with depression… younger people. You come across that a lot like gambling addiction, drug addiction, you name it really, like… It's hard*."

Participants often act as first responders, a role that deeply intertwines with their community ties. This participant shared their response to a suicide crisis:

"*My phone rings, quick, quick, quick, my [name] is hanging off the [location]… That, for me, I think it was very hard at the time. For me, I wasn't able to cope with it on the day because I felt I owed it to [person] that rang me for help, and I couldn't get the ambulance there fast enough*."

Responding to crisis situations was a prevalent theme; *"Parents ringing me and telling me that they were in A&E with their child. That they had to cut their child down off a rope and things."* The participants not only talked about their experiences supporting individuals struggling with

suicidal ideation, but also about their experiences of responding and supporting families impacted by suicide. Another participant recalled a personal tragedy:

"[victim] committed suicide, and that was kind of a big trauma, for everybody, most people in the project, because everybody knew [victim]… we (staff) would have gone out together… [victim] would have been in our company."

These narratives highlight the intersecting role Traveller staff play and the complex impact of suicide on Traveller staff, affecting them in a professional and personal capacity.

4.4 Theme 3: Unable to switch off

All participants described the emotional and psychological toll of their work, specifically mentioning difficulties with sleeping and '*switching off'* from their responsibilities. One participant shared the depth of their concern:

"It would play on your mind because you're saying, lads, we know these people. We grew up with them all our lives… I often went to bed and, my mind would be working, you know, going round and round and round thinking about the one thing all night…"

Another participant, recalling a distressing incident when supporting a young Traveller child who was called a racial slur in school, shared:

"My legs started to shake, my hands started to shake. I went into a kind of fight and flight. I couldn't drive the car… if I hear the term 'Knacker' used, it just boils something up inside me. It changes me into something that I'm not."

When asked how they maintain a healthy work-life balance, almost all of the participants revealed difficulties in separating their personal and professional lives, with one participant noting:

"It's very hard for Travellers to switch off… It's alright saying don't bring your problems home but we are the kind of people that do bring our problems home. For the simple reason,

we're thinking, is that family okay? Have they lights? Have they enough to eat? Have they water?"

While another participant reflected on being constantly accessible:

"If somebody else is 9-5, their phones are off. You can't do that in the Traveller community, not when you're a Traveller yourself in the community, like… You can meet them in the shop or on your day off… so there is no switch-off period, really."

A third participant also echoed this sentiment:

"I could be in Tesco's… Out socialising on the weekend, and someone might bring up to me about domestic violence and things, you know? We can't switch-off like the settled people can switch off. We're in the community, and sometimes that's very hard as well."

These reflections demonstrate the strong commitment of participants to their community. However, the complexities of having close connections with clients as community members can affect professional responsibilities.

4.5 Theme 4: Lack of acknowledgement from other professionals

Four participants echoed a common theme of feeling undervalued by the wider professional sector. One participant shared; *"I would love to see respect… Just because we are employed by a local Traveller organisation doesn't mean we are any less than the person working in the HSE."* Another participant voiced the challenge of feeling ignored by other professionals: *"You never kind of get a reply from them… So I go to my line manager or my boss. They'll answer them back faster… So to me, you're not recognised as anyone then, like."* The feeling of being dismissed during a crisis was particularly poignant for another participant:

"It made me feel very, very low… I think they knew I was a Traveller on the phone and ehm; they weren't taking me serious enough. That's why I say I would like us to be acknowledged as professionals."

Another participant expressed frustration over their qualifications being overlooked:

"We have the degrees the same way they have them but we're not getting the credit for it… It's just challenging with the services, trying to get the services to trust you, to believe in you… We had to prove ourselves to them…"

While this participant expressed their hurt when meeting some non-Traveller professionals passing them a corridor:

"The expression on their face… For instance, if you met them in the hallway… you hold the door, they would just walk past, and, you know, never say thank you… Just a bad manner and you can just get that expression on their face."

4.6 Theme 5: Coping Strategies

4.6.1 Sub-Theme: Professional Development

Training and education emerged as crucial for all participants in handling professional challenges, enhancing skills, and fostering resilience. Programs such as the Social and Health Education Project (SHEP) and Applied Suicide Intervention Skills Training were specifically noted for their impact. One participant reflected, *"I learned through courses… the SHEP now, the coercive control courses… we would have had people in the organisation delivering training around counselling and things and managing our own personal issues and things."* Another participant stressed the necessity for ongoing professional development for Traveller staff, saying: *"Continuous professional development is key… we need professionals… we want Traveller professionals, but if they can't meet the criteria of what's been required, we can't give them the roles."*

4.6.2 Sub-Theme: Training for non-Traveller Staff

Most participants discussed Traveller Culture and Awareness Training (TCAT) as a valuable resource for addressing challenges experienced by Traveller staff. They said mandating such training in other agencies could enhance understanding of Traveller culture and prevent potential biases. As noted by one participant; *"With that (TCAT), they might have an*

understanding of where we are and what our culture is about… they might second think about what they're going to say and not be biased towards us."

4.6.3 Sub-Theme: Team Work

All participants highlighted the significance of trust, teamwork, open communication, and peer support, which was apparent in the strength of the team's relationships with their manager and feeling valued; *"We have a very good boss, and I'm not just saying that… we can say look this happened, and I can't stop thinking about it… we can go to our boss… we will get the reassurance…"* Another participant stated: *"It's a good workplace. I really have good bosses; we have a good connection and relationship with each other."* The next participant captured the essence of the collaboration between Traveller and non-Traveller staff in a powerful observation:

"*We're not lone rangers, but together, our skillset is magnificent… Alone with just say me, as a [role]… I wouldn't be as powerful as I am, as with my team that's around me. If I need …. help… all I have to do is knock on their door… So we work holistically as a team… that's the biggest support that I have.*"

4.6.4 Sub-Theme: Organisational Resources

All participants expressed that management had a genuine concern for their well-being. A positive relationship with the team leads and the general manager was repeatedly mentioned, including job flexibility when needed, with one participant noting; *"We could take time off, or we are always offered to work from home if we are after having an experience."* Another participant succinctly articulated the support and resources available:

"We can get counselling and stuff like that ourselves through the organisation. And through our team, you'd have great support… My line manager would be a very, very good support to me and even [name] my boss. There's a good network here to bring you through it."

All of the research participants confirmed that they received professional supervision. However, there was a variation — some participants described supervision as irregular but always available upon request. One participant stated: *"There is no official protocol in place if*

that makes sense… and I suppose with mental health so high in the community, that would be a concern for me." In contrast, other participants described a more consistent and structured approach:

"We usually have it once a month… if we have any challenges or any issues… we'll talk about it… what I didn't like, what did work well, what didn't work well,… how can we change it for the next time… If they didn't like something I did or I didn't like something they did, we'll talk about it."

As noted in the literature review, structured reflective supervision among professionals exposed to primary and secondary is crucial for the well-being and safety of staff (Menschner & Maul, 2016). Van Dernoot Lipsky & Burk (2007), widely recognised that many practitioners may also be survivors of trauma. Therefore, there is an increased risk of psychological harm, particularly when a client's experiences are similar to those of the supervisee's. Staff may need support from their supervisor to handle boundaries in current or future cases.

4.6.5 Sub-Theme: Self-Care

The majority of participants discussed various self-care practices, including but not limited to meditation, gardening, the gym, spending recreational time with family and friends and spiritual practices. As noted by one participant: "*I kinda go away for walks*." While another participant recounted detailed coping and self-care strategies:

"So when I wasn't sleeping... If I heard of suicide… it would come to the forefront of my mind… I can see it like it was yesterday. But I managed to cope… I did a lot of [activity] and then I sought professional help to try to, kinda, come to terms with it."

Chapter Five: Discussion and Analysis

5.1 Discussion

The Key objectives of this CBPR study were to explore the following:

The purpose of this study was not to measure or diagnose trauma. Rather, it was to explore the impact of trauma exposure. The aim of the thematic analysis was to capture the majority of re-occurring themes, which in this section turned out to be:

(1) Wounded healers – past history of trauma
(2) Primary and secondary trauma exposure in the workplace due to the high rates of suicide among Travellers.
(3) Cost of caring – negative consequences and challenges of working with trauma
(4) Lack of professional recognition
(5) Resilience and coping strategies

The themes were decided to ensure they addressed the research questions, which were: Discuss the most common types of trauma exposures experienced by the Traveller staff at Kerry Traveller Health and Community Development Project; What impact does trauma exposure have on Irish Traveller staff's well-being? What factors challenge or contribute to Irish Traveller staff's perseverance, and what resources or support are instrumental in this process?

5.2 Wounded Healers

As noted in the literature review, an estimated 60% of helping professionals have experienced traumatic events in their personal lives (Mathieu, 2012). The interviews with KTHCDP participants revealed a similar trend, as the majority reported a history of trauma, often related to discrimination and the unexpected or premature death of loved ones, including death by suicide. These traumas were not a surprising find because, as outlined in the literature review, the Traveller Community National Survey in 2017 found that 77% of Travellers experienced discrimination in the past year. Life expectancy for Irish Travellers is an average of 66 years, with an infant mortality rate 3.5 times higher than the general population, and 10% of Traveller children die before the age of two (AITHS, 2010; Reilly, 2018). This is borne out by the data collected with KTHCDP research participants.

The findings of this research correspond with Satterthwaite's (2018) observations that many human rights advocates come from the communities they advocate for. Similarly, participants in this study cited several motivating factors for their desire to work in the Traveller NGO sector, with most of them rooted in using their personal experiences of trauma to support others

who may be going through similar challenges. Woods (2020) and Conti O'Hare (1998) use Carl Jung's 'Wounded Healer' archetype to describe professionals such as the research participants for this study.

As one participant shared: "*We had a huge trauma… I try to help people from my experience."* Another participant was motivated to educate themselves and their community following the suicide of a loved one, aiming to foster empathy rather than blame. These personal accounts align with the perspectives of Laskowski & Pellicore (2002), suggesting that the participants' advocacy work has helped with their own healing journeys, which also serves as a form of self-care (Barnett, 2007). One research participant at KTHCDP perfectly summed up the sentiment, stating that advocacy work can give *"you the voice you're looking for"*. Extensive research indicates that the level of trauma one experiences can vary, depending on factors such as proximity to the traumatic event, trauma history, and access to resources like therapy or social support (Lynch, 2017). The study's results suggest that working in advocacy was an important factor in mitigating the negative effects of trauma. As noted by another participant, *"the best privilege that you can actually have because you can see the benefit yourself"*.

The participants of this study demonstrated strong characteristics of resilience and post-traumatic growth. One participant succinctly expressed: *"I've faced it. I've been through it…"*. Their determination not to let younger Travellers face the same hardships is a testament to the power of resilience. As noted in the literature review, resilience is the ability to bounce back from adversity (Rutter, 2007; Yao & Hsieh, 2019), while post-traumatic growth theory highlights the positive psychological changes that occur because of experiencing trauma (Tedeschi et al., 2018). As outlined in this study, the participants transformed their traumatic experiences into a commitment to deliver positive change for their community. This is consistent with the literature regarding Wounded Healers along with PTG and Resiliency, which suggests that people who experience trauma can often achieve growth in its aftermath (Wood, 2020; Vieselmeyer et al., 2017).

5.3 The Dual Trauma of Suicide

Much like the study by Tobin et al. (2018) on Irish Traveller health workers, the participants from KTHCDP are a distinct research sample due to their ethnicity and their professional roles within their community. The participants' extensive knowledge of the issues that impact Irish

Travellers is further strengthened by their strong collaboration with other agencies on a local and national level. Given that the research participants were sampled based on their professional roles within the Traveller NGO sector, the researcher theorised that suicide would emerge as a secondary (indirect) trauma exposure, and this was proven accurate in the data. The recurring theme of suicide is in line with the literature that 11% of Traveller deaths are caused by suicide, with 65% of Traveller suicides occur among individuals under the age of 30 (AITHS 2010; Quirke 2020; Rorke 2023). These statistics coincide with a statement from one participant who described youth suicide as a secondary trauma when recollecting Traveller parents ringing them because *"they had to cut their child down off a rope"*.

However, the researcher did not anticipate the prevalence of suicide as a risk of primary trauma exposure due to several research participants acting as first responders in crisis situations.

One participant cited the suicide of a close friend and fellow Traveller as *"a big trauma for everybody"* while also highlighting *"we know these people. We grew up with them all our lives."*

The findings of this study highlight that Irish Traveller advocates can experience dual trauma, firstly as professionals responding to or supporting individuals impacted by suicide and secondly as community members. As noted in the literature review, a key characteristic of Irish Travellers is their extended family system and the close-knit ties of the community. Traveller professionals who work within the community can have very close relationships with the people they are supporting. As a result, suicide can be experienced as either a primary or secondary trauma.

5.4 The Cost of Caring

One research participant described experiencing fight-or-flight responses upon hearing the racial slur "*knacker*" used against a young Traveller. This aligns with research by trauma expert Bessel Van Der Kolk (2005) who notes that traumatic incidents tend to create distinct behavioural and biological responses that serve as reminders of the trauma. In simpler terms, the trauma can resurface as a physical or emotional reaction rather than a memory. Another participant described themselves as a *"workaholic"*, finding it challenging not to bring work home. This aligns with Satterthwaite's (2018) findings that many human rights workers are at

risk of emotional exhaustion as they believe that their work is critical therefore, they can struggle to "take a break or step back" (p. 487). Similar to the participants in this study, Satterthwaite (2018), also notes that some human rights advocates have difficulty establishing boundaries because of the high level of need in their sector. As a result, this can cause advocates to feel indispensable and, in turn, vulnerable to psychological and emotional harm.

The most frequently reported challenge among five of the research participants was the inability to establish and enforce clear boundaries or to *"switch off"* from their professional responsibilities. This phenomenon is complex and highlights the intersectionality of being both a community member and a professional advocate within the community. This finding coincides with Tobin et al. (2020), who discuss the intersectionality among Traveller health workers who "live and work in the midst of extensive grief" and loss due to their dual status within the community (p.147).

During the interviews, several research participants noted an occupational contrast between Traveller and non-Traveller staff at KTHCDP, *"we can't switch off like the settled people can switch off*." The participants discussed with sincerity, that Traveller staff face unique challenges as they live within the community. This sentiment is consistent with Satterthwaite's (2018) findings, which highlight that human rights advocates from minority backgrounds often live within the communities they represent. Furthermore, Traveller staff can experience discrimination or intergenerational burdens that their non-Traveller counterparts do not. However, this does not suggest that non-Traveller staff are not impacted by trauma exposure, it simply highlights that they may experience or be affected by the work differently.

This study found that the participant's difficulty in *switching off* from work is associated with disrupted sleep. This was not surprising considering the upsetting narratives of the interviews. One participant discussed instances of premature deaths, addiction, and mental health issues among Traveller service users as difficult. Another participant recounted distressing conversations with parents who had to intervene when their children attempted suicide through hanging. As outlined in the literature review, individuals who struggle with sleep disturbance, intrusive thoughts, and vivid recollections of traumatic events are at an increased risk of compassion fatigue or secondary traumatic stress. According to Figley (1995), this is the "cost of caring" and the "natural behaviours and emotions that arise from knowing about a traumatising event experienced by a significant other – the stress resulting from helping or

wanting to help a traumatised person" (p.xiv). VT can have both personal and professional impacts.

Notably, Figley (1995) notes that people with a past history of trauma are also more vulnerable to experiencing compassion fatigue. This is significant to this study as several of the research participants reported experiencing a trauma in the past. According to the literature review, professionals with a history of trauma can be susceptible to countertransference reactions with their clients. This means that the practitioner may find it difficult to establish clear boundaries or unconsciously project their unresolved trauma onto their clients or try to fulfil their personal needs through the working relationship. As noted by Corey (1991), while it may not be possible to eliminate countertransference entirely, it is important to be able to recognise and address it through supervision. By managing countertransference, practitioners can maintain healthy relationships and prevent potential harm or the re-traumatisation of their clients.

5.4 The Soft Bigotry of Low Expectations

According to The All-Ireland Traveller Health Study (2010), more than two-thirds of healthcare providers acknowledged Travellers can experience discrimination in healthcare settings due to the perception of being less deserving. More recent studies indicate that many Travellers avoid mainstream services due to feelings of stigma and distrust (Villani, 2023; Friel, 2021; Quirke, 2020; Mckey et al, 2020. These sentiments were echoed by several of the research participants who discussed a lack of acknowledgement by some professionals from other services. Consequently, several of the participants described feeling "*low*" and "*not recognised as anyone"* when attempting to engage with some professionals. Another participant discussed their hurt concerning a lack of basic etiquette, such as holding the door open for non-Traveller professionals and *"they would just walk past, and, you know, never say thank you"*. One participant believed that their qualifications were not acknowledged due to their ethnicity, requiring them to constantly feel that they have to "*prove* them*selves"*.

This poverty of expectation reflects the low academic expectations that teachers have for Traveller students, as per the findings of McGinley (2021). Boykin (2013) refers to this phenomenon as the Soft Bigotry of Low Expectations, a type of discrimination experienced by individuals or communities who are held to a lower standard based on their ethnicity or social status. Boykin (2013) suggests that this bias is rooted in the belief that marginalised or ethnic

minority groups are inherently disadvantaged and in need of saving, ultimately revealing underlying beliefs of superiority among the dominant group. This conscious or unconscious bias can limit positive outcomes and opportunities for minority individuals. The findings of this study highlight the importance of challenging negative stereotypes, which can perpetuate inequality and restrict Travellers' ability to maximise their full potential as professionals.

The research participants were asked how discrimination and bias against Traveller professionals could be mitigated, and they overwhelmingly referred to Traveller Culture and Awareness Training (TCAT). As noted by one research participant, *"With that [TCAT], they might have an understanding of where we are and what our culture is about… they might second think about what they're going to say and not be biased towards us."* This suggestion is in line with the findings and recommendations of Villani et al. (2023), who believe that TCAT can help build mutual trust and inclusion through the development of culturally appropriate services. Villani et al. (2023) recommend developing and standardising TCAT training to maximise its impact by ensuring that the rationales, content, and potential outcomes of the training are consistent nationally (p.79).

According to Shepherd (2019), while cultural awareness training is well-intentioned, its effectiveness lacks concrete evidence. Shepherd (2019) notes that the common workshop format is often too short for attendees to fully understand and effectively apply the information. These sessions often focus on health issues, historical injustices, and the suffering of the cultural group, which may inadvertently evoke pity and reinforce a bias of helplessness rather than enhancing the practitioner's ability to effectively communicate or engage with the cultural group. Shephard (2019) suggests that staff training should focus on issues concerning the specific community locally rather than homogenous or broad generalisations. Additionally, training should be more reflective and aim to reinforce important values such as openness, non-judgment, and responsiveness among staff members (Shephard, 2019).

When conducting the interviews, the researcher was not familiar with Shephard's (2019) findings and, therefore, did not ask the participants follow-up questions about why they believed TCAT training was effective. It would be valuable to determine whether the services the participants have challenges with engaged in TCAT and whether KTHCDP has noticed any positive changes as a result.

5.5 Professional Perseverance

The findings of this study highlight that all of the research participants report high levels of job satisfaction and are passionate about their work. One participant remarked that their job *"fulfils"* them, while another considered it *"the best privilege"*. Furthermore, the findings suggest that the participants have developed a strong sense of resilience through their lived experiences which they have been able to utilise as a personal strength. As noted in the literature review, professionals can experience post-traumatic growth and high levels of job satisfaction, including confidence in their skills, as a result of witnessing the people they support grow and heal. Additionally, when asked about what resources and support were most helpful to them in their professional experience, the majority of participants highlighted the value of continuous professional development. This echoes the findings of Menschner & Maul (2016) on the impact of learning on professional growth.

All the participants discussed the importance of teamwork, peer support, and trust within the organisation, encompassing Travellers and non-Traveller staff. One participant noted, "*We work holistically as a team… that's the biggest support I have"*. The participants expressed that management had a sincere interest in the well-being of the staff. A prevalent theme emerged regarding the positive relationship between the participants, their team leads and the general manager; *"My line manager would be a very, very good support to me and even my [name] boss. There's a very good network here to bring you through it"*. The study revealed that all of the participants displayed a high level of familiarity regarding the availability of counselling supports through KTHCDP and were well-informed on how to access them if needed. Participants also noted that they could take time off or work from home after a difficult experience. The findings of this study suggest that KTHCDP management has fostered a strong sense of trust and safety among staff, which are key characteristics of trauma-informed care (SAMHSA, 2014).

Chapter Six: Conclusion and Recommendations

6.1 Introduction

This research sought to explore the following questions: How does exposure to trauma manifest among Irish Traveller staff who work with distressed individuals? What impact does trauma exposure have on Irish Traveller staff's well-being? What factors challenge or contribute to Irish Traveller staff's perseverance? What resources or support are instrumental in this process? This chapter will make a number of recommendations based on the findings of this research. The research will share the findings with KTHCDP and present them in person to the team.

6.2 Recommendations

The researcher would recommend the following:

1. **Trauma-Informed Training:** KTHCDP has begun the initial stages of developing trauma-informed care (TIC) training for staff members. A recommendation would be to include all staff members, including receptionists, as they may often be the first point of contact for service users, either in person or over the phone. TIC training should also extend to volunteers to ensure a uniform understanding of trauma across all departments.
2. **Peer Support and Advocacy:** Explore the possibility of developing peer support groups and mentoring programmes with other Traveller NGOs where all advocates can share their experiences and coping strategies in a supportive environment. Validating their experiences and sharing coping mechanisms will help mitigate potential feelings of low self-esteem.
3. **Reflective Supervision:** Provide regular and structured professional reflective supervision to all staff and volunteers.
4. **Boundary Setting and Work-Life Balance:** Develop an initiative that supports staff in establishing and maintaining healthy boundaries between their professional and personal lives. Explore practical options that staff may be able to incorporate to disengage from work, which is crucial to preventing burnout and compassion fatigue.
5. **Addressing the Soft Bigotry of Low Expectations and Enhancing Professional Recognition:** Re-evaluate the Traveller Cultural and Awareness Training to assess whether it could be enhanced so that non-Traveller practitioners are encouraged to reflect upon their personal values and ethics.

6. **Continuous Professional Development:** Continue to empower staff to utilise their unique skills and valuable knowledge by availing of further education and training opportunities to promote their career development and promotion opportunities.
7. **Research and Continuous Learning:** Explore possible ongoing Traveller led research and feedback mechanisms within the Traveller NGO sector to continually assess the impact of trauma on staff and to refine support strategies accordingly. This might include developing case studies, conducting regular surveys, and updating training programs based on the latest trauma and mental health research.
8. **Self-Care Funding:** When applying for funding for initiatives, the cost of meeting staff psychosocial needs, such as a well-being or self-care activity, should be included. Funders need to be reminded of the value and importance of trauma-informed care.
9. **Non-Traveller Staff:** The researcher is conscious that the voice of non-Traveller staff is not incorporated in this report. Therefore, a recommendation would be to assess how non-Traveller staff experience trauma exposure.
10. **Supervision for team leads and management:** There is a lot of responsibility assigned to management of KTHCDP, therefore a further recommendation would be to ensure management are kept psychologically safe and have access to regular supervision also.

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Appendices

Appendix 1: Information Sheet

Interview Participation Consent Sheet

Thank you for considering participating in this research project. This document explains what the work is about and what your participation would involve, enabling you to make an informed choice.

This study focuses on exploring the experiences of work-related trauma exposure among staff at the Kerry Traveller Health Community Development Project (KTHCDP). The research is conducted by Anne Marie Quilligan, a Master of Social Work student from University College Cork, as part of the Community Action Research Links (CARL) project for KTHCDP. If you decide to participate, your involvement will include participating in a one-to-one interview. It is anticipated the interview will last between 40 to 60 minutes and will be audio-recorded.

Participation in this study is entirely voluntary. You are under no obligation to take part, and if you choose to participate, you can opt not to answer specific questions or withdraw from the interview at any time. You have a three-week window following the conclusion of the interview to withdraw your contribution.

All of the information you provide will be kept confidential and anonymous and will be available only to the researcher Anne Marie Quilligan and their U.C.C supervisor, Sara Kelleher. The only exception is where information is disclosed, which indicates that there is a serious risk to you or to others. In the event that information is disclosed during the course of this research that indicates a serious risk to the participant or others, the following steps will be taken:

The researcher, Anne Marie Quilligan, will conduct an immediate assessment of the situation to determine the nature and severity of the identified risk. If deemed appropriate and feasible, the researcher will contact the participants to discuss the disclosed information, assess their well-being, and explore potential interventions. The researcher will promptly consult with their U.C.C. supervisor, Sara Kelleher, to discuss the situation, share relevant details, and seek guidance on the appropriate course of action. If necessary, the researcher, in consultation with their supervisor, will make referrals to relevant support services or appropriate authorities, to ensure the safety and well-being of the participant and others. The ethical oversight body responsible for this research will be promptly notified of the identified serious risk, outlining the steps taken and the outcomes of any interventions. The entire process, including the identification of the serious risks, actions taken, and outcomes, will be thoroughly documented in accordance with ethical guidelines. This documentation will be made available to the ethical oversight body upon request.

Once the interview is completed, the recording will be immediately transferred to an encrypted laptop and wiped from the recording device. The data will then be transcribed by the researcher, and all identifying information will be removed. Once this is done, the audio recording will also be deleted, and only the anonymized transcript will remain. This will be stored on a University College Cork-supported cloud storage platform UCC Microsoft Teams account. The data will be stored by U.C.C for at least ten years.

The information you provide may contribute to research publications and/or conference presentations. In addition, the researcher will use the data to contribute to a dissertation and a Community Academic Research Links report.

We do not anticipate any negative outcomes from participating in this study. We do not intend to cause any distress to participants. Some of the topics broached in the interview, however, are of a sensitive and personal nature. Should you wish to do so, you can choose not to answer questions or to bring the interview to an end at any time. Should you experience distress arising from the research process, a designated support person will be assigned to offer you support via Andy Walker, KTHCDP health coordinator. Additionally, the contact details for support services provided below may be of assistance.

- Samaritans are there for everyone 24 hours a day, seven days a week, on freephone 116 123
- Pieta House 1800 247 247
- Text: 'HELLO' to 50808
- Text: 'PAVEE' to 50808
- Irish Traveller Counselling service, 9 am to 6 pm.
  Landline: 01-8685767 Mobile:086-3081476 Email: info@travellercounselling.ie

This study has obtained ethical approval from the UCC Social Research Ethics Committee.

Appendix 2: Consent Form

Research Interview Consent Form

I……agree to participate in Anne Marie Quilligan's research study.

The purpose and nature of the study has been explained to me in writing.

I am participating voluntarily.

I give permission for my interview with Anne Marie Quilligan to be audio recorded.

I understand that I can withdraw from the study, without repercussions, at any time, whether before it starts or while I am participating.

I understand that I can withdraw permission to use the data within three weeks of the interview, in which case the material will be deleted.

I understand that anonymity will be ensured in the write-up by disguising my identity.

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I understand that disguised extracts from my interview (e.g. my name / location won't be used) may be quoted in presentations and publications (e.g. article, book chapter, student thesis, social media publicity of the study's findings, etc.), if I give permission below (please tick one box):

I agree to participate in this study ☐

I do not agree to participate in this study ☐

Signed: …….. Date: ……..

PRINT NAME:……

Appendix 3: Interview Questions

Research Participants one to one Interview Questions:

1. Can you tell me how long you have worked with Kerry Travellers Health Community Development Project?
2. Do you work directly with members of the Irish Traveller community as part of your role?
3. What motivated you to become an Irish Traveller human rights advocate?
4. What would you consider the most difficult part of your job?
5. What are some of the most common work-related traumas that you have experienced in your role as an advocate?
6. How did that make you feel?
7. How do you cope with the emotional demands of your work?
8. Can you describe some of the challenges you face when working with traumatised individuals?
9. How do you maintain a healthy work-life balance?
10. What resources or support do you find most helpful in your work?
11. What are some of the most rewarding aspects of your job?
12. How do you think your work contributes to the Irish Traveller community?
13. What changes would you like to see in the way that Irish Traveller human rights advocates are supported?
14. What advice would you give to someone who is considering a career in Irish Traveller human rights advocacy?
15. Is there anything else that we haven't covered that you would like to add?

Appendix 4: Research Ethics Committee Approval

UCC
University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

MSW Research Ethics Committee
School of Applied Social Studies

Applicant:	Anne- Marie Quilligan, 2023/24
Committee Date:	16th January 2024
Tutor(s):	Sara Kelleher
Reference:	2023-1

Dear Anne-Marie

Thank you for your resubmission to the MSW research ethics committee.

Your application is **approved, with minor changes**. The committee made the following observations below: you need to discuss these with your tutor, but you do not need to resubmit. You need to send one email to k.burns@ucc.ie by Friday 19th January to say that you accept the recommended changes and that you will work on these changes with your tutor.