AN INVESTIGATION INTO THE EFFECTS OF VICARIOUS TRAUMA EXPERIENCED BY HEALTH CARE WORKERS

by

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DECLARATION

I declare that **AN INVESTIGATION INTO THE EFFECTS OF VICARIOUS TRAUMA EXPERIENCED BY HEALTH CARE WORKERS** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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SIGNATURE **DATE**

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ABSTRACT

This study features an examination of the effects of working with traumatised individuals, namely vicarious traumatisation. Predictor variables such as age, career longevity, personal trauma history and workload were correlated with vicarious trauma. Support systems used by nurses were explored. The questionnaire consisted of items of the TSI Belief Scale, demographic characteristics of persons with a personal trauma history, work related aspects and support systems. Participants were 37 nurses (30 female and 7 male) who render a community mental health service in the Cape Metropole. Results of the study indicate that the variables *age* and *career longevity* were statistically significantly related to vicarious trauma. There was no relationship between personal trauma history, workload and vicarious trauma. The nurses identified the psychiatrist and psychologist as their main support systems in dealing with vicarious trauma. Recommendations were made to assist the organisation and nurses on how to deal with vicarious trauma.

KEY CONCEPTS

Vicarious trauma/traumatisation, nurses, compassion fatigue, secondary traumatic stress.

DEDICATION

This study is dedicated to all the nurses rendering a mental health service to victims of

trauma, who amidst all the adversity faced in their daily work, persevere in order to create a therapeutic environment to aid in their

patients'
recovery.

List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
APA	American Psychiatric Association
CSDT	Constructivist Self Development Theory
HIV	Human Immune Virus
HIV/AIDS	Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome
MDHS	Metro District Health Service
PTSD	Post Traumatic Stress Syndrome
TSI	Traumatic Stress Institute
WC	Western Cape

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CHAPTER 1

Orientation to the study

1.1 INTRODUCTION

Traumatic events occur and affect people during their lifetime. Trauma may be the result of psychological events such as violence, for example being abused. Trauma can also be of a physical nature, for example learning that one has a terminal disease, such as cancer, or finding out about a positive Human Immune Deficiency Virus (HIV) status. The traumatised individual may seek the assistance of health personnel, such as nurses, to help them cope with these traumatic experiences. According to Figley (1999:8), traumatised people often complain that their friends and family discourage them from articulating their experiences, as it is too distressing for them to hear.

Nurses share their compassion with these traumatised people because of their caring nature (Schwam 1998:642). Health care professionals, specifically nurses, are trained in basic counselling skills to serve as counsellors to assist people to overcome the adverse reactions of trauma. Nurses assist those individuals affected by trauma to function optimally within their working environment (Figley 1999:4; Stamm 1997:3).

Nurses and other health care workers, who are exposed to others' trauma in their daily work, are often traumatised and overburdened by narratives and events that happened to others. According to McCann and Pearlman's (1990:136) Constructivist Self-Development

Theory (CSDT) (see section 1.10.2), nurses will give meaning to traumatic events depending on how they as individuals experience them. These interpretations of the traumatic events can result in nurses' experiencing changes in the way they view themselves, others and their world. McCann and Pearlman (1990:137) coined the term "vicarious trauma" to describe the disruptions in cognitive schemas (i.e., core beliefs about self, others and the world) and behaviour changes experienced by nurses who treat the traumatised (Steed & Bicknell 2001:2). Vicarious trauma is an occupational hazard for nurses and other health persons who care for and support trauma survivors (Pearlman & Saakvitne 1995a:31). Neuman and Gamble (1995:344) purport that nurses experiencing vicarious trauma begin to see the world through "trauma lenses" and Pearlman and MacIan (1995:558) suggest that continuous exposure to trauma survivors sustains this view.

The focus is usually on the effects of trauma on the primary victims and not on those who care for and support them (secondary victims) (Galea, Ahern, Resnick & Kilpatrick 2002:982; Kleijn, Hovens & Rodenburg 2001:527; Kubany 2002:111; Leskela, Dieperink & Thuras 2002:223). Because secondary victims are not directly involved in the traumatic event, their distress often goes undetected (Brady, Guy, Poelstra & Brokaw 1999:386). Shifts in this approach have to occur, as these secondary victims need to be assisted in their role as counsellors so that they can continue to help the primary victims to cope with their trauma.

Cunningham (2003:456), McCann and Pearlman (1990:146), Pearlman and Saakvitne (1995a:309; 1995b:165) focus on the personal trauma history of people who counsel the traumatised. According to them, personal trauma history may be indicative of vicarious

traumatisation as the nurse is exposed to the traumatic narratives of others, which conjures up painful memories of own traumatic experiences.

The effects of vicarious trauma experienced by nurses need to be understood in the context of the work environment.

Nurses who render a service to traumatised individuals, however, often become the victims of trauma themselves. It is thus imperative to ensure that psychological support services are developed to assist nurses to deal with their own vicarious trauma.

1.2 BACKGROUND TO THE STUDY

Nurses working at primary health care (PHC) clinics are the first contact for people who have been traumatised. The disease and violence profile of the South African society influences the nature of the nurses' work as it dictates what types of patients will be treated on a daily basis at the clinics. The disease profile of the Western Cape is changing as HIV/Acquired Immune Deficiency Syndrome (HIV/AIDS), tuberculosis (TB) and other diseases such as cancer influence it. Table 1.1 depicts statistics reflecting the mortality rate of diseases, which give an indication of the change in the disease pattern from 2000 to 2004 in the Cape Metropolitan area (excluding Oostenberg district) (City of Cape Town 2005:1).

Table 1.1 Disease mortality rate

Disease	2000	2001	2002	2003	2004
Communicable diseases including HIV/AIDS and TB	1367	2835	5220	4037	2796
Neoplasms (Cancer)	1368	2937	2603	3357	3124
Chronic diseases of lifestyle	4348	6915	8375	8085	8882

Source: City of Cape Town (2005:1)

According to table 1.1, deaths due to communicable diseases, including HIV/AIDS and TB, have increased by 107% from 2000 to 2001. This excessive increase could possibly be due to the mobility of people from provinces such as the Eastern Cape who seek employment and medical care in the Western Cape. Hattingh (2001:7) maintains that the process of industrialisation and urbanisation in South Africa has caused the influx of people in informal settlements around cities where disasters, such as outbreaks of disease, and social problems, such as poverty and unemployment, have increased. A decline of deaths by 23% from 2001 to 2002 due to communicable diseases is also depicted. This decline could possibly be due to the introduction of antiretroviral treatment for people with HIV/AIDS. In addition, there could be under-reporting of deaths due to communicable diseases in certain districts. Statistics on deaths due to HIV/AIDS are difficult to obtain as the cause of deaths on death certificates is usually indicated as complications of AIDS such as pneumonia. Table 1.1 indicates that deaths due to cancer and chronic diseases of

lifestyle also increased from 2000 to 2004 by 128% and 104%, respectively. These high death rates give an indication of the increase in the burden of disease and allude to the increased workload of nurses rendering a PHC service to victims of trauma at community health care centres.

The incidence of criminal activities such as violent attacks on people in the Cape Metropolitan area also increased. Table 1.2 reflects the change in the number of violent crimes.

Table 1.2 Violent crime rate

Crime category	**2000/2001**	**2001/2002**	**2002/2003**	**2003/2004**
Murder	2288	2296	2619	1863
Rape	3912	4040	3809	3679
Attempted murder	3079	3110	3894	2912
Indecent assault	1340	1554	1660	1799
Kidnapping	403	424	344	336
Abduction	461	437	504	472
Carjacking	632	759	931	992

Source: South African Police Services (2004:1)

The crime statistics depicted in table 1.2 reflect the various crime categories experienced by the population of the Cape Metropolitan area. In 2000/2001 and 2003/2004, violent crimes, such as rape, decreased by 5.9%. Under reporting of rape is common due to the

sensitive nature of the crime and the inadequate convictions of perpetrators that are reported. Crimes such as indecent assault, abduction and carjacking increased from 2000/2001 to 2003/2004 by 34%, 2% and 57%, respectively (see table 1.2).

Nurses work with victims of these violent crimes and often witness the severe physical and emotional trauma created. These visual scenes and hearing the conditions of the crime create psychological trauma in nurses. From table 1.1 and 1.2 it is evident that nurses working in hospitals and clinics are the people that need to deal with the changes in the disease and violence profile of the South African society as well as the social changes in the country, such as poverty and unemployment.

Nurses are often not equipped or trained to manage the demands made on their own mental health. The number of nurses also does not correspond with the inordinate demands made on them with the increased traumatic events that they have to handle. Hattingh (2001:2) emphasises that the health care system is overextended with patients presenting with social and mental problems and chronic diseases. This study therefore explores and describes the effects (secondary traumatisation) of working with primary victims of trauma to provide an insight into nurses' experience of vicarious traumatisation.

A total of 37 nurses render mental health care and psychiatric services to the population of approximately three million people in the Cape Metropolitan area (Department of Health 2003:11). The Cape Metropole is divided into eight sub-districts (see Annexure C: Map of Cape Town Metropole).

Nurses are geographically dispersed in 48 community health centres in these eight districts with some nurses rendering services at two or more community health centres as well as local authority clinics. The nurses' main function and responsibility is to render comprehensive mental health care and psychiatric services to individuals, families and the community. This service includes counselling victims of violence such as murder, rape, attempted murder, indecent assault, kidnapping, abduction and carjacking. In addition, nurses render a mental health care service to people who have experienced other trauma; for example, people who have been diagnosed as HIV positive, with a communicable disease such as TB, or with debilitating and chronic illnesses such as cancer or diabetes mellitus. Dealing with the trauma of others brings emotional overload in nurses. This causes chronic stress in nurses and can result in vicarious traumatisation. Nurses suffering from vicarious traumatisation often function relatively well in their work and personal life, thus symptoms of vicarious trauma are often undetected (Lerias & Byrne 2003:136).

No current formal studies could be found on nurses working in community health care centres who are exposed to secondary trauma therefore authorities do not currently recognise the adverse effects of vicarious trauma on nurses who have to deal with the death, dying and trauma reflected in the disease and trauma profiles in tables 1.1 and 1.2. Nurses are subjected to all these adverse conditions without having a support system where they can learn to manage their own pain and trauma. These aspects will be discussed further in chapter 2 (see section 2.5)

1.3 RATIONALE FOR THE STUDY

The rationale for this study is that trauma work is emotionally taxing and people cannot remain focused and boundaried when dealing with the complexities of meaning and awareness during the therapeutic process (Pearlman & Saakvitne 1995a:360). The researcher is of the opinion that nursing curricula do not include enough relevant knowledge about trauma-focused theoretical frameworks to adhere to when nurses are taught basic knowledge and skills to do counselling. Theoretical frameworks such as the CSDT emphasise therapeutic integration, meaning and adaptation to trauma (Pearlman & Saakvitne 1995a:56).

Aspects of counselling are generic therefore the effects of vicarious trauma specific to trauma work are also not addressed.

Nurses are not equipped to provide the services reflected by the changing disease profile as well as the increasing demand made on them to manage victims of disease and violence. There is limited supervision, training and support for nurses who are required to deliver these services. The absence of a multidisciplinary team at PHC level creates difficulties for those nurses who treat traumatised people.

1.4 PROBLEM STATEMENT

Vicarious traumatisation is an important occupational hazard in the nursing profession as the effects accumulate and may change how the nurses' view themselves and their world. The effects of vicarious traumatisation experienced by nurses in the workplace, the

relationship between personal trauma history and vicarious trauma, and support systems need to be investigated as nurses who are overburdened with work and stress and their own trauma have little resources left to care for and comfort others.

1.5 RESEARCH QUESTIONS

To achieve the aim, the study wishes to answer the following research questions:

- What is the prevalence of vicarious traumatisation in nurses rendering a mental health service at community health centres?
- Is nurses' personal trauma history associated with vicarious trauma?
- What work-related aspects create vicarious trauma in nurses?
- What support systems are there for nurses who work in community mental health care services?

1.6 AIM OF THE STUDY

The overall aim of the study is to describe the effects of vicarious traumatisation experienced by registered nurses providing psychological care to victims of trauma in the Cape Metropolitan area and to make recommendations for support and further research.

1.7 OBJECTIVES OF THE STUDY

The objectives of this study are to

- explore the prevalence of vicarious trauma in nurses who render a mental health service at community health centres

- explore to what extent nurses' personal trauma history is associated with vicarious trauma
- describe the work-related aspects that create vicarious trauma in nurses
- describe the support systems for nurses who work in community mental health care services.

1.8 SIGNIFICANCE OF THE STUDY

The significance of this study is that it would document the prevalence of vicarious trauma in nurses who render a mental health service. Furthermore, it should establish whether there is a relationship between vicarious trauma and nurses' personal trauma history. This study will make the Department of Health and the authorities aware of the psychological needs of nurses to prevent the adverse effects of psychological trauma. In addition, it should create an awareness of the shortcomings in the support of nurses in the clinical field. The findings should facilitate future planning of additional support, which could be rendered to nurses in the areas where they work with violence and diseases such as HIV/AIDS in the community health centres.

1.9 DEFINITIONS

For the purposes of this study, the following terms are used as defined below:

- **Vicarious trauma**

Vicarious trauma is “the psychological consequence resulting from repeated exposure to the patient’s traumatic experience” (Schauben & Frazier 1995:53). Pearlman and MacIan (1995: 558) define vicarious trauma as “disruptions to the therapist’s inner experience, as a result of repeated exposure to the clients’ traumatic narratives”. In this study, vicarious trauma is the psychological disruptions to the nurses’ inner experience, as a result of repeated exposure to the clients’ traumatic narratives. According to the CSDT, these psychological disruptions have an effect on how the nurses view themselves and their world

- **Personal trauma history**

Personal trauma history is the unique personal history of the nurse which includes traumatic life experiences (Pearlman & Saakvitne 1995a:309). McCann and Pearlman (1990:146) define personal trauma history as the nurses’ own unresolved victimisations of early childhood experiences. In this study, personal trauma history includes trauma experienced by nurses as individuals or being aware of traumatic experiences of family or friends. These traumatic experiences include being victims of violence and other trauma such as being diagnosed with a disease like TB, HIV/AIDS or cancer.

- **Registered nurse**

A nurse is a person who is registered under section 16 of the Nursing Act, 50 of 1978, as amended. In this study, the term nurse is consistent with the South African Nursing Council's (SANC) definition as a person who is registered with the SANC with an additional qualification in psychiatric nursing science as reflected in Regulation 880 of 1975 as amended and Regulation 425 of 1985 as amended by the SANC and who is working in a community health care centre where trauma is dealt with.

- **Community health centre**

Community health centres are the main service centres for the provision of primary health care. These centres render and co-ordinate all primary care services considered appropriate for the community (Flisher, Jansen, Lund, Martin, Milligan, Robertson & Winkler 2003:37). In this study, a community health centre is regarded as a centre in the Western Cape Metropole, where primary and mental health care services are rendered by nurses.

- **Mental health service**

Flisher et al (2003:3) define mental health services as services that are rendered to individuals or groups on an outpatient basis. In this study, a mental health service is a

service rendered by nurses at a community health care centre in the Western Cape Metropole to patients and their families who have been exposed to psychological trauma.

- **Mental health care**

Mental health care is a wide variety of treatment approaches that foster and promote mental health and prevent mental health conditions arising in at-risk individuals (Flisher et al 2003:7). In this study, mental health care provided by community health centres in the Western Cape Metropole is the treatment approach that the nurse applies to clients and their families who have been exposed to trauma to promote mental well being and prevent mental illness.

1.10 THEORETICAL FOUNDATION

Assumptions formed the basis for this study and McCann and Pearlman's (1990:136) CSDT served as the theoretical foundation on which this study was based.

1.10.1 Basic assumptions

Assumptions refer to the basic principles that are accepted as true based on logic, but without any scientific proof or verification (Polit & Beck 2004:711). In this study the following assumptions are made.

- Nurses have not been equipped for the changing disease and trauma profile in the health care services

- Nurses exposed to clients traumatised from violent traumatic incidents experience adverse effects in their own mental and psychological health.

1.10.2 Theoretical framework

McCann and Pearlman's (1990:136) CSDT served as the theoretical foundation for this study. The CSDT is a developmental interpersonal theory that provides an understanding of the psychological, interpersonal and adaptation effects that traumatic events have on the individual who counsels victims of trauma. McCann and Pearlman (1990) use the term "helper" to describe the person who assists traumatised individuals. In this study, the term "nurse" will be used to describe the person who assists traumatised individuals.

The CSDT is based on the following assumptions:

- *Constructivism*

The underlying premise of the constructivist perspective is that the meaning that individuals attach to the traumatic event is related to how they experience that event. This is because individuals construct their own reality through developing cognitive structures known as schemas. These schemas include beliefs, assumptions and expectations of the self and the world. The CSDT suggests that the changes to helpers' cognitive schemas are pervasive (potentially affecting all areas of the helpers' life) and cumulative (potentially permanent because each traumatised client the nurse encounters reinforces these changes) (McCann & Pearlman 1990:136-7).

- *Individual differences*

Every individual adapts differently to trauma. These differences include life experience, personal trauma history, personality and the meaning attached to trauma (Pearlman & Saakvitne 1995a:58).

- *Developmental perspective*

The central premise of the development perspective is that individuals' early development shapes the way they experience and interact with the self and others. Trauma, for example childhood sexual abuse, arrests the individual's development (Pearlman & Saakvitne 1995a:58).

According to the CSDT there are five aspects of the **self** that are impacted by psychological trauma:

- *Frame of reference*

Refers to the individuals' framework for viewing themselves and the world. Frame of reference is important as it refers to how the individual perceives and interprets life experiences (Pearlman & Saakvitne 1995a:61). According to McCann and Pearlman (1990:141), "a meaningful frame of reference for human experience is a fundamental human need". Frame of reference encompasses individuals' world-view, identity and spirituality.

World-view refers to the helpers' beliefs about the world which includes attitudes about others, their worth, intentions and role in the individual's life (Pearlman & Saakvitne 1995a:61).

Identity reflects the individuals' inner experience of self which includes their personal story, relationship with themselves and their perception of themselves in relation to others (Pearlman & Saakvitne 1995a:61).

Spirituality refers to the meaning about themselves in the world. There are four components: orientation to the future and sense of meaning in life, awareness of all aspects of life, relation to the non-material existence and the connection with something beyond themselves, for example a god or a higher power (Pearlman & Saakvitne 1995a:63).

- *Self-capacities*

Refer to the "inner capabilities that allow the individual to maintain a consistent, coherent sense of identity, connection, and positive esteem" (Pearlman 1998:9; Pearlman & Saakvitne 1995a:64).

These self-capacities allow individuals to manage emotions, maintain interpersonal relationships and sustain positive feelings about themselves. When the nurse experiences vicarious traumatisation, these self-capacities are disrupted and the nurse may experience loss of identity, interpersonal difficulties, difficulty in controlling negative emotion or self-doubt in meeting significant others' needs (Trippany, White Kress & Wilcoxon 2004:33).

- *Ego resources*

Ego resources are “inner faculties that the individual uses to navigate the interpersonal world and meet his/her psychological needs” (Pearlman & Saakvitne 1995a:67).
There are two sets of resources:

- resources important to the counselling process: intelligence, willpower and initiative, awareness of psychological needs, striving for personal growth
- protecting oneself from harm: ability to conceive consequence, ability to set boundaries, ability to self-protect (Pearlman & Saakvitne 1995a:67).

Disruptions may promote perfectionism and the inability to be empathetic (Trippany et al 2004:33).

- *Psychological needs and related schemas* (in relation to self and others)

Cognitive manifestations of the psychological needs, namely, safety, trust, esteem, intimacy and control are known as schemas (McCann & Pearlman 1990:137).

- Safety is the need to feel safe from harm by oneself and others (Pearlman & Saakvitne 1995a:62).

- Trust includes self trust and trust of others. The need to trust own perceptions and beliefs, as well as to depend on others (Pearlman & Saakvitne 1995a:62; Trippany et al 2004:34).
- Esteem is the need to feel valued by oneself and to value others. Also the need to perceive others as worthy of respect (McCann & Pearlman 1990:140; Pearlman & Saakvitne 1995a:62).
- Intimacy is the nurses' "need to feel connected to oneself and others" (Pearlman & Saakvitne 1995a:62).
- Control is the nurses' need to self-manage as well as to manage others in interpersonal situations (McCann & Pearlman 1990:139).

The CSDT views the responses of the nurse to the clients' traumatic narratives as being shaped by the nurses' own psychological needs (safety, trust, esteem, intimacy and control), cognitive schemas and by the characteristics of the situation. All individuals possess these five psychological need areas and appear to be very sensitive to psychological trauma. As individuals are unique beings, each need area is more or less salient for each individual, meaning that if the nurse has disrupted safety needs, there will be an increased feeling of insecurity when working with trauma victims (Pearlman & Saakvitne 1995a:68, 309).

- *Memory system*

Within the CSDT, traumatic memory is descriptive. Pearlman and Saakvitne (1995a:73-4) identify five aspects of the memory:

- Verbal memory (cognitive narratives)
- Imagery (pictures in the mind)
- Affect (emotions experienced)
- Somatic memory (physical sensations)
- Interpersonal trauma (dynamics in current interpersonal relationships).

Each aspect of memory can represent a fragment of a traumatic event when a person experiences trauma. According to the CSDT, these fragments interfere with one's awareness if they are not therapeutically integrated (Trippany et al 2004:31).

Trippany et al (2004:35) maintain that the memory of the traumatic narratives remains with the nurse after the counselling session has ended. Some nurses use defence mechanisms such as numbing, avoidance or denial to deal with vicarious trauma, which only offers temporary relief. Ortlepp (1998:179) states that some people alter their state of consciousness, enabling them to distance themselves from the state of unbearable arousal associated with trauma. In her study on emergency services' professionals, Hattingh (2001:442) found that some respondents were reluctant to admit that traumatic situations affected them, stating rather that they were used to coping with trauma. Hattingh alludes further to the profound psychic numbing that occurs in health care professionals who are exposed to extreme, longstanding or repeated trauma. Nurses treating victims of trauma can experience intrusive thoughts, flashbacks and dreams that have no meaning. Imagery is related to the nurses' psychological need area. These traumatic memories can become permanently entrenched in the nurse's memory system (McCann & Pearlman 1990:143).

1.11 RESEARCH DESIGN AND METHODOLOGY

Burns and Grove (2001:26) define research methodology as " the application of all the steps, strategies and procedures for gathering and analysing data in a research investigation in a logical and systematic way". Babbie and Mouton (2001:75) add that research methodology is the "process and procedures to be used in a study which is conducted in a systematic and logical way". The researcher selected to undertake a quantitative, exploratory and descriptive study.

1.11.1 Research design

Polit, Beck and Hungler (2001:167) define the research design as "a blueprint for conducting a study and is necessary as it maximizes control over factors that interfere with the validity of the findings". In order to achieve the goal, a strategy or plan is required to conduct the study. Burns and Grove (1999:223) state that the design "guides the research in planning and implementing the study in a way that is most likely to achieve the intended goal".

1.11.1.1 Quantitative design

Quantitative research is a formal and objective process for generating information about the world. Logical systematic steps are adhered to. The purpose of quantitative research is to describe new situations (Burns & Grove 1999:23). In this study, the researcher used a structured questionnaire to collect data from nurses who render mental health services to victims of trauma in the Western Cape Metropole.

1.11.1.2 Exploratory design

Exploratory research is aimed at exploring the full nature of the phenomenon, the manner in which it is manifested and its underlying processes (Polit & Hungler 1999:17,18).
In this study, the researcher explored the prevalence of vicarious traumatisation and personal trauma history experienced by nurses and the underlying processes of integration, meaning and adaptation alluded to in the CSDT.

1.11.1.3 Descriptive design

Descriptive studies describe aspects of a situation as they occur naturally (Brink & Wood 1998:289). In this study, aspects of vicarious trauma, namely aspects of the work situation and support systems were described within the context of nurses' rendering a service to trauma victims (see chapter 3).

Population, sample and selection of cases, context, data-collection instrument, reliability and validity, data analysis, scope and limitation, and ethical considerations will be briefly considered next.

1.11.2 Population

Polit and Hungler (1999:278) describe a population as "the representation of the entire set of individuals that meet the criteria, also known as the 'target population'". Polit et al (2001:233) add that the population is the "entire aggregation of cases that meet a specified

set of criteria". In this study, the population consists of all nurses who render a mental health service in the urban areas of the Republic of South Africa (RSA).

1.11.3 Sample

According to Polit et al (2001:234), a sample is the "subset of the target population selected through a sampling process to study". In this study, all the nurses who render a mental health service at the 48 community health clinics in the Cape Metropolitan area were selected according to the following inclusion criteria:

- Participants have to be registered nurses with an additional qualification in psychiatric nursing science rendering a mental health service to the population of the Cape Metropolitan area.
- Must be employed on a full-time or part-time basis by the Department of Health of the Western Cape Province.
- Must be directly involved in counselling victims of psychological trauma, for example people with a positive HIV status, other debilitating diseases such as TB, or terminal illnesses, such as cancer, and victims of violence, namely rape, attempted murder, indecent assault, kidnapping, abduction and carjacking.
- Must work at a community health centre or a local authority clinic in the Cape Metropolitan area.

1.11.4 Context

According to Polit et al (2001:44), context refers to “the setting within the site where the data collection will occur”. In this study, the data was collected from 35 nurses working in the 48 community health care centres administered by the Provincial Administration of the Western Cape under the auspices of the Metro District Health Services after permission had been obtained from the regional director of the Metro District Health Services (see annexure A). As the sample size was too small for sound statistical analysis, questionnaires were also distributed to seven community mental health nurses working in the surrounding rural areas of the Cape Metropole.

1.11.5 Data-collection instrument

An existing questionnaire was selected as a data-collection instrument for this study (see Section B: “self-concept” of the questionnaire in annexure D). The Traumatic Stress Institute (TSI) Belief Scale is an instrument developed by the Traumatic Stress Institute to measure disrupted cognitive schemas in people working with the traumatised (Pearlman & Saakvitne 1995a:408). There are four more sections to the questionnaire, namely biographical data, personal trauma history, work related experiences and support which were specifically developed for this study (see section 3.2.4).

1.11.5.1 Validity

Polit and Beck (2004:422, 416) define validity as “the degree to which an instrument measures what it is supposed to measure”. The existing instrument used as section B of the current questionnaire, has proven validity as it has been used in previous studies. The research supervisors and a statistician assisted with formulating the questions for the other sections.

1.11.5.2 Reliability

Reliability is “the consistency with which an instrument measures an attribute” (Polit & Beck 2004:416). In addition, “for an instrument to be reliable it must yield the same measure when used twice” (Burns & Grove 2001:399). Section B of the instrument has proven reliability as it has been used in previous studies and has an internal consistency measure indicative of reliability.

The instrument was pre-tested during the pilot study on five individuals who did not participate in the data collection process of this project (see section 3.2.5).

1.11.6 Data collection

According to Polit et al (2001:36), data collection is the “method used to collect information required to conduct the research study”. Research objectives in a quantitative study must be accomplished with the data collected (Burns & Grove 1999:50). In this study, the

researcher collected the data through the use of a structured questionnaire (annexure D) presented to the 37 nurses according to the inclusion criteria (see description under the heading “sample” below).

1.11.7 Data analysis

The Statistical Analysis System, Version 12.0 (SAS 12.0) computer program was used in the analysis of the data, with the assistance of a statistician. Frequencies and basic statistics were calculated and presented in tables and graphs (see chapter 4).

1.12 SCOPE AND LIMTATIONS

This study is unique as it was conducted at the 48 community health care centres in the Cape Metropolitan area where a study of this nature had not been conducted before. These clinics offer PHC services in line with the Western Cape Governmental policy, *Health Care 2010* and the African National Congress (ANC) *National Health Plan* (ANC1994:20) to ensure accessible, affordable and equitable health care to all the population of the Western Cape. These clinics are also the first point of contact for clients in need of health care.

1.13 ETHICAL CONSIDERATIONS

Burns and Grove (2001:191) declare that in order to maintain a high standard of research, “the conduct of nursing research not only requires expertise and diligence but also honesty and integrity”. In addition, ethical research is essential to generate sound knowledge for

practice. Polit and Beck (2004:141) are of the opinion that in order to ensure a high standard of research, ethical guidelines are set to direct researchers. The ethical considerations followed in this study are discussed in chapter 3.

The research proposal was sent for approval to the Research and Ethics Committee at the Department of Health Studies of the University of South Africa prior to commencement of the study as well as to the Department of Health of the Western Cape Province (see Annexure A).

1.14 OUTLINE OF THE STUDY

Chapter 1 discusses the rationale for, purpose, objectives and significance of the study, defines key terms, and describes the theoretical framework, namely the CSDT, the research design, methodology and ethical considerations.

Chapter 2 discusses the literature review undertaken on the effects of vicarious trauma, defines terms used to identify the deleterious effects of working with trauma victims and describes vicarious trauma, with reference to the CSDT.

Chapter 3 discusses the research design and methodology, including the selection and development of the data-collection instrument.

Chapter 4 discusses the data analysis and presents the findings.

Chapter 5 concludes the study, briefly discusses its limitations and makes recommendations for practice and further research.

1.15 CONCLUSION

This chapter outlined the background to, rationale for, and the purpose, objectives and significance of the study. The researcher defined key terms, discussed the basic assumptions and theoretical framework and briefly described the research design and methodology, the data-collection instrument and the ethical considerations.

Chapter 2 discusses the literature review on the effects of vicarious trauma on persons who treat the traumatised.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The researcher conducted a literature review of the empirical and theoretical literature sources on the effects of vicarious trauma experienced by people working with victims of violence and debilitating and terminal diseases for example HIV/AIDS and cancer to identify baseline data on what is known about vicarious trauma.

Sources researching and describing the negative effects of rendering a trauma counselling service, specifically vicarious trauma, pertaining to nurses in the Cape metropolitan area could not be found. In order to put this study in perspective, the researcher searched for data on aspects of secondary traumatisation globally. The literature search included the following computer-assisted data based bibliographies: MEDLINE (Medical Literature Online), Academic search premier, Nexus and CINAHL (Cumulative Index to Nursing and Allied Health Literature) and concepts such as vicarious traumatisation (McCann & Pearlman 1990:133) burnout (Maslach, Jackson & Leiter 1996:4) compassion fatigue, secondary traumatic stress (Figley 1995:14; Stamm 1997:1-2), counter-transference, posttraumatic stress disorder (PTSD) (American Psychiatric Association (APA) 2000:463), and traumatoid states (Thomas & Wilson 2004:82). All these terms are associated with the effects nurses experience when working with traumatised people. The researcher applied the CSDT to provide an insight into vicarious trauma, in the context of community health

centres, as experienced by nurses in the line of duty. It is inevitable that nurses rendering a counselling service to traumatised individuals should experience some after effects of their work (Sabin-Farrell & Turpin 2003:450).

The review revealed a considerable amount of literature on the above-mentioned concepts. Most of the populations in the various studies were therapists who counselled survivors of sexual abuse.

2.2 PURPOSE OF THE LITERATURE REVIEW

The purpose of the literature review was to ascertain what is already known about the effects of vicarious trauma on people who treat victims of trauma, and to describe the current understanding of the research questions in the study by examining similar studies.

A literature review

- assists in refining the problem statement, research design and data analysis process (Polit & Beck 2004:88).
- assists in the methodology and the identification of instruments used in previous studies to describe the effects of vicarious trauma (Burns & Grove 1999:107; De Vos 2001:57).
- is used to develop a conceptual context into which the study will fit and avoid unintentional duplication (Polit & Hungler 1999:80).

- assists in ascertaining what empirical findings within the field of vicarious trauma are widely accepted (Mouton 2001:87).
- will give the researcher perspective on the research problem, which will assist when interpreting the results of the study (Polit & Hungler 1999:80).
- is necessary for comparing results of earlier findings in order to explore what further research would be necessary (Polit & Hungler 1999:80). As this study will be linked to other similar research, the findings will be understood within the existing base of knowledge about vicarious trauma and the effects on nurses.
- identifies any limitations or inconsistencies in the research and guides the researcher in overcoming them (Polit & Beck 2004:88).
- aids in the clarification of the significance of the study as data gleaned focused mainly on health care workers, namely therapists, which was relevant to the study.

2.3 VICARIOUS TRAUMATISATION

In this section vicarious traumatisation will be clarified and other concepts, namely burnout, compassion fatigue/secondary traumatic stress, counter-transference, posttraumatic stress disorder and traumatoid states, will be defined to give clarity on their conceptualisation within trauma work. The differences and similarities between these concepts and vicarious trauma will be alluded to.

2.3.1 The concept of vicarious traumatisation

Pearlman and Saakvitne (1995a:279) define vicarious traumatisation as a process through which the nurses' "inner experience about the self and the world is negatively transformed as a result of empathetic engagement with trauma survivors". Through exposure to their clients' accounts of traumatic events and the realities of people's intentional cruelty to one another, and the experience of reliving terror, grief and yearning, the nurse is vulnerable through empathic engagement as both witness and participant in these traumatic re-enactments. These effects are cumulative and may be permanent (Pearlman & Saakvitne 1995a:279). According to Dane and Chachkes (2001:33), vicarious traumatisation develops over time and affects a person's professional and social identity. However, not everyone who is vicariously exposed to traumatic narratives develops symptoms of vicarious traumatisation (Lerias & Byrne 2003:132).

According to the CSDT (McCann & Pearlman 1990:136), as the nurse bears witness to the graphic details of the clients' trauma, disruptions in the psychological need areas of safety, trust, esteem, power and intimacy may occur. The nurse may also experience disruptions in

- frame of reference, which includes world-view, sense of identity and spirituality
- self capacities
- ego resources and
- memory system (Pearlman & Saakvitne 1995b:61; Thomas & Wilson 2004:85).

Vicarious trauma can result in the nurse portraying cynicism, fear, sadness and despair (Collins 2001:11; Stevens-Guille 2003:18). Vicarious trauma is a normal response to working with traumatised people and is not the result of nurses' inadequacies. The effects of vicarious traumatisation are unique to each nurse, which is consistent with the individual difference premise in the CSDT. This uniqueness is dependent on the nurse's personality, defence mechanisms used and inner resources. Based on the theoretical framework that the individual nurse uses during work with the traumatised, the effects of vicarious trauma are predictable (Gentry, Baggerly & Baranowsky 2004:148; Pearlman 1999:52; Pearlman & MacIan 1995:558).

While there are positive aspects of working with the traumatised, such as a sense of competence about coping and maintaining an objective motivation, the concept vicarious traumatisation focuses on the negative aspects of transformation within the inner self of the person working with victims of trauma (Bell 2003:518). Vicarious trauma often includes symptoms of PTSD (see table 2.2) that intrude on the nurse's everyday life. Somatic symptoms such as headaches, backache, gastrointestinal distress and insomnia may also be present (Adams, Matto & Harrington 2001:368; Collins 2001:11).

Various concepts are used to describe the negative effects of working with traumatised people, including vicarious trauma (MacCann & Pearlman 1990:133), burnout (Maslach et al 1996:4), compassion fatigue, secondary traumatic stress (Figley 1995:14; Stamm 1999:1-2), counter-transferance, PTSD (APA 2000:463), and traumatoid states as in occupationally-related stress response syndromes (Thomas & Wilson 2004:82).

2.3.2 Burnout

Maslach et al (1996:4) define burnout as “a syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment that can occur amongst individuals who work with people”. According to Bell, Kulkarni and Dalton (2003;464), vicarious trauma may present with emotional exhaustion, depersonalisation and reduced personal accomplishment. These effects are unique to trauma work, however. Burnout is similar to vicarious trauma as it results from exposure to clients who are emotionally charged through challenging jobs which results in the nurse being unable to render an effective service (Jenkins & Baird 2002:425). Although burnout is not limited to persons working with the traumatised, it can occur as a result of repeated exposure to people’s traumatic experiences (Salston & Figley 2003:168).

Trippany et al (2004:32) maintain that burnout is a feeling related to difficult, that is, chronic and complex, client population, whereas vicarious traumatisation reactions are related to specific client traumatic experiences. While burnout is related to workplace conditions, vicarious trauma focuses on the process of empathic engagement with traumatised people (Jenkins & Baird 2002:425). Annscheutz (1999:18) is of the opinion that people most vulnerable to burnout are those who are unable to confide in others. Nurses, like persons from other professions (e.g., doctors), are bound by the ethical principle of confidentiality which prohibits them from discussing the narratives of overwhelming horror and cruelty experienced by their traumatised clients, with others. Unaddressed vicarious trauma sets the stage for burnout, resulting in nurses leaving the mental health service.

2.3.3 Compassion fatigue

Compassion fatigue is also known as secondary traumatic stress, secondary traumatic stress disorder or compassion stress**.** Compassion fatigue is the preoccupation with the individual's trauma, which includes re-experiencing the event, avoiding/numbing the event and hyperarousal (Thompson 2003:4). The onset of compassion fatigue is acute and sudden. Although both compassion fatigue and vicarious trauma are both associated with the "cost of caring", these constructs are conceptually different (Figley 1995:9). While compassion fatigue focuses on symptom constellation, vicarious trauma emphasises the role of meaning and adaptation to trauma work (Annscheutz 1999:20). Thomas and Wilson (2004:84) describe a lack of strength, exhaustion, lack of energy and vitality as compassion fatigue.

According to Jenkins and Baird (2002:425), vicarious trauma and secondary trauma/compassion fatigue differ on four dimensions (see table 2.1).

Table 2.1 Differences between vicarious trauma and compassion fatigue/secondary traumatic stress

Vicarious trauma	**Compassion fatigue/secondary traumatic stress**
Focuses on the theoretical framework, namely the CSDT	Compassion fatigue focuses on symptoms
Content of PTSD symptoms focuses on belief system changes such as world-view.	Describes PTSD symptoms with a sudden onset
Focuses on mental health professionals working with survivors of sexual abuse in a therapeutic relationship. These professionals bear witness to the narratives of abuse in an ongoing therapeutic relationship.	Focuses on professionals who provide emergency services to survivors of sexual assault, namely, police officers, nurses and trauma therapists. These professionals bear witness to the physical and emotional aftermath of the trauma.
Mental health care professionals' exposure to victims of trauma **over time** in a therapeutic relationship such as counselling victims of violence; for example rape, hijacking	Exposure to the experience of **one** person's traumatic narratives, such as treating a rape victim.

Source: Jenkins and Baird (2002:425)

From Table 2.1 it is evident that vicarious trauma is rooted in a theoretical framework, namely the CSDT, to describe the effects of working with victims of trauma whilst

compassion fatigue focuses on PTSD symptomatology. Studies also differ in their selection of samples used in that mental health professionals were mostly used to measure vicarious trauma while other categories of professionals, such as police officers, were used in studies measuring compassion fatigue.

2.3.4 Counter-transference

Counter-transference is “an awareness and legitimate recognition of our emotional reactions to events which increase the repertoire of data we have to understand that are stirred up within us when we are interacting with others” (Kapur 1999:221). Figley (1999:13) defines counter-transference as “the process of over-identifying with the client”. Counter-transference can also be described as the affective and physical responses of the nurse to the client and the nurse’s conscious and unconscious defences against these affects (Pearlman & Saakvitne 1995a:23). Counter-transference responses can precipitate vicarious traumatisation when self-awareness is decreased by the therapist’s overwhelming feelings during a therapeutic relationship. Counter-transference is specific to a therapeutic relationship while vicarious trauma is cumulative and manifests through empathic engagement with traumatized clients (Pearlman & Saakvitne 1995a:317, 318).

Catherall (1999:82) is of the opinion that if there is no forum for nurses to discuss their counter-transference reactions, they may act out these reactions and develop vicarious traumatisation. Moreover, Catherall views the fact that some nurses work with no supervision as unethical. Supervision provides an opportunity for self-analysis to work through counter-transference reactions. Through reflection, the nurse can gain insight into the client, the self and the therapeutic relationship (Sexton 1999:395).

2.3.5 Posttraumatic Stress Disorder (PTSD)

According to the APA (2000:463), PTSD involves “learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate”. An individual who is vicariously traumatised may experience PTSD symptoms (see table 2.2). The diagnostic criteria for PTSD focus on symptom constellation about a specific traumatic event and for vicarious trauma on integration, meaning and adaptation to others traumatic narratives over time (Annscheutz 1999:20).

Table 2.2 Symptoms of PTSD

Symptom	**Symptom description**
Re-experiencing the event	Recurrent and distressing recollections of the event Recurrent distressing dreams of the event Acting or feeling as if the event was recurring Intense psychological distress at exposure to reminders of the event Intense physical distress on exposure to the event
Persistent avoidance	Efforts to avoid thoughts, feelings and conversations related to the event Efforts to avoid places, activities and people who are reminders of the event An inability to remember important aspects of the event Reduced interest and participation in significant activities Feelings of estrangement and detachment from others A restricted range of affect

Symptom	Symptom description
	A sense of a foreshortened future
Increased anxiety and arousal	Difficulties staying or falling asleep Irritability or outbursts of anger Difficulty concentrating Hyper vigilance and preoccupation with one's safety Exaggerated startle responses
Impairment	The above symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning

Source: APA (2000:468)

From table 2.2 it is evident that PTSD focuses on a specific traumatic event while vicarious trauma is cumulative (McCann & Pearlman1990:136-137). There is also a degree of impairment in social, occupational and other significant areas of functioning. Lerias and Byrne (2003:136) assert that people who are vicariously traumatised experience symptoms that are less severe than those diagnosed with PTSD.

2.3.6 Traumatoid states

Traumatoid states as occupationally related stress response syndrome develop when a professional is actively involved or exposed to a traumatised client. These states include the emotional, psychological and interpersonal processes of trauma work (Thomas & Wilson 2004:88). Traumatoid states further include compassion fatigue, secondary

traumatic stress, secondary traumatic stress disorder and vicarious trauma. Thomas and Wilson (2004:84) found that their research strongly supported the definition of vicarious trauma as the subjects reported changes in identity, views of society and sense of meaning in life. The helpers in their study took an active role in advocating for their clients. Thomas and Wilson (2004:88, 91) maintain that using the term “traumatoid states” is generic thus all the effects that nurses experience while working with traumatised clients can be understood within the context of traumatoid states. Given the differences and similarities between the above concepts, the deduction can be made that one concept – traumatoid states – cannot adequately address all the processes involved in the nurses’ inner experience of and response to traumatic narratives of victims of trauma.

2.4 PSYCHOLOGICAL NEEDS IMPACTED BY VICARIOUS TRAUMA

The five psychological needs of safety, control, trust, esteem and intimacy and their other dimensions, namely other-safety, other-control, other-trust, other-esteem and other-intimacy which McCann and Pearlman (1990:137) assert will be disrupted by working with traumatised individuals, manifest cognitively as schemas. Disrupted schemas reflect negative beliefs about the self and others. These beliefs impair interpersonal relationships (Pearlman & Saakvitne 1995a:69). These needs will be defined and discussed with reference to the CSDT.

2.4.1 Safety

The psychological need area of safety focuses on self-safety, which includes the need to feel safe and out of harm's way. Other-safety focuses on the need to feel that important others are safe from harm (Rosenbloom, Pratt & Pearlman 1999:70).

In a study in the RSA, Ortlepp and Friedman (2002:219) examined e negative and positive consequences and the prevalence of doing trauma work. Ortlepp and Friedman concluded that the participants, namely workplace lay counsellors, felt an increasing need to protect themselves (self-safety) and their families (other-safety). Furthermore, 20% of the participants became aware of their own and their loved ones' vulnerability. The disruptions in the safety need area were regarded as positive as they were seen within the context of the increasing violence in the RSA. As these disruptions were still evident at six weeks' post trauma counselling, they were considered permanent.

In their study on counsellors' experiences of working with perpetrators and survivors of domestic violence in Australia, Iliffe and Steed (2000:405) found that counsellors' concern for survivors' safety (other-safety as defined by the CSDT) after leaving a domestic violence relationship was very real as the survivors were more likely to be harmed by the perpetrators. The counsellors took on more responsibility for their clients' safety as they struggled with feelings of responsibility. More than 50% of both male and female participants observed that they felt less secure (self-safety) and the male participants were particularly concerned about their partners' and children's safety (other-safety).

Pearlman and Saakvitne (1995a:290) report that persons, who do trauma work and are parents, are ambivalent as to what excessive risks are that could result in becoming overprotective towards one's children. Disruptions within the safety need area are evident in therapists who have an increased sense of personal vulnerability. Behavioural changes such as checking doors repeatedly and taking self-defense lessons occur. Cognitive beliefs such as "I am not safe anywhere" replace the formerly held belief of a safe world (Rosenbloom et al 1999:71).

In a study on the mental health effects on people in the USA following the September 11 th terrorist attack, Schuster, Stein, Jaycox, Collins, Marshall, Elliot, Zhou, Kanouse, Morrison and Berry (2001:1510) found that 47% of the parents felt that their children were worried about their own safety or the safety of loved ones. These children were not present at the traumatic event but had observed television coverage of the event.

With regard to the emotional reactions of rape victim female advocates, Wasco and Campbell (2002:126) observed that 39.5 % of the participants feared for their safety (self-safety) from alleged perpetrators. Advocates also described being fearful for the safety of family members (other-safety).

In Australia, a study on psychologists and professional counsellors found that eight of the 12 therapists reported increased vigilance regarding their own safety (self-safety) and the safety of others (other-safety). All the therapists reported an increasing sense of vulnerability (Steed & Downing 1998:4-5).

2.4.2 Control/Power

Self-control is the need to feel in control of one's thoughts, feelings and behaviour; other-control is the need to control others' behaviour (Rosenbloom et al 1999:74; Pearlman & Saakvitne 1995a:73).

According to Iliffe and Steed (2000:406), all the participants in their study in Australia identified feelings of no control (powerlessness) over the safety of their clients and their clients' children. The social and justice system that was deemed not supportive of the clients rendered feelings of powerlessness in the counsellors. In a study on the effects of vicarious trauma of female counsellors working with sexual survivors, Schauben and Frazier (1995:62) supported the notion that counsellors can be traumatised by the ineffectiveness and injustices of the legal and mental health services that purport to assist survivors. Disruptions in the area of self-control are evident in counsellors' experiencing feelings of powerlessness. Steed and Downing (1998:4) noted that therapists reported feeling frustrated at their inability to change their clients' situation (self-control).

2.4.3 Trust/Dependency

Self-trust and trust of others as psychological need areas are disrupted by engaging in trauma work. Self-trust is the need to trust one's own judgement. Other-trust is the need to depend on others' to meet one's emotional and psychological need (Pearlman & Saakvitne 1995a:71). Schauben and Frazier (1995:57) found that counsellors reported becoming

more distrustful of men after hearing about the abuse, which consequently resulted in changes in their beliefs about the world.

Iliffe and Steed (2000:399) observed that the counsellors often questioned their own competency and judgement. Most participants in the study concluded that domestic violence work did not impact on their ability to trust people in general (self-trust). Several participants reported that they were less trusting of information that they received from perpetrators, who were usually male.

Steed and Downing (1998:5) noted that some psychologists and counsellors developed mistrust in their ability to work effectively. These therapists also experienced a decreased sense of trust in their partners and were wary of men in general. When colleagues disagree more than usual with the therapist on therapeutic issues, it can be concluded that there are disruptions in the psychological need area of self-trust (Carbonell & Figley 1996:54).

2.4.4 Esteem

Self-esteem is the need to feel valued by others; other-esteem is the need to value others (Pearlman & Saakvitne 1995a:72; Rosenbloom et al 1999:72).

Schauben and Frazier (1995:53) reported that disruptions in cognitive schemas relating to other-esteem was strongly linked to vicarious trauma associated with working with victims of violence. Pearlman and MacIan (1995:559) concur with Schauben and Frazier (1995:57) that disruptions in self-esteem (the belief that one is valuable) were evident. The length of time doing trauma work was associated with increasing disruptions in self-esteem.

2.4.5 Intimacy

Self-intimacy is the need to feel connected to oneself; other-intimacy is the need to feel connected to and close to others (Rosenbloom et al 1999:73; Pearlman & Saakvitne 1995a:72).

Ortlepp and Friedman (2002:219) noted that lay trauma counsellors reported changes in cognitive schemata relating to interpersonal relationships. Thirty percent of the counsellors interviewed became more aware of the importance of family and key relationships. Steed and Downing (1998:4) observed that counsellors working in the field of sexual abuse reported that their work impacted negatively on their relationships with their families (other-intimacy). In a study in New South Wales on counsellors working with sexual assault victims, Johnston and Hunter (1997:326) observed that counsellors who reported personal relationship difficulties overlapped with problems encountered at work.

Carbonell and Figley (1996:54) are of the opinion that there are disruptions in the area of other-intimacy when therapists prolong the length of the counselling sessions and all their energy is invested in the counselling. Clients may also indicate that the therapist is treating them differently. In addition, therapists may feel dissatisfied with their own performance (self-intimacy).

2.5 SUPPORT SYSTEMS FOR NURSES WORKING IN COMMUNITY HEALTH CENTRES

According to Hattingh (2001:162), constant support and understanding from colleagues is important in coping with trauma. Professionals involved in the helping profession have implemented “self-made” support systems, mainly social networks and professional colleagues (Inbar & Ganor 2003:110). Maintaining a balance between professional, personal, physical and emotional aspects of living is important (Clay 2001:36; Salston & Figley 2003:171). According to Sexton (1999:401), part of self-care is remembering why one chooses to do trauma work and to appreciate the rewards it offers, such as people’s resilience to withstand adversity.

Peer supervision groups are important for nurses working with traumatised clients as they can share their experiences of vicarious trauma, resulting in normalisation of vicarious experiences. Normalisation of vicarious trauma experiences assists the nurse in maintaining objectivity. Importantly, peer supervision allows nurses to debrief ethically, especially within the limitations of confidentiality (Levine 2001:358; Maytum, Bielski, Heinman & Garwick 2004:177; Trippany et al 2004:35-6).

According to Trippany et al (2004:35), professional development resources should be available for nurses. In the Cape metropolitan area, the professional development resources exist:

- Opportunities for supervision. Peer supervision with nurses is conducted by a psychiatrist and psychologist once per week for a period of one hour. Bell et al (2003:468) emphasise that weekly group supervision is important to discuss traumatic material and the personal effect may be processed and normalised as part of trauma work.
- Consultation. Nurses have telephonic access to members of the multidisciplinary team, which includes psychiatrists, psychologists, occupational therapists, social workers, and nurses of the major psychiatric hospitals in the Cape Metropole. A community psychiatrist is also available in a supportive and advisory capacity.
- Continuing education. Training in 'traumatology' (Pearlman & Saakvitne 1995b:171) is offered by non-governmental organisations (NGOs) but these courses are not obligatory for nurses. In 2002, a basic and advanced counselling course was offered by a psychologist as part of in-service training but because of the high turnover of nurses, not all nurses attended. Furthermore, all training needs have to be in line with the metro district health service's operational plans for each district. If trauma-counselling courses are not identified as a priority for a particular health district, in the midst of all the other health needs like HIV/AIDS and TB, then such courses are not paid for by the skills development fund. As these courses are expensive, the nurses do not access them.
- Nurses' training should include a theoretical framework for understanding trauma and the negative effects that could occur. Trauma-specific education also decreases the risk of vicarious trauma (Bell et al 2003:467). Bell et al (2003) discovered that social workers with master's degrees experienced lower levels of secondary stress compared to social workers with baccalaureate degrees. A deduction from this could possibly be that nurses should be encouraged to undertake further studies to equip

themselves to deal with trauma victims or they may be older, wiser and more experienced.

- Collins and Long (2003:423) suggest that self-awareness programmes should be a core focus for persons rendering a counselling service to victims of trauma. Collins (2001:13) points out that a counselling service was offered to nurses following the Omagh bombing in Northern Ireland, and although support and counselling cannot be forced on anyone, this service should be available. Staff, who feel the need to access this service, should be encouraged to do so and not be made to feel a failure for not coping.
- Ongoing staff training should include information on vicarious trauma and self-care strategies to ameliorate the effects of vicarious trauma (Way, Van Deusen, Martin, Applegate & Jandle 2004:67).
- Psychological debriefing is a structured intervention that promotes the emotional processing of traumatic events through normalising feelings and preparing the individual for possible future experiences. Psychological debriefing, the teaching and reinforcing of coping skills and anxiety reduction techniques, ensures that the basic psychological needs of nurses as depicted in the CSDT are met (Cooper 1995:23-25; Lane 1993-94:301).

In their evaluation of the success of psychological debriefing of vicarious trauma of ten debriefing effectiveness studies, Everly, Boyle and Lating (1999:232) found a significantly positive effect of psychological debriefing to mitigate the symptoms of psychological distress. This outcome demonstrated that psychological debriefing is not situation specific like the meta-analysis extended to a wide variety of subject groups such as emergency and trauma medicine, law enforcement, primary victims and fire fighters.

2.6 FACTORS INVOLVED IN THE DEVELOPMENT OF VICARIOUS TRAUMA IN NURSES

Several factors are involved in the development of vicarious trauma experienced by nurses working in community health care centres.

2.6.1 Empathy

According to Pearlman (1999:52), anyone who engages empathically with trauma survivors can become vicariously traumatised. Empathy is having an understanding for another person's subjective experience from that person's perspective (Pavio & Laurent 2001:216). *Time frame* refers to the **past** in which the person experiencing the trauma event was a child and **present** refers to the adult stage of development when the trauma was experienced. Pearlman and Saakvitne (1995a:296) describe two types of empathic engagement involved in the therapeutic relationship with the traumatised client, namely cognitive and affective empathy. *Cognitive empathy* is how the nurse experiences the trauma event as told by the traumatised client and *affective empathy* is how the nurse experiences the client's feelings of pain, anger and shame, associated with the trauma event. Past affective empathy is where the nurse is most vulnerable to experiencing vicarious trauma, especially if the nurse has a personal trauma history (Pearlman & Saakvitne 1995a:295). In terms of the CDST, disruptions to the nurse's ego resources result in the inability of the nurses to be empathetic.

According to Nelson-Gardell and Harris (2003:6), it is the empathy that childcare workers use when listening to the sordid details of adult abuse of children that is a conduit for the

stress suffered by the workers. Nelson-Gardell and Harris use the term “secondary traumatic stress” synonymously with “compassion fatigue” and “vicarious traumatisation”.

2.6.2 Aspects of the work

Aspects of the work include empathic engagement with trauma material, graphic trauma material, intentional cruelty and client re-enactments.

- Empathic engagement with trauma material

Given the increase in violent crimes and social diseases such as HIV/AIDS (see tables 1.1 and 1.2) in the RSA, nurses working in clinics will be exposed to traumatised clients. As the PHC clinics are the first point of contact for these trauma survivors, the nurses working at these clinics will assess and treat them. Empathy forms the basis from which the nurse engages in a therapeutic relationship with the client. According to the constructivist perspective of the CSDT (Pearlman & Saakvitne 1995a:57), the meaning that the nurse attaches to the traumatised client’s story is how the nurse experiences the event. As people are individuals (individual perspective), that traumatic event will be experienced differently according to the nurse’s personal trauma history, personality and the meaning that is attached to the traumatic event. Empathy within the therapeutic relationship is conferred accordingly.

- Graphic trauma material

Nurses who counsel traumatised clients are exposed to clients' graphic trauma material. This is exacerbated by the media's portrayal of horrific incidences of violence. Pearlman and Saakvitne (1995a:298) are of the opinion that nurses who are exposed to graphic trauma material may develop somatic symptoms of nausea, headaches and bodily pain.

- Intentional cruelty

The intensity of the cruel acts of violence against clients results in questioning the existence of a higher power and the meaning life has, accompanied by feelings of helplessness by the nurse (Gibson, Swartz & Sandenbergh 2002:68-9). According to the CSDT, the nurses' schema of safety is challenged and the nurse may become hyper vigilant.

- Clients re-enactments

During counselling the client engages in reenactments of their trauma histories. The nurse is the helpless bystander in these reenactments thereby increasing the risk of vicarious traumatisation. The nurse's beliefs about the world being benign are challenged (Pearlman & Saakvitne 1995a:299).

2.6.3 The nature of the trauma counselling

Nurses who do trauma counselling are exposed repeatedly to the clients' traumatic material by empathic engagement that may contribute to vicarious trauma (Pearlman & Saakvitne 1995a:299). Schauben and Frazier (1995:62) note that counsellors felt that working with traumatised clients, who invariably had difficulty trusting others and had problems adjusting to the structure of a therapeutic relationship, was difficult and made them vulnerable to vicarious trauma.

2.6.4 Other contextual factors of trauma therapy

Nurses working at PHC centres treat a mixed caseload of clients, including clients with major psychiatric illnesses, such as schizophrenia and bipolar mood disorder, and they counsel clients who have been traumatised. As these nurses are the first point of contact for the traumatised clients, they are unable to set limits on the number of traumatised clients they counsel. An increasing number of trauma clients can contribute to vicarious traumatisation (Pearlman & Saakvitne 1995a:300).

In a study in the USA on 114 self-identified female sexual trauma therapists Trippany, Wilcoxon and Satcher (2003:56) noted no relationship between client caseload and the experience of vicarious traumatisisation. Nevertheless, they do suggest that vicarious trauma could have lessened over time.

Iliffe and Steed (2000:408), however, differ from Trippany et al (2003:56) in that the participants in their study reported more symptoms of vicarious trauma associated with a high caseload of trauma clients. High caseloads of trauma clients were also associated with more disrupted beliefs about themselves and others.

Bell et al (2003:465) concur with Iliffe and Steed (2000:408) that balancing clients with different problems, limiting caseload and working with clients other than trauma survivors can prevent vicarious trauma.

2.6.5 The nature of the clientele

Nurses working at PHC centres in the Cape Metropole area are exposed to clients living in abject poverty in addition to being severely traumatised by violence and diseases such as HIV/AIDS and cancer. The disease profile and crime statistics depicted in tables 1.1 and 1.2 are indicative of the increasing burden of disease and crime rates. The nature of the clients that the nurse counsels relates to how these clients **adapt** to traumatic events that occur in their lives. Client adaptation includes factors such as suicidality and interpersonal style.

- Suicidality

In addition to counselling the traumatised, the nurse is confronted by traumatised patients who are chronically suicidal. In a study on working with suicidal patients, Richards (2000:333) found that psychotherapists reported feeling hopeless and helpless with a sense of failure in their work as therapists. These feelings can set the stage for vicarious

traumatisation as nurses start doubting their competency as they do not share the images that their patients portray of themselves as being worthless (Pearlman & Saakvitne 1995a:302).

- Interpersonal style

Job satisfaction and self-esteem are important in preventing the nurse from becoming vicariously traumatised. Nurses' identity becomes challenged when they cannot set limits or are perceived by their clients as being the perpetrators in their re-enactments (Pearlman & Saakvitne 1995a: 302). Marsh (2001:1) suggests that nurses who work with traumatised clients should develop a sense of awareness and connectedness. These nurses should learn to set limits and boundaries. When the nurse is vicariously traumatised, the ego resources are challenged thus creating an inability to set boundaries. When there are no boundaries and limit setting, there is a negative impact on the therapeutic relationship between the nurse and the patient (Maytum et al 2004:176; Pearlman 1998:12).

2.6.6 Aspects of the work context

Aspects of the work that affect the nurse and make her vulnerable to vicarious trauma include organisational, professional and social context (Pearlman & Saakvitne 1995a:303-5).

- *Organisational context*

Nurses are located geographically in eight health sub-districts across the Cape Metropolitan area, in 48 community health centres. There may be one or two nurses per community health centre with some community health centres sharing a nurse who renders a counselling service to victims of trauma. Feelings of isolation are prominent as nurses are alienated by the nature of their work and the geographical dispersion of the mental health service across the eight districts in the Cape metropolitan area (Pearlman & Saakvitne 1995a:303). Iliffe and Steed (2000:405) found that the counsellors in their study, who worked alone, reported feeling extremely isolated as they felt that their non-counselling colleagues had difficulty in understanding their work.

- *Professional context*

Community mental health services in the Cape metropolitan area was historically located in the three major psychiatric hospitals. Since 1994, in line with the ANC National Health Plan (ANC 1994:19), these services were decentralised to district level. The stigma attached to mental health services still exists today, with nurses being equated by their “generalist” colleagues to the clients that they serve. Pearlman and Saakvitne (1995a:305) purport that nurses can lose sight of their own needs in this turmoil and become vicariously traumatised. The self-capacities of the nurse who is vicariously traumatised are disrupted and a sense of alienation from other professional colleagues is experienced (Iliffe & Steed 2000: 405; Pearlman 1998:9).

- *Social context*

Trauma occurs within a social context. The manner in which trauma is viewed by the communities in the Cape Metropole also sets the stage for the nurse to become vicariously traumatised. A recent spate of intimate partner murders in the Western Cape and the increasing rape of females may suggest a climate of misogyny. The nurse, who is mostly female, may not get the necessary support to render a service to traumatised clients (Pearlman & Saakvitne 1995a:305).

2.6.7 Aspects of the nurse

The nurse in her role as counsellor is a major contributor to vicarious traumatisation. Anything that affects the nurse's **self** can contribute to vicarious traumatisation. Aspects of the self with reference to the CSDT are discussed next.

- **The Self**

According to the CSDT's frame of reference, aspects related to the self include world-view, identity and spirituality (Pearlman & Saakvitne 1995a:307).

- *World-view*

Working with the traumatised may result in the nurses' beliefs about people and the world being altered. The nurse may view the world as unsafe and people as untrustworthy and controlling (Rosenbloom et al 1999: 69). With regard to the impact of trauma work on social

work clinicians, Cunningham (2003:457) observed that clinicians with 40% more of their caseload made up of sexually abused clients reported significant disruptions in their world-view. Galloucis, Silverman and Francek (2000:15) found that the impact of trauma exposure on the cognitive schemas of a group of paramedics resulted in 18% reporting disrupted beliefs about the meaningfulness of the world.

- *Identity*

Nurses may start questioning the sense of who they are in the many roles that they fulfil as parent, nurse and breadwinner (Rosenbloom et al 1999:69). Vicarious traumatisation alters the nurses' self-capacities, resulting in loss of identity, which is important in maintaining interpersonal relationships.

- *Spirituality*

Nurses may find there is a shift in their spiritual beliefs. The question of why a God would allow such evil to happen results in a disconnection between the self and a higher power (Rosenbloom et al 1999:69).

According to Pearlman and Saakvitne (1995a:63), spirituality is "an inherent human capacity for awareness of an elusive aspect of experience". The implication is that spirituality is about the meaning of who one is within the world, and without a sense of meaning, the nurse may become cynical and emotionally detached. A loss of sense of meaning results in disrupted cognitive schemas and distorts the nurse's world-view, which is consistent with the CSDT (Trippany et al 2004:36).

Trippany et al (2004:35) maintain that individuals who are at risk of developing vicarious trauma can use any source that brings about a sense of spirituality, such as religious gatherings and meditation, among other things. Individuals are responsible for developing their own sense of spirituality.

- **Affect style**

The ability to accept responsibility for one's mistakes and failures, to tolerate ambivalence and disappointment and display affect through words and imagery displays a healthy affect tolerance (Pearlman 1998:10). Nurses who have difficulty in tolerating strong affect may experience shame, denial and confusion in their work with traumatised clients. These nurses are vulnerable to vicarious trauma because of their high standards of self-criticism (Pearlman & Saakvitne 1995a:308).

- **Ability to recognize and meet one's needs**

When the nurse's needs are not met, the risk of vicarious trauma is increased. Leichtling (2004:91) suggests that people in helping professions should take joy in being a part of another's recovery. Furthermore, nurses should "renew themselves" psychologically, spiritually and emotionally and also be realistic about the level of help that can be provided without promising miracles. Pearlman (1999:59) states that nurses who are vicariously traumatised are unable to recognize and meet their own psychological needs as their ego resources are challenged which may result in an inability to protect oneself from harm.

- **Personal trauma history**

Trauma workers with a personal trauma history may harbour unresolved trauma issues, which could be activated by accounts of similar trauma from survivors (Cerney 1995:139; Figley 1999:21). Furthermore, Hattingh (2001:441) alludes to the fact that previous exposure to personal trauma has the potential to impact on the traumatic experiences that nurses face in the workplace. This may result in increased personal vulnerability to the negative effects of working with trauma victims. Kassam-Adams (1999:45) found that personal trauma history was closely associated with secondary trauma symptoms. Childhood incidence of trauma was also strongly associated with PTSD symptoms (see table 2.2) in therapists who work with survivors of sexual trauma.

Trippany et al (2003:55) found that female therapists of child survivors of sexual trauma, who had a personal history of trauma, experienced vicarious traumatisation symptoms. In a study of child abuse history and secondary traumatic stress of childcare workers working at child welfare organizations, Nelson-Gardell and Harris (2003:21) corroborated the findings of Kassam-Adams (1999:45) and Trippany et al (2003:55) that a personal experience of childhood trauma, namely child abuse and neglect, increases the risk of secondary traumatic stress and vicarious trauma. Cunningham (2003:456) found that clinicians who had a personal history of sexual abuse or trauma found working with clients who were sexually abused, distressful and this increased their risk of vicarious trauma. Yet, in the USA, Adams et al (2001:368) found that personal trauma history in clinical social workers was not related to vicarious trauma. Way et al (2004:65) also concluded that therapists with a personal trauma history did not have an increased vulnerability to vicarious trauma.

- **Experience/Age**

Adams et al (2001:368) found that new, inexperienced social workers reported more disturbances in beliefs about themselves and more somatic symptoms than older, more experienced social workers. Cunningham (2003:457) also reported that clinicians new to trauma work experienced symptoms of vicarious trauma.

At the same time, however, Nelson-Gardell and Harris (2003:22) did not find that years of experience and age increased the risk of secondary traumatic stress. Trippany et al (2003:55) concluded from their study that career longevity, namely years of experience, did not increase the risks of vicarious trauma.

- **Perceived social support**

In a national sample of clinical social workers, Adams et al (2001:368) found that lower perceived social support from friends predicted disturbances in the areas of trust, intimacy and personal security.

- **Ineffectual legal and mental health services**

Iliffe and Steed (2000:406) reported that the counsellors in their study were traumatised by the legal and mental health service that was ineffectual in supporting survivors of sexual trauma. For instance, they felt powerless in their ability to assist their clients when the services that were meant to help them were inadequate.

2.7 Signs and symptoms of vicarious trauma in nurses working in community health clinics

Table 2.3 depicts the signs and symptoms of vicarious trauma experienced by nurses.

Table 2.3 Vicarious trauma signs and symptoms

Signs and symptoms	Examples
Physiological symptoms resembling posttraumatic reactions	Intrusive symptoms, flashbacks, nightmares, obsessive thoughts, pictures and visual images, avoidance, hyper vigilance around strangers
Somatic symptoms	Sleep disturbances, headaches, gastrointestinal disturbances
Affective responses	Anger, pain, frustration, sadness, shock, horror, distress

Adapted from: Adams et al (2001:368); Clark and Gioro (1998:85);
Collins (2001:1); Figley (1995:2); Schwam (1998:647); Trippany et al (2004:35)

Nurses who are vicariously traumatised may experience similar physiological symptoms to people suffering from PTSD, such as flashbacks, intrusive thoughts, nightmares and being hypervigilent around strangers. Somatic symptoms are also common, with nurses possibly displaying sleep disturbances, headaches and complaining of gastrointestinal disturbances

such as abdominal pains, nausea and vomiting. Affective responses such as anger, shock and sadness may also be experienced (Adams et al 2001:368; Clark & Gioro 1998: 85; Collins 2001:11; Figley 1995:2; Schwam 1998:647; Trippany et al 2004:35).

2.8 The effects of vicarious trauma experienced by nurses on the relationship with the client and his/her family

During the process of assisting these traumatised individuals, nurses form therapeutic relationships with the traumatised. Cunningham (2003:458) is of the opinion that although traumatised individuals need to heal within an empathetic therapeutic relationship, the clinicians, namely nurses, providing this therapeutic environment are at risk of developing vicarious trauma. Therefore, nurses exposed to others' trauma may experience the effects of vicarious trauma. Nurses who are vicariously traumatised are unable to maintain and sustain a therapeutic relationship with clients who have been traumatised. Trippany et al (2004:35) maintain that as nurses' vulnerability to the traumatic experience increases, so does the potential for errors in clinical judgement and therapeutic impasses. Sexton (1999:397) concurs with Trippany et al (2004:35) that helpers who do not adequately deal with their vicarious trauma are likely to experience therapeutic impasses and terminate client counselling prematurely.

Disruptions in cognitive schemas lead nurses to compromise therapeutic boundaries; for example, forgotten appointments, emotional and sexual abuse of the client and disempowering the client by "rescuing". The nurse may resort to victim blaming as the client is perceived as threatening and manipulative. Clients are also labelled as "borderline or antisocial personality disordered" and this has negative effects on the therapeutic

relationship (Collins & Long 2003:419;Trippany et al: 2004:33). Within the CSDT, individuals whose self-capacity is underdeveloped through early traumatic experience may experience difficulty in the therapeutic relationship, as they are suspicious of the nurses caring for them because they believe that the nurses have a hidden agenda (Pearlman 1998:12). According to Cerney (1995:138), some trauma therapists lose objectivity because they find their clients' narratives so overwhelming thus they are unable to sustain a therapeutic relationship.

2.9 Recommendations for the support, training and supervision of nurses exposed to vicarious trauma

Ortlepp and Friedman (2002:221) suggest that selection criteria should be used when identifying nurses to do trauma work. The personal trauma history should be considered and how persons coped with traumatic incidents in the past should be elicited. The nurses' prospective work and available work support structures should be explored as research finding indicate that they are related to the ability to withstand the potential effects of vicarious trauma.

Steed and Bicknell (2001:8) assert that vicarious trauma should be recognised, acknowledged and normalised within the context of doing trauma counselling. They go on to suggest that educational programmes for staff and managers should be instituted and supportive supervision made mandatory.

Way et al (2004:67) recommend ongoing staff training, including information on vicarious trauma and self-care strategies, to ameliorate the effects of vicarious trauma.

Nelson-Gardell and Harris (2003:23) recommend regular support groups and rotation in type of caseload and job responsibility and in addition that educators enable student to make informed decisions about using empathy in practice.

2.10 CONCLUSION

This chapter discussed the literature review conducted to gain insight into the effects of vicarious trauma that nurses experience by working with victims of trauma. Various terms used to identify the secondary effects of trauma were clarified and their differences and similarities to vicarious trauma were alluded to. The concept of vicarious traumatisation was explored in depth with reference to the CSDT. Both local and international literature was reviewed.

Chapter 3 discusses the research design and methodology used in the study.

CHAPTER 3

Research design and methodology

3.1 INTRODUCTION

This chapter describes the research design and methodology used in the study, including population, data collection, validity and reliability, and ethical considerations. The overall aim of the study was to explore and describe the effects of vicarious trauma experienced by nurses working at community health centres in the Western Cape Metropole. The research methodology facilitates the attainment of the following research objectives:

- To explore the prevalence of vicarious trauma in nurses who render a mental health service at community health centres.
- To explore to what extent nurses' personal trauma history is associated with vicarious trauma.
- To describe the work-related aspects that create vicarious trauma in nurses.
- To describe the support systems for nurses who work in community mental health care services.

A quantitative, exploratory and descriptive design was used because the purpose of the study was to gather new information and statistics and to describe their significance (Burns & Grove 1999:192).

3.2 RESEARCH METHODOLGY

Polit et al (2001:223) state that research methodology refers to “the techniques used to structure a study and gather and analyse the data in the course of the research investigation and consists of a set of orderly, disciplined procedures to acquire information”.

3.2 1 Research design

A research design is an overall plan for collecting and analysing data, including specifications for enhancing the internal and external validity of the study (De Vos 2001:77; Polit & Hungler 1999: 155). Burns and Grove (2001:223) describe the research design as a “blueprint for conducting a study that maximises control over factors that could interfere with the validity of the findings”.

In this study, the research approach was quantitative in nature with an exploratory and descriptive design in order to understand the phenomenon under investigation. The study was applied research because the knowledge generated could influence the support, training and supervision of nurses who assist victims of trauma. Polit et al (2001:38) state that the purpose of applied research is to “solve problems, make decisions or control outcomes in real-life situations”. The following research concepts underpinned this study:

- quantitative
- exploratory
- descriptive

3.2.1.1 Quantitative approach

According to Burns and Grove (2001:26), quantitative research is the “formal, objective, systematic process in which numerical data is used to obtain information about the world”. This method is used to describe variables, examine relationships between variables and determine cause-effect interactions between variables. The purpose of quantitative research is to describe new situations (Burns & Grove 1999:23). Formal instruments, such as questionnaires, are used to collect information and data is analysed using statistical procedures (Polit & Hungler 1999:13). The researcher selected a quantitative design in order to explore and describe the effects of vicarious trauma experienced by nurses. In this study the researcher aimed to limit the extraneous factors, which could influence the results.

3.2.1.2 Exploratory design

Exploratory research is aimed at “exploring the full nature of the phenomenon, the manner in which it is manifested and the underlying processes” (Polit & Hungler 1999:17-18). Exploratory studies are done “to acquire a better understanding of the phenomenon and can yield new insights into the research topic” (Babbie & Mouton 2001:80). The exploratory design was used in the study to explore the prevalence of vicarious trauma and the co-variable, personal trauma history, in depth so as to arrive at how the nurses view the self (i.e., themselves) and the world.

3.2.1.3 Descriptive design

According to Burns and Grove (2001:26), descriptive designs help to "identify problems in current practice with the view to improve practice outcomes. Descriptive studies describe aspects of a situation as they naturally occur." Descriptive design involves the complete description of a single variable within a given population (Brink & Wood 1998:289). Descriptive research is not aimed at determining the relationship between independent and dependant variables; no hypothesis is therefore required (Polit & Hungler 1999:195; Brink & Wood 1998:283, 288). The researcher selected a descriptive design in order to describe the aspects of the work-related experiences with reference to career longevity and support systems.

3.2.2 Population

The population is "all elements (individuals, objects or substances) that meet certain criteria for inclusion in the study" Kerlinger (1986) (cited in Burns & Grove 1999:40). The population is "the entire set of individuals having some common characteristics" (Polit & Beck 2004:727). The target population for this study was all the nurses, male and female, who render a psychiatric and mental health service in urban areas in the Cape Metropole. Eligibility criteria refer to criteria that specify population characteristics (Polit & Beck 2004:290; Polit & Hungler 1999:701). For the purposes of this study, the participants had to:

- Be registered nurses with an additional qualification in psychiatric nursing science, rendering a mental health service.

- Be employed on a full-time basis by the Department of Health of the Western Cape Province.
- Be directly involved in counselling victims of trauma; for example, people with a positive HIV status, cancer, and victims of violence.
- Work at a community health centre or a local authority clinic in the Cape Metropolitan area.

3.2.3 Sample

A sample is a small portion of the population that is selected for a particular study (Burns & Grove 1999:41). Polit and Hungler (1999:714) define a sample as “a subset of a population selected to participate in a research study”. Sampling is the process of selecting a portion of the population (people, events, and behaviour) to represent the entire population (Burns & Grove 1999:41; Polit & Beck 2004:291).

In this study the researcher adopted a non-probability sampling approach. Non-probability sampling “uses the judgement of the researcher to select those subjects who know the most about the phenomenon and who are able to articulate and explain nuances to the researcher” (Brink 1996:135). All the nurses who met the inclusion criteria for the study were included. The sampling was thus a census as all the nurses rendering a mental health service to the population of the Cape Metropole area who met the eligibility criteria were included in the study. Generalisation to all the nurses working at community health centres in the Cape Metropole area will therefore be possible.

Sample size refers to the number of participants selected to participate in the study. The sample size for this study was 37 as there are only 37 nurses working in the community health centres in the Cape Metropole area.

3.2.4 Data-collection instrument

In this study, data was collected using a structured questionnaire. Polit and Beck (2004:349) describe the questionnaire as “a written formal schedule that respondents complete themselves”. Questionnaires tend to be selected for descriptive studies to obtain information from individuals, facts about situations or beliefs of the subjects (Burns & Grove 1999:272). One self-reporting questionnaire, namely the TSI Belief Scale (Pearlman & Saakvitne 1995a: 408-410) was selected (see Section B of the questionnaire) for this study to gather data on disruptions to cognitive schema in nurses. Questionnaires consist of a set of questions and in most cases have predetermined response alternatives (Polit & Hungler 1999:334). The researcher also devised questions relating to biographical data, personal trauma history, workplace experiences and support systems to fulfil the research questions and objectives.

3.2.4.1 Advantages of questionnaires

Questionnaires are less costly and require less time and energy to administer than interviews (Polit & Beck 2004:350). As complete anonymity is possible, participants are more likely to provide honest answers (Polit & Beck 2004:350). The format of the questionnaire is standard, therefore questions are consistent and there is less opportunity for interviewer bias (Polit & Hungler 1999:334).

3.2.4.2 Disadvantages of questionnaires

Questionnaires have certain disadvantages, but the researcher took steps to overcome them as indicated below.

The response rate may be low. The researcher hand delivered the questionnaires and set time limits for collection of questionnaires to overcome this limitation. Personal contact has a positive effect on response rates (Polit & Beck 2004:366).

Brink (1996:153) points out that the participants may misunderstand items and there may be no opportunity to clarify uncertainties. The researcher enclosed instructions for completion to overcome this. The researcher was also available telephonically for points of clarification. In addition, a pilot study was conducted to test the clarity of the questions.

Questionnaires using closed questions are difficult to construct. They also lack depth. Participants may be forced to select responses that do not reflect their precise opinions (Polit & Hungler 1999:335). In this study, this aspect was overcome by concluding the questionnaire with a space for remarks/comments.

3.2.4.3 Selection of the questionnaire as an instrument

The selection of the questionnaire involved the following steps:

The researcher consulted literature on instruments used in previous studies to measure the effects of vicarious trauma experienced by nurses when counselling victims of trauma. Various existing instruments were compared. One existing questionnaire,

namely the TSI Belief Scale, was selected as it addressed the research questions and objectives of this study. The researcher then drafted a questionnaire, which included the TSI Belief Scale (Section B) and four sections, namely biographic data, personal trauma history, work-related experiences and support systems. The draft questionnaire was discussed with the research supervisors and a statistician and their recommendations implemented. The questionnaire was compiled in English as English is the universal language used by most health care workers in the Cape Metropolitan area.

3.2.4.4 The questionnaire

The questionnaire consisted mainly of structured, closed questions and was divided into five sections.

(1) Section A: Biographical data

This information was required to obtain knowledge about the respondents' characteristics and experiences. The respondents were asked to indicate gender, age, professional qualifications and years of experience as a registered nurse, and experience in community mental health service.

(2) Section B: Traumatic Stress Institute (TSI) Belief Scale

The TSI Belief Scale is an 80-item self-report instrument using a 6-point Likert scale (1 = *disagree strongly*, 6 = *agree strongly*) that measures disruptions in five cognitive schemes/beliefs, thought to be sensitive to trauma and vicarious trauma (Pearlman & Saakvitne 1995a: 408-410). The areas, namely safety, trust, esteem, intimacy and

control, have a self, and other dimension, yielding ten subscales. Scores obtained include a total score calculated from the sum of all the responses; a higher score indicates greater disruption (Jenkins & Baird 2002:427). These psychological need areas are described in the CSDT.

(3) Section C: Personal Trauma History

Five dichotomous questions relating to personal trauma history were included in this section.

(4) Section D: Work-related experiences

Four items on work- and workload-related experiences of nurses were included to ascertain the effects of work exposure to traumatised patients.

(5) Section E: Support

Six items were included in the questionnaire to assess support for nurses doing trauma work. A 4-point Likert scale (*1= Never; 4= Very often*) was used to illicit what support systems nurses found most helpful in their work with the traumatised. There were two dichotomous questions relating to debriefing. The research questions and objectives informed the development of these questions.

3.3 VALIDITY AND RELIABILITY

Validity and reliability are the major criteria for assessing the instruments quality and adequacy (Polit & Beck 2004:416)

3.3.1 Validity

Validity refers to “the degree that an instrument measures what it is supposed to measure” (De Vos 2001:83). Content validity refers to “the extent that the questionnaire includes all the major elements relative to the concept being measured” (Burns & Grove 1999:260; Burns & Grove 2001:400). The validity of the TSI Belief Scale has been established with four criterion groups (n = 807), mental health professionals (n = 247), students (n = 256), outpatient clients (n = 186), and chronic patients (118) (Pearlman & Saakvitne 1995a:407). The other questions were developed using the research objectives and questions as a point of departure. The research supervisors and a statistician evaluated the questionnaire.

3.3.2 Reliability

Polit et al (2001:305) describe reliability as “the consistency with which an instrument measures the attribute”. An instrument is said to be reliable if it measures accurately and reflects the true score of the attribute under investigation. Reliability may be obtained by measuring internal consistency by using the split-half technique (Polit & Hungler 1999:414). In this research, Cronbach’s alpha coefficient was used to test the

internal consistency or homogeneity or reliability of the study (Polit & Hungler 1999:415).

Pretesting the instrument on five individuals that did not participate in the study enhanced the reliability of the instrument.

3.4 PILOT STUDY

According to Brink (1996:174) a pilot study is a “small-scale study, which is conducted before the main study on a limited number of subjects from the same population as that intended for the eventual project”. The data collection instrument was pretested on five individuals who are considered experts in the field of mental health. These individuals did not participate in the actual study. Their recommendations were considered and implemented.

3.5 ETHICAL CONSIDERATIONS

According to De Vos (2001:24) ethical guidelines serve as a basis upon which a researcher conducting research can evaluate his conduct. Furthermore Polit and Hungler (1999:147) state that the researcher needs to carefully consider the ethical requirements of research during the planning phase. Ethical considerations are vital to any study because of the influence on the researcher’s ability to acquire and retain participants (Polit & Hungler 1999:13).

The following ethical principles were observed in this study:

3.5.1 Right to self-determination

All the subjects were respected and treated with dignity and as autonomous agents. The prospective subjects were informed of their right to decide voluntarily if they wanted to participate in the study (Polit & Beck 2004:147).

3.5.2 Right to full disclosure

The researcher fully described the nature of the research by speaking to each nurse personally. The nurses were informed of their right to refuse participation and asked to sign a consent form (see Annexure B), which gave them the option of refusing participation. The researcher also explained researcher responsibility and the risk/benefit ratio to the subjects (Polit & Beck 2004:147).

3.5.3 Principle of justice

All the subjects received fair treatment and their right to privacy was maintained. Anonymity was ensured, as they were not required to write their names on the questionnaire (Polit & Beck 2004:147).

3.5.4 Principle of beneficence

The researcher has the duty to do good and avoid harm. The researcher tried to avoid harm to the subjects as they were informed of their right to terminate their participation in the research at any time if psychological harm was predicted (Polit & Hungler

1999:134). An objective of the study was to determine the need for support services for these nurses in order to ensure that their psychological well being was maintained.

3.5.5 Rights of institution

The rights of the institution were protected by fully disclosing the nature of the study and the researcher's responsibility to the organisation. The approval of the necessary authorities was sought in order to ensure that they were informed about the study and to gain their cooperation.

3.5.6 Scientific honesty

Experienced researchers supervised the study to ensure that the researcher was competent to conduct the research. The researcher acknowledged all ideas or work from others used in the study (Brink 1996:47).

3.5.7 Informed consent

The prospective subjects were fully informed of the nature, purpose, scope and procedures used to collect the data (Polit & Hungler 1999:140). Each subject was furnished with a consent form to sign stating that they had given permission to participate in the study (see Annexure B).

3.6 DATA COLLECTION

In this study, data was collected using a structured questionnaire. Polit and Beck (2004:349) describe the questionnaire as “a written formal schedule that respondents complete themselves”. The questionnaire was delivered by hand to each participant. A covering letter, explaining the purpose of the study, was included (see Annexure B). Clear and concise instructions for completing the questionnaire were included. The researcher collected the questionnaires personally after a period of two weeks.

3.7 DATA ANALYSIS

The questionnaires were numbered and coded to facilitate data capturing and auditing of captured data**.** The SAS version 12.0 computer program was used for data analysis. The program covers frequency tables, graphs, diagrams, statistical pies and representative characteristics or values, such as averages and percentages. A statistician assisted with the statistical analysis. Descriptive statistics were used to describe and synthesise data.

3.8 CONCLUSION

This chapter discussed the research design and methodology in detail, including the research instrument, the method of distributing and collecting the questionnaires to ensure a high return rate, validity, reliability and ethical considerations.

Chapter 4 discusses the research findings.

CHAPTER 4

Data analysis and findings

4.1 INTRODUCTION

This chapter discusses the data analysis and findings. The questionnaire used in this exploratory, descriptive study was carefully analysed to ensure that the data gathered was presented clearly with the aid of tables, percentages and graphs, where possible.

The overall aim of this study was to describe the effects, namely vicarious traumatisation, experienced by registered nurses providing psychological care to victims of trauma in the Cape Metropolitan area and to make recommendations for support. Work-related aspects were also analysed and presented, bearing in mind that the mental health nurses not only treat victims of trauma but also care for patients with major psychiatric illnesses.

The questionnaire comprised five sections with a total of 100 structured closed questions and two exploratory questions that were developed to ensure rigor and objectivity.

Section A covers the biographical data, qualifications and experience as a registered nurse.
Section B contains the 80-item TSI Belief Scale (Pearlman & Saakvitne 1995:408-10) and comprised of 10 subscales:
Section C contains five questions, covering the trauma history and intervention
Section D contains four questions, covering the exposure of mental health nurses to psychological trauma.
Section E comprises of categories which contain questions on support systems.

4.2 DATA COLLECTION

Initially, the total population of 37 mental health nurses working in the community mental health service were identified to participate in the study. However, one nurse was unavailable to complete the questionnaire and one did not meet the eligibility criteria as she was an enrolled nurse auxiliary and was thus eliminated from the study. As the sample was small,

the researcher identified seven mental health nurses working in the surrounding rural areas of the Cape Metropolitan area and included them in the study. A total of 43 questionnaires were distributed with a response rate of 86% (n=37). According to Polit and Hungler (1999:348), a response rate of greater than 60% is ideal. Nelson-Gardell and Harris (2003:16) had a response rate of 88%; Ortlepp and Friedman (2002:215), a response rate of 51%, and Way et al (2004:55), a response rate of 33%.

The data was entered into the excel sheet on the computer. This information was protected by a secret password, to which only the researcher had access.

4.3 DATA ANALYSIS

The data was captured from 37 questionnaires and subjected to computer analysis, with the assistance of a professional statistician and converted into percentages. Furthermore, the data was summarised in the form of tables, graphs and figures to make the data presentation more meaningful. The data was analysed according to the research questions.

Section A: Biographical data

This section covered the gender distribution, age distribution, professional qualifications, years of experience as a registered nurse, and years of experience working in community mental health services of the research population.

4.3.1.1 Gender distribution

Figure 4.1 depicts the respondents' gender distribution.

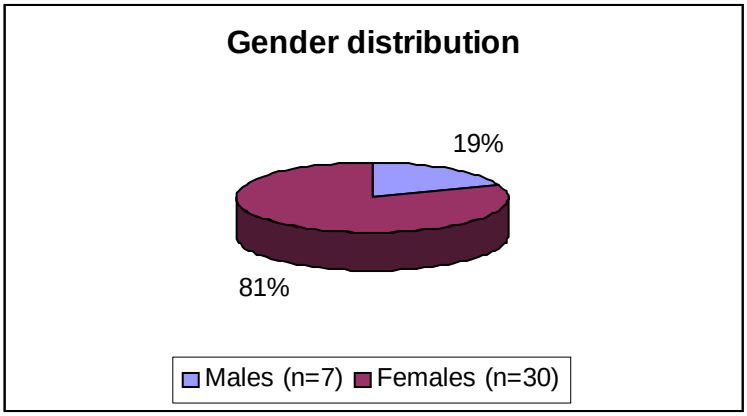

Figure 4.1

Respondents' gender (N=37)

According to figure 4.1, 81% (n=30) of the respondents rendering a mental health service were females, indicating that nursing is predominantly a female profession in comparison to males who accounted for 19% (n=7) of the sample.

This is consistent with Cunningham's (2003:454) finding that 82% of social work clinicians rendering services to victims of trauma were females. Furthermore, in Trippany et al's (2003:50) study on factors influencing vicarious trauma, the sample consisted of 114 self-identified female therapists. These findings suggest that females serve predominantly as counsellors for victims of trauma. The researcher is of the opinion that females generally assume the "caring" role and therefore work in the helping professions as nurses, social workers and teachers.

4.3.1.2 Respondents' age distribution

Figure 4.2 depicts the respondents' age.

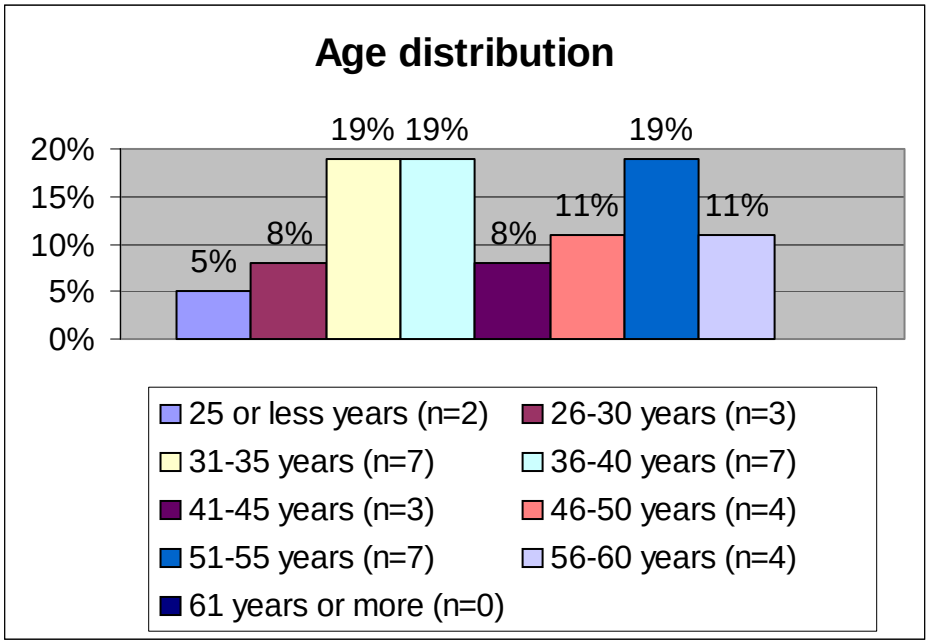

Figure 4.2

Respondents' age distribution (N=37)

Of the respondents, 19% were in the age groups 31-35, 36-40 and 51-55; 11% were in the age groups 46-50 and 56-60; 8% were in the age groups 26-30 and 41-45, and 5% were in the age group 25 or less years. These findings indicate that the nurses' ages ranged from 25 to 60. Trippany et al (2003:52) found that the nurses were aged between 24 and 68.

4.3.1.3 Professional qualifications

Table 4.1 depicts the respondents' professional qualifications.

Table 4.1 Professional qualifications

Professional qualifications	**N=37**	**PERCENTAGE**
General nursing	37	100
Midwifery	35	94.56
Community nursing science	32	86.49
Psychiatric nursing science	37	100
Nursing administration	9	24.32
Nursing education	1	2.70
Other: BA.Cur- Advanced Psychiatry-3 Clinical Nurse Practitioner-2 BA Psychology-1	 7 3 1 1	

The population studied accounted for 100% registered nurses of whom all (100%; n=37) possessed an additional qualification in psychiatric nursing science. These nurses therefore met one of the eligibility criteria to be included in the study. Of the respondents, 94.56% (n=35) had qualifications in midwifery; 86.49% (n=32) in community nursing science; 24.32% had a qualification in nursing administration; 8.11% (n=3) had a diploma in advanced psychiatry; 5.41% (n=2) in clinical nurse practitioner; 2.70% (n=1) had baccalaureate degrees in nursing, and 2.70% (n=1) in psychology. These findings suggest that community mental health nurses have a wide range of qualifications. The researcher is of the opinion that these qualifications assist nurses in their daily work as they work independently (see chapter 1). It is of concern, however, that none of the respondents had master's degrees. Trippany et al (2003:53) found that all their participants had either a master's or a doctoral degree.

4.3.1.4 Nursing experience as a registered nurse

Figure 4.3 indicates the respondents' experience in nursing as a registered nurse in

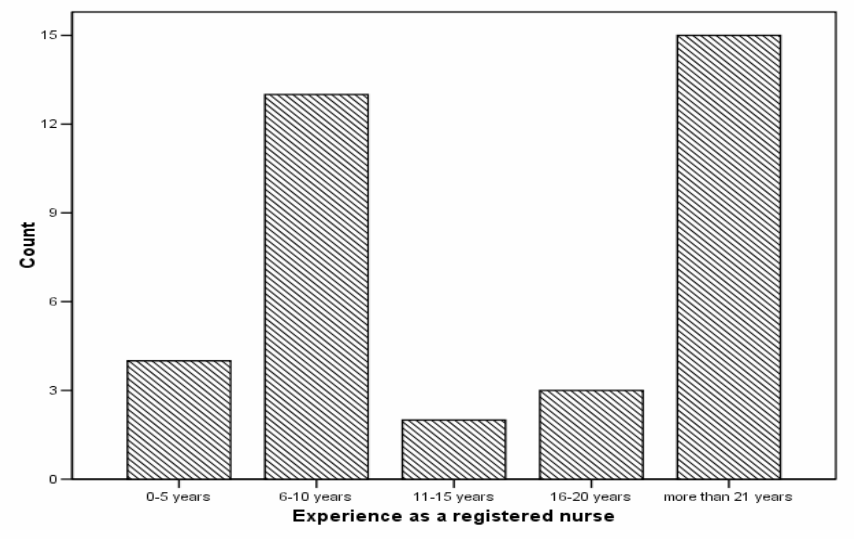

Figure 4.3

Respondents' experience as registered nurses

Of the respondents, 41% (n=15) had more than 21 years' experience of working in community mental health services; 35% (n=13) had 6-0 years' experience; 11% (n=4) had 0-5 years' experience; 8% (n=3) had 16-20 years' experience, and 5% (n=2) had 11-15 years' experience. These findings suggest that the more experienced nurses counsel victims of trauma at community health centres.

4.3.1.5 Nursing experience in community mental health services

Figures 4.4 and 4.5 depict the respondents' experience in community mental health services.

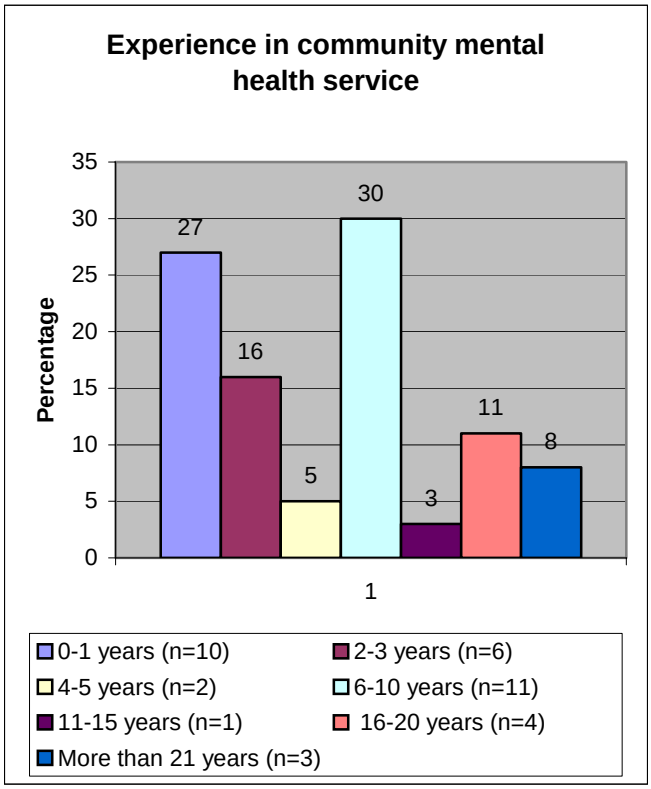

Figure 4.4

Respondents' experience in community mental health service

Of the participants, 30% (n=11) had 6-10 years' experience in mental health community service; 27% (n=10) had only 0-1 years' experience; 16% (n=6) had 2-3years' experience; 11% (n=4) had 16-20 years' experience; 8% (n=3) had more than 21 years' experience; 5% (n=2) had 4-5 years' experience, and 3% (n=1) had 11-15 years' experience.

The researcher regrouped the years' experience categories to assist in data analysis and enable analysis of relationships between career longevity and the ten subscales. Figure 4.5 depicts the regrouping as follows:

Group 1 = 0-1 year or 2-3 years (little experience)

Group 2 = 4-5 years or 6-10 years (average experience)

Group 3 = 11-15 years or 16-20 years or more than 21 years (extensive experience)

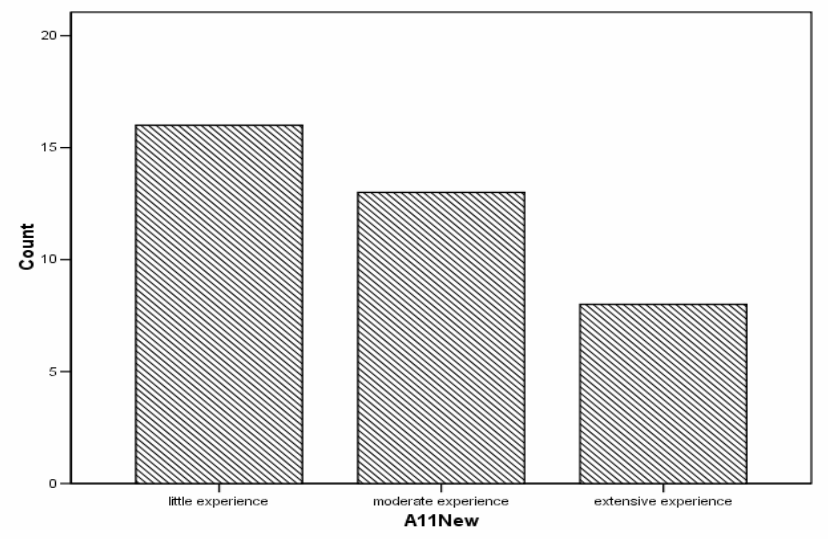

Figure 4.5

Grouping of years of experience in community mental health service

Figure 4.5 indicates that 16 (43%) respondents had little experience in community mental health service; 13 (35%) had moderate experience, and 8 (22%) had extensive experience. Community mental health nurses work independently and are regarded as specialists in their field. New and inexperienced nurses accounted for most (43%) of the respondents rendering mental health services. Cunningham (2003:457) found that new and inexperienced staff was most likely to experience vicarious trauma.

4.3.2 SECTION B

This section contained the 80-item TSI Belief Scale. The TSI Belief Scale is a perception scale that measures how people view themselves and their world. Ten subscales, namely safety, other-safety, esteem, other-esteem, trust, other-trust, control, other-control, intimacy and other-intimacy were created (see annexure D). These subscales may be considered interval-scale variables. Table 4.2 presents a summary of the descriptive statistics relating to the ten subscales.

Table 4.2 Respondent's views on their TSI Belief Scale (N=37)

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Safety	34	16	33	26.21	4.073
O-Safety	36	20	36	29.08	3.760
Esteem	33	45	77	67.42	6.792
O-Esteem	37	23	44	36.84	4.317
Trust	35	14	24	20.20	2.471
O-Trust	36	30	59	45.94	7.735
Intimacy	34	25	47	35.82	4.840
O-Intimicy	36	22	53	44.72	6.139
Control	36	12	42	33.31	5.801
O-Control	34	20	40	32.68	4.650
Valid N (listwise)	25				

As depicted in table 4.2, the subscales had varying means since they consisted of different numbers of questions that were added. From the 'Valid N (listwise)' equal to N=25, there were different missing cases suggesting that not all the respondents answered the 80 questions that were asked for the 10 subscales. The sample would reduce to N=25 if those respondents were excluded from the data analysis process. The subscale *esteem* had the highest mean, 67.42 whilst *trust* had the lowest at 20.20. The mean TSI Belief scale score for the entire sample was 37.22. Pearlman and MacIan (1995:560) obtained a mean score of 184 in their study, which was the lowest score they had obtained in data collected over the years.

The standard deviations also varied, indicating more or less symmetrical distributions.

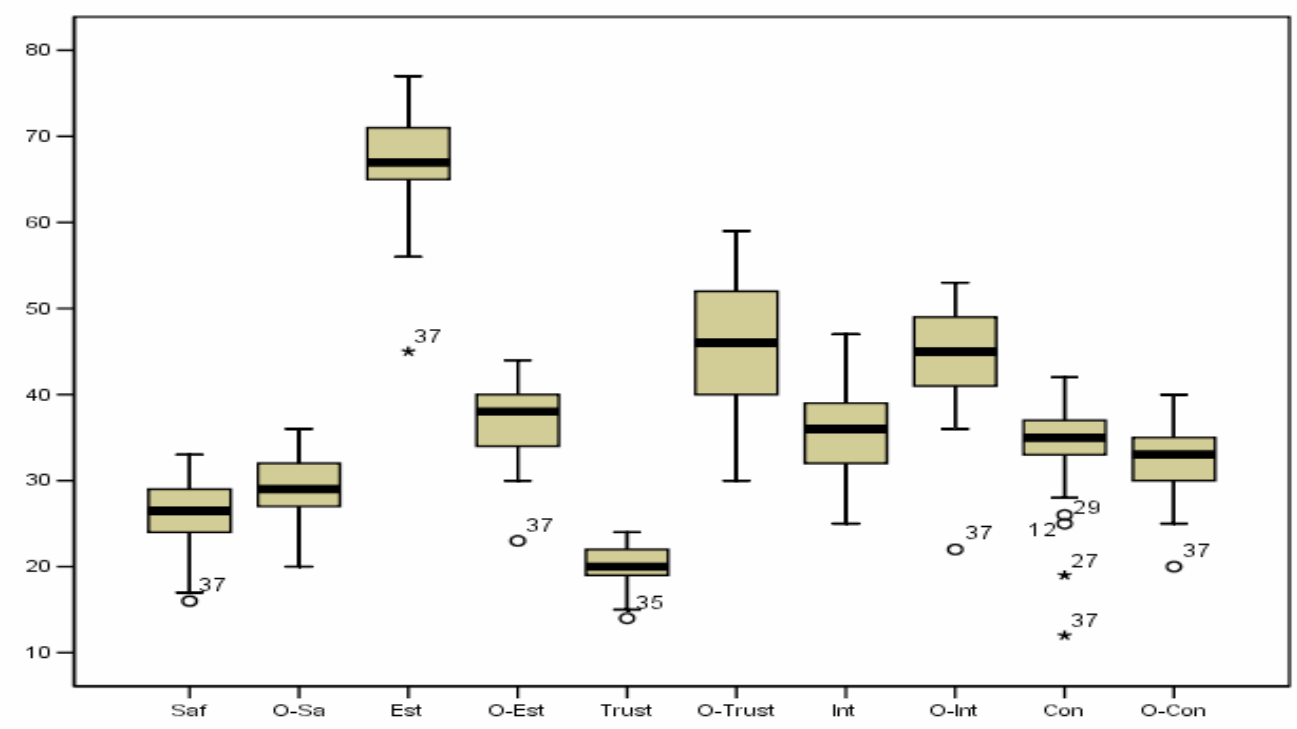

Figure 4.6

Composite box-plot of ten subscales of the respondent's views on the TSI Belief Scale (n=37)

A composite box plot (figure 4.6), further denotes the descriptive statistics reflected in table 4.2. As depicted in figure 4.6, the distributions look normal. Observation number 37 was considered an "outlier" due to missing data. The numbers in the box-plot refer to the respondents who did not complete the questions relating to the subscales; for example, participant 37 did not answer the all the questions relating to subscales, esteem, other-esteem, other-intimacy, control and other-control.

To investigate the relationship between the subscales, pair-wise correlation coefficients were computed (see table 4.3). According to Polit and Hungler (1999:458), Pearson's product-movement correlation coefficient (Pearson's r) is the most commonly used correlation index that is computed to measure variables on an interval scale, as was the case with the ten subscales. Furthermore, Polit and Hungler (1999:459) conclude that for variables of a psychological nature, an r of .70 is high, meaning that the relationship between the variables has a strong positive correlation.

Pair-wise correlations between the values of the ten subscales

Table 4.3 depicts the pair-wise correlations between the values of the ten subscales. There are three values in each cell:

(1) the Pearson product moment correlation coefficient
(2) the p-value for the hypothesis test H0 p=0
(3) the sample size

All the correlations (except Trust vs O-Trust with r = .121) were significant at the 5% level of significance (implying that the hypothesis of no correlation was rejected). The highest correlation was .804, which depicted a strong positive relationship between participants' **other-intimacy** and **control** psychological need areas. As stated in chapter 2, section 2.4, other-intimacy refers to the need to feel connected to others and control refers to the need to be able to manage one's feelings. Disruptions in the need area of other-intimacy result in individuals having few friends and intimate connections with others. Disruptions in the control need area result in dissociation by individuals (Pearlman & Saakvitne 1995:72-3).

Table 4.3 Pair-wise correlations between the values of the ten subscales

		Con	Est	Int	O-Con	O-Est	O-Int	O-Sa	O-Trust	Safety	Trust
Control	Pearson correlation	1	.736**	.595**	.711**	.587**	.804**	.455**	.520**	.360*	.317
	Sig. (2-tailed)	.	.000	.000	.000	.000	.000	.006	.001	.040	.068
	N	36	33	34	33	36	35	35	35	33	34
Esteem	Pearson correlation	.736**	1	.722**	.727**	.514**	.730**	.562**	.318	.408*	.616**
	Sig. (2-tailed)	.000	.	.000	.000	.002	.000	.001	.076	.023	.000
	N	33	33	31	31	33	32	32	32	31	31
Intimacy	Pearson correlation	.595	.722**	1	.483**	.489**	.519**	.592**	.287	.478**	.684**
	Sig. (2-tailed)	.000	.000	.	.005	.003	.002	.000	.106	.007	.000
	N	34	31	34	32	34	33	33	33	31	32
O-Control	Pearson correlation	.711**	.727**	.483**	1	.632**	.663**	.626**	.657**	.470**	.358*
	Sig. (2-tailed)	.000	.000	.005	.	.000	.000	.000	.000	.008	.044
	N	33	31	32	34	34	33	33	33	31	32
O-Esteem	Pearson correlation	.587**	.514**	.489**	.632**	1	.736**	.590**	.663**	.516**	.179
	Sig. (2-tailed)	.000	.002	.003	.000	.	.000	.00	.000	.002	.304
	N	36	33	34	34	37	36	36	36	34	35
O-Intimacy	Pearson correlation	.804**	.730**	.519**	.663**	.736**	1	449**	.517**	.296	.401*

		Con	Est	Int	O-Con	O-Est	O-Int	O-Sa	O-Trust	Safety	Trust
	Sig. (2-tailed)	.000	.000	.002	.000	.000	.	.007	.001	.094	.019
	N	35	32	33	33	36	36	35	35	33	34
O-Safety	Pearson correlation	.455**	.562**	.592**	.626**	.590**	.449**	1	.375**	.589**	.401*
	Sig. (2-tailed)	.006	.001	.000	.000	.000	.007	.	.024	.000	.017
	N	35	32	33	33	36	35	36	36	33	35
O-Trust	Pearson correlation	.520**	.318	.287	.657**	663**	.517**	.375*	1	.420*	.121
	Sig. (2-tailed)	.001	.076	.106	.000	.000	.001	.024	.	.015	.490
	N	35	32	33	33	36	35	36	36	33	35
Safety	Pearson correlation	.360*	.408*	.478**	.470**	.516**	.296	.589**	420*	1	.390*
	Sig. (2-tailed)	.040	.023	.007	.008	.002	.094	.000	.015	.	.027
	N	33	31	31	31	34	33	33	33	34	32
Trust	Pearson correlation	.317	616**	.684**	.358*	.179	.401*	.401*	.121	.390*	1
	Sig. (2-tailed)	.068	.000	.000	.044	.304	.019	.017	.490	.027	.
	N	34	31	32	32	35	34	35	35	32	35

**. Correlation is significant at the 0.01 level (2-tailed)

*. Correlation is significant at the 0.o5 level (2-tailed)

The pair-wise correlations between the values of the ten subscales are further illustrated in a scatter plot in figure 4.7

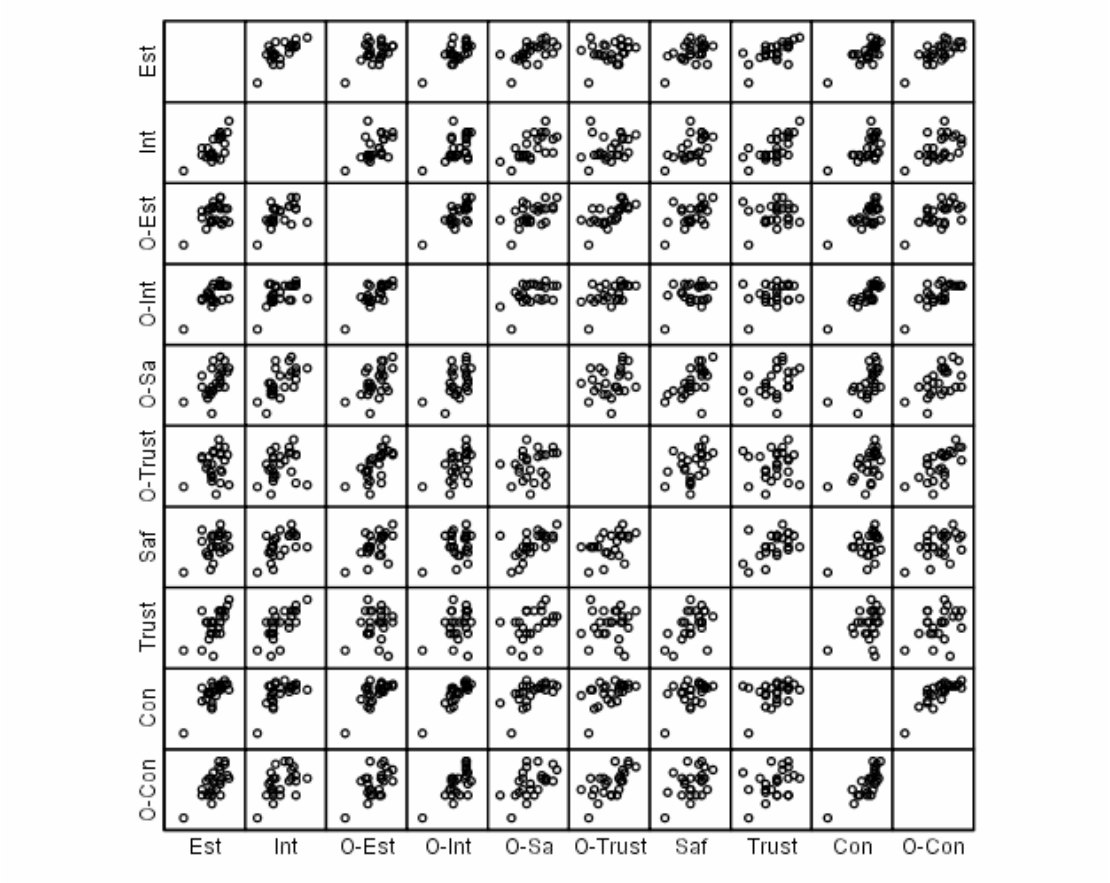

Figure 4.7

Pair-wise scatter plots of the ten subscales

The scatter plot (figure 4.7) gives a visual representation of the relationship between two variables, for example intimacy vs other-control. Pairs of scores for the ten subscales are plotted on a graph by placing dots to indicate where each pair of variables relating to the subscales intersect.

Inspection of the scatter plot (figure 4.7) denotes that **trust** vs **other-trust** have a weak positive linear relationship with r=.121. Trust refers to the need to trust one's own judgment and other-trust is the need to depend on others to meet one's emotional, psychological and

physical needs (see chapter 2, section 2.4). Disruptions in trust and other-trust need areas result in individuals being unable to trust their own judgment (self-trust) nor the judgment of others (other-trust) (Pearlman & Saakvitne 1995a:71).

4.3.3 SECTION C

This section dealt with the respondents' personal trauma history. Personal trauma history includes any psychological trauma experienced by the participants, their families or friends. Also included were questions relating to intervention they received to deal with the trauma.

4.3.3.1 Personal trauma history

Figure 4.8 depicts the respondents' personal trauma history.

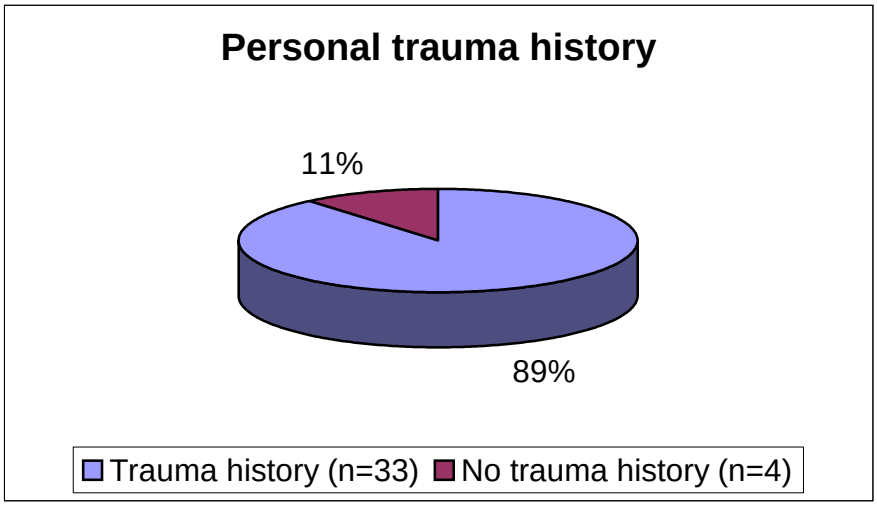

Figure 4.8

Personal trauma history (N=37)

Of the respondents, 89% (n=33) had a personal trauma history while 11% (n=4) did not have a personal trauma history. The equivalent non-parametric Mann-Whitney test was used to

test for differences between personal trauma history and the 10 subscales measured by the TSI belief scale (see table 4.4).

Table 4.4 Personal trauma history and 10 subscales

	Mann- Whitney U	Asymp. Sig. (2-tailed)
Safety	64.500	.941
O-Safety	35.000	.128
Esteem	46.000	.841
O-Esteem	47.000	.350
Trust	57.000	.654
O-Trust	56.000	.642
Intimacy	61.000	.806
O-Intimacy	56.500	.641
Control	51.000	.461
O-Control	40.500	.210

Table 4.4 shows the test results for each of the 10 subscales as correlated with personal trauma history. None of the results were significant thus indicating that there was no relationship between personal trauma history and vicarious trauma. This non-significant finding could possibly be attributed to the small sample size. Adams et al (2001:368) and Way et al (2004:66) reported that personal trauma history was not a predictor of vicarious trauma.

4.3.3.2 Trauma experience

Figure 4.9 depicts the participant, family member, friend or other person who experienced the trauma.

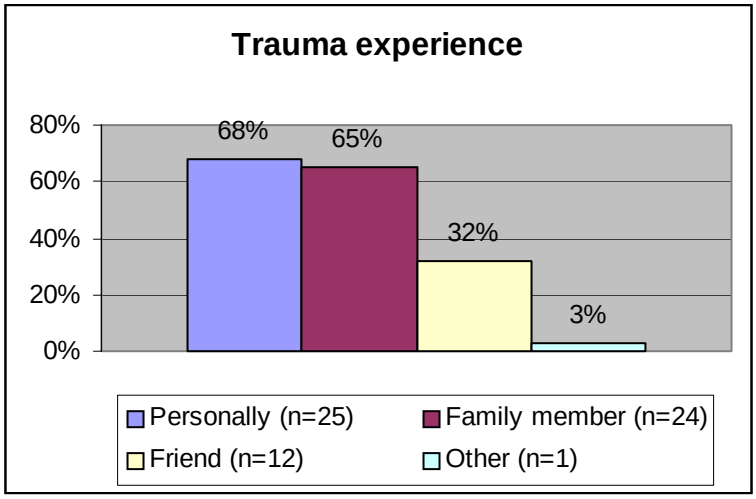

Figure 4.9

Trauma experience of family, friend or others (n=37)

Of the participants with a trauma history, 68% (n=25) personally experienced the trauma; 65% (n=24) experienced trauma through a family member, and 32% (n=12) experienced trauma through a friend. It is evident that some of the participants experienced trauma personally, to family members and to friends thus having a multiple trauma history. These findings reflect people's experience of living in the RSA with the spiralling increase in violent crimes (see chapter 1, table1.2).

4.3.3.3 Psychological intervention

Figure 4.10 depicts the participants' involvement in psychological intervention to deal with trauma.

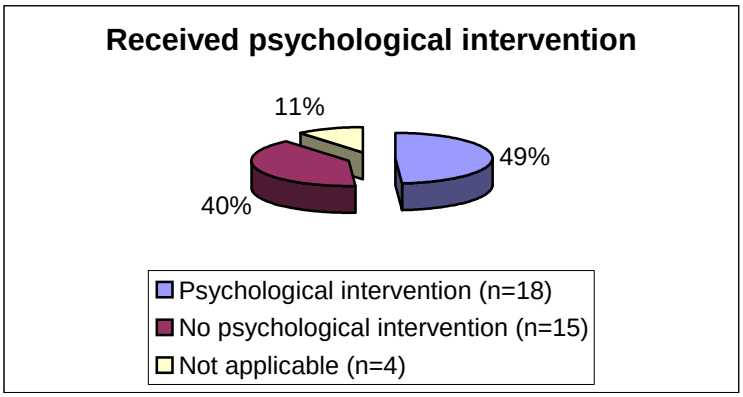

Figure 4.10

Psychological intervention (N=37)

According to figure 4.10, 49% (n=18) of the participants received psychological intervention to deal with their personal trauma; 40% (n=15) did not receive intervention, and 11% (n=4) had no personal trauma history thus intervention was not deemed necessary as the questions were related to psychological intervention received for dealing with personal trauma. According to Collins (2001:13), the reasons why nurses in his study did not make use of psychological intervention were fear that counselling would make matters worse, and the guilt and shame nurses felt when thinking that others were worse off than them.

4.3.3.4 Type of psychological intervention

Figure 4.11 depicts the type of intervention the participants received.

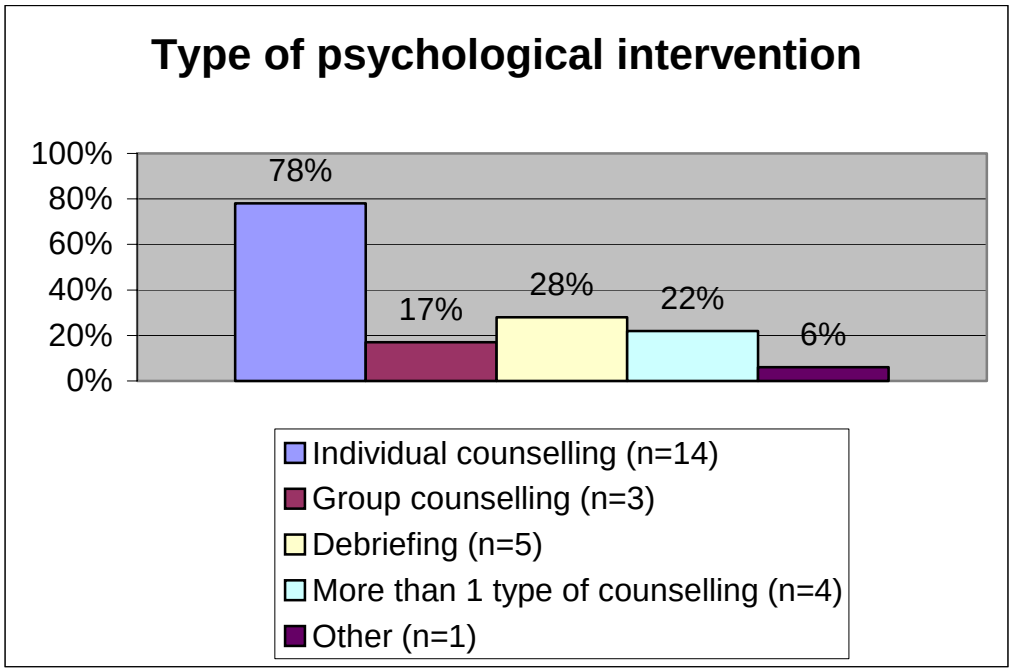

Figure 4.11

Type of psychological intervention received counselling (N=18)

Of the participants, 78% (n=14) received individual counselling; 17% (n=3) received group counselling to cope with their personal trauma; 28% (n=5) had debriefing; 22% (n=4) had more than one type of counselling, and only 6% (n=1) received other intervention, namely medication, to deal with the trauma. The high percentage of participants seeking counselling to deal with their trauma could be attributed to the participants being mental health nurses and thus aware of resources available.

4.3.3.5 Benefits of psychological intervention

The respondents were asked to indicate whether psychological intervention was beneficial (see figure 4.12).

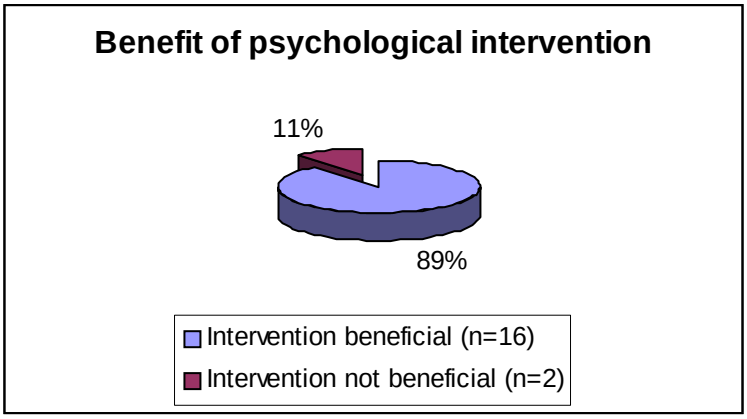

Figure 4.12

Benefit of psychological intervention for participants (N=18)

Only 49% (n=18) of the participants answered the question relating to the benefits of psychological intervention. Of the 18 participants who responded, 89% (n=16) found the psychological intervention beneficial while11% (n=2) reported no benefit. As depicted in figure 4.10, 15 participants did not have psychological intervention while 4 reported no personal trauma history (figure 4.8).

4.3.4 Section D

This section dealt with the work-related experiences of the nurse that might be related to vicarious trauma and explored whether all mental health nurses were subjected to psychological trauma. A composite variable workload of nurses with relevance to victims of violence and terminal illnesses was created as an index of workload. Furthermore, the time spent counselling victims of trauma was also depicted.

4.3.4.1 Subjection of mental health nurses to psychological trauma

Figure 4.13 depicts whether mental health nurses are subjected to psychological trauma.

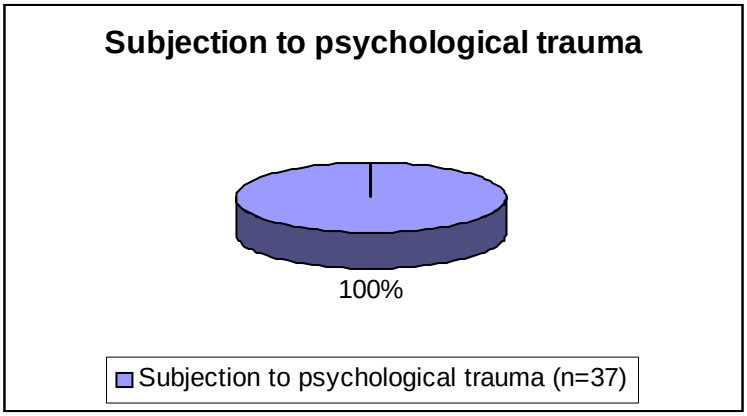

Figure 4.13

Subjection to psychological trauma

All the participants (100%; n=37) were of the opinion that mental health nurses are subjected to psychological trauma by the nature of their work. Geyer (2004:34) found that all nurses had been exposed to secondary trauma in their daily work. Verbal abuse experienced by patients and family members, and being exposed to others' trauma appeared to be perceived as the main contributors to the participants' feeling that they were subjected to psychological trauma.

4.3.4.2 New cases seen

In table 4.5, the case processing summary which depicts the number of respondents who indicated the amount of new trauma cases they see and the missing data is alluded to.

Table 4.5 Case processing summary

	Valid		**Missing**		**Total**	
	N	**Percent**	**N**	**Percent**	**N**	**Percent**
Cumulative new trauma cases	25	67.6%	12	32.4%	37	100%

According to table 4.5, 67.6% (n=25) of the participants indicated the new trauma cases seen while missing data accounted for 32.4% (n=12). The Department of Health (2003:20) refers to the challenges relating to data collection of mental health statistics at PHC level in the metropole. However, a composite variable, namely workload, was created of the 67.6% participants who completed the information and is depicted in figure 4.14

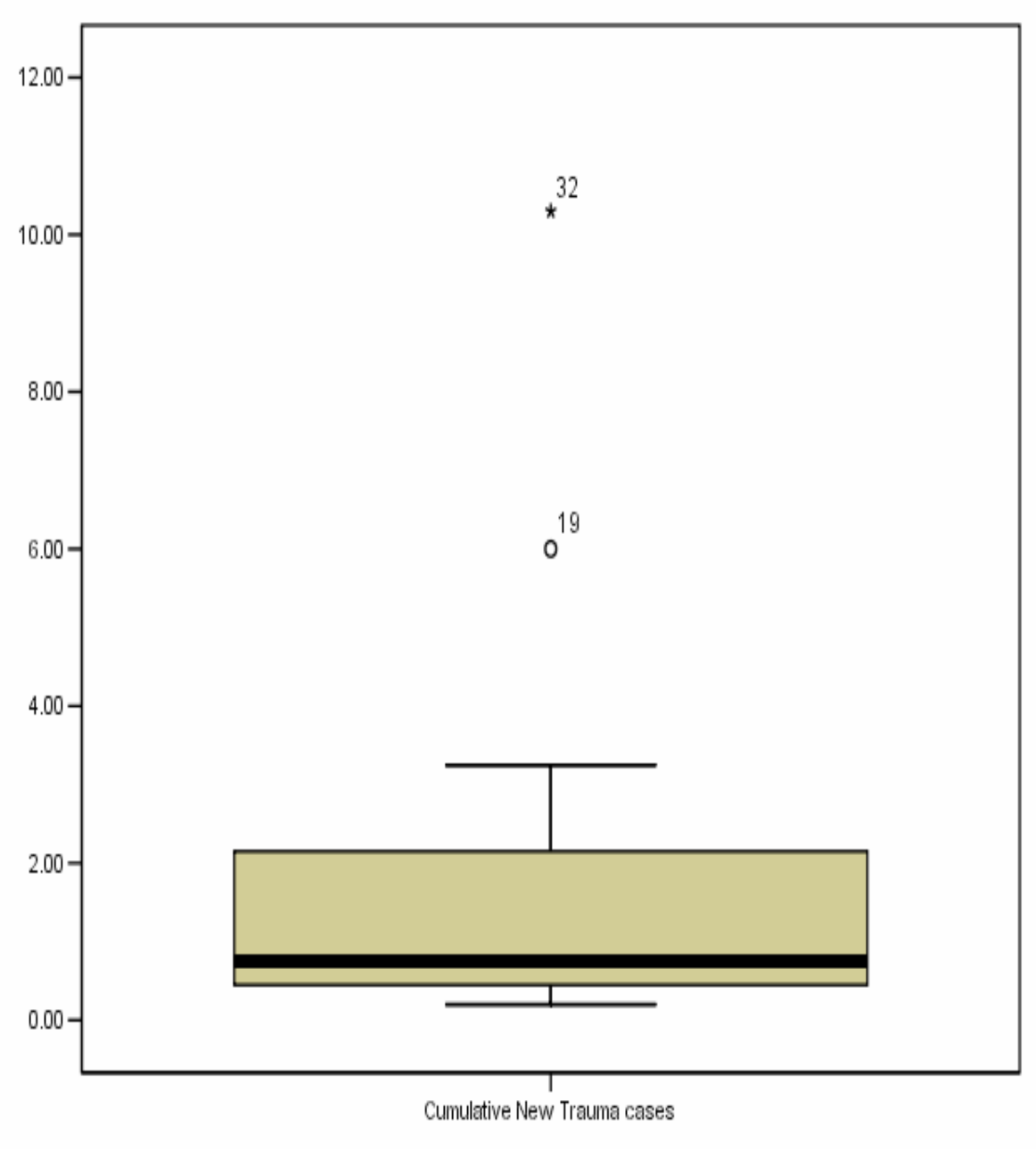

Figure 4.14

Box plot of composite variable workload

The original variables expressed in the questionnaire were the frequency per day, per week and per month of new cases for various kinds of abuse. This was converted to a percentage of cases seen per day to make the data more meaningful. A composite variable (figure 4.14) was created to create an index of workload. This variable can be treated as an interval scale variable.

As depicted in figure 4.14, the minimum number of new trauma patients that a mental health nurse sees per day is 0.20. An illustration of the minimum number of new trauma patients seen per week is calculated as follows: 0.20 patient x 5 days =1 new trauma patient per week. Respondent 19 and 32 saw an average of six and ten new cases on a daily basis. These discrepancies in the number of new cases seen need further investigation. As no studies could be found on trauma cases seen by mental health nurses, no comparison was possible.

4.3.4.3 Informing person of terminal illness

Table 4.6 reflects the percentages of community mental health nurses who had informed patients that they had a terminal illness.

Table 4.6 Informing patients of terminal illness

Terminal illnesses	N	Never	Sometimes/ often
HIV positive	35	32%	54%
Cancer	34	49%	44%

As indicated in table 4.6, 54% of the participants had informed patients that they were HIV positive while 32% (n=35) had never done so. Community health centres in the Cape metropole employ HIV counsellors who conduct voluntary counselling and testing (VCT) for the population of the metropole. It is possible that there are counsellors who render this service in areas where nurses had never informed patients of their positive HIV status. Furthermore, 49% (n=49) of the participants indicated that they had never informed patients

that they had cancer. The researcher is of the opinion that patients are already diagnosed with terminal illnesses, such as cancer, at secondary or tertiary hospitals. The nurses' main focus is counselling patients to accept their diagnosis and to assess the complications, such as complicated bereavement, grief and depression, associated with having a terminal illness.

4.3.4.4 Counselling time of new cases

Figure 4.15 depicts the average time the respondents spent counselling new trauma victims.

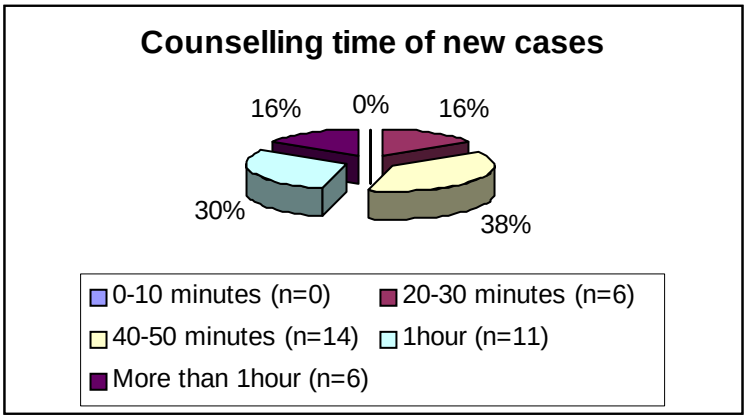

Figure 4.15

Counselling time of new cases by nurses (n=37)

According to figure 4.15, 38% (n=14) of the participants spent 40 to 50 minutes; 30% (n=11) spent one hour; 16% (n=6) spent more than one hour, and 16% (n=6) spent 20 to 30 minutes counselling new trauma victims. This statement is consistent with Halloran (2003-2005:2) who alludes to 50-minute counselling sessions to deal with distressing events in an individuals life, for example trauma. This author also suggests that sessions may be longer or less frequent. Goode (2001:1) purports that 90 minute counselling sessions are effective in dealing with PTSD relating to traumatic events such as the September 11 terrorist attack on the USA.

4.3.5 Section E

This section focused on support systems deemed helpful in working with traumatised people, the availability of debriefing in the workplace, who presented debriefing and who should

present it are noted. A list of support systems that might be helpful in limiting vicarious trauma in nurses was indicated.

4.3.5.1 Support systems

To make the data more meaningful, the categories “never” and “sometimes” were grouped as Group 1 (less) and the categories “often” and “very often” were grouped as Group 2 (most) (see table 4.7).

Table 4.7 Support systems of participants

Support	N	Less	Most
Peer supervision groups	33	38%	51%
Talking to friends and family	35	35%	60%
Psychiatrist	36	22%	76%
Psychologist	35	33%	62%
Occupational therapist	30	65%	11%
Social worker	26	43%	19%
Nurses at psychiatric hospital	31	27%	54%

Of the respondents, 76% (n=36) indicated that they felt supported by a psychiatrist and 62% (n=35) by a psychologist in their work with traumatised patients. A psychiatrist and psychologist provide supervision for community mental health nurses in the metropole (see chapter 2, section 2.5). Of the respondents, 60% (n=35) found talking to family and friends of support and helpful in dealing with trauma clients. Hattingh (2000:436) emphasises that the support of family and significant others is important for the individual to maintain a healthy physical, psychological and social life. Furthermore, the absence of significant others’ support creates feelings of alienation and loneliness in the individual. In addition, 65% (n=30) of the participants never or sometimes found occupational therapists helpful. Accessibility to occupational therapists is a challenge as there are only four occupational therapists employed by the metro district health services in the metropole (Department of Health 2004:65).

4.3.5.2 Workplace psychological debriefing

Figure 4.16 depicts the availability of workplace psychological debriefing reported by the participants.

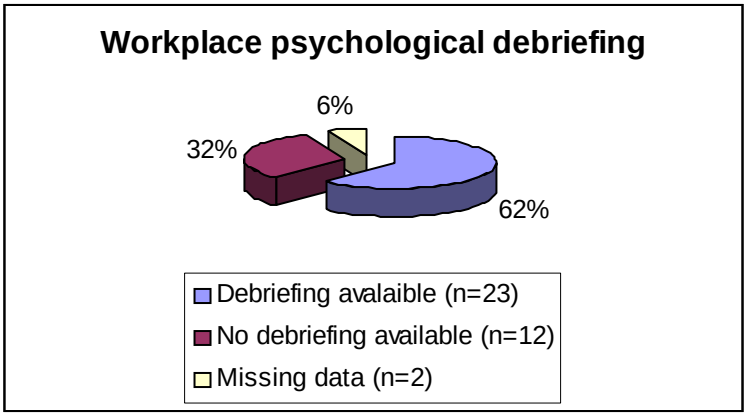

Figure 4.16

Workplace psychological debriefing

Of the respondents, 62% (n=23) indicated that debriefing services were available at the workplace; 32% (n=12) indicated that there were no debriefing services, and missing data accounted for 6%(n=2) of the results. An Employee Assistance Programme as well as an external agency, namely Independent Counselling and Advisory Service (ICAS), are employed by the metro district health services to offer psychological support to staff at community health centres (Department of Health 2004:40). That 32% of the respondents stated that there was no debriefing services would seem to indicate that they had never used or were unaware of these services. Hattingh (2001:445) found that emergency personnel were not aware of support services provided by their organisation and further that the support systems for emergency personnel were not fully used.

4.3.5.3 Presenting psychological debriefing

The respondents were asked to indicate the availability of workplace psychological debriefing and who presented it (see table 4.8).

Table 4.8 Presentation of psychological debriefing of participants

Presenters of debriefing		**Percentage**
Peers (other nurses)		65.21%
Clergy (minister of religion)		4.34%
Lay counsellor		4.34%
Psychologist		60.86%
Social worker		13.04%
Hospital management		34.78%
Other: Independent Counselling Advisory Service or Employee Assistance Programme		8.69%

Of the 23 participants who answered the question, 65.21% (n=15) indicated that nurses presented the debriefing; 60.86% (n=14) indicated psychologists; 34.78% (n=8) indicated hospital management; 13.04% (n=3) indicated social workers; 8,69% (n=2) indicated ICAS and the Employee Assistance Programme, and 4.34% (n=1) indicated clergy and lay counsellors. An Employee Assistance Programme and ICAS, an external agency, are employed by metro district health services to offer psychological support to staff at community health centres (Department of Health 2004:40). A nurse coordinates the services rendered by psychologists. From the findings it is apparent that less than 40% of the participants were unaware of who presented debriefing services to employees in the metro district health services.

4.3.5.4 Supportive psychological debriefing

Table 4.9 reflects the participants' opinion of the helpfulness of the workplace debriefing services.

Table 4.9 Supportive psychological debriefing

	N	Percentage
Workplace debriefing helpful	19	82.6%
Unsure	2	8.69%
Missing data	2	8.69%

Of the 23 participants who indicated that psychological debriefing was available at the workplace, 82.6% (n=19) found these services useful; 8.69% (n=2) were unsure, and 8.69% (n=2) accounted for missing data. More than half of the sample found the debriefing services useful, which might indicate that if the other 18 respondents (including those who indicated that no services existed and those who did not answer) were to use the services, they might also find workplace debriefing helpful in dealing with psychological trauma. Geyer (2001:22) points out that although not all mental health practitioners agree that debriefing is helpful, it does have positive outcomes in that staff can express their feelings and obtain support to cope with trauma.

4.3.5.5 Appointment to do debriefing

Figure 4.17 reflects the respondents' views on who should be appointed to render a psychological debriefing service.

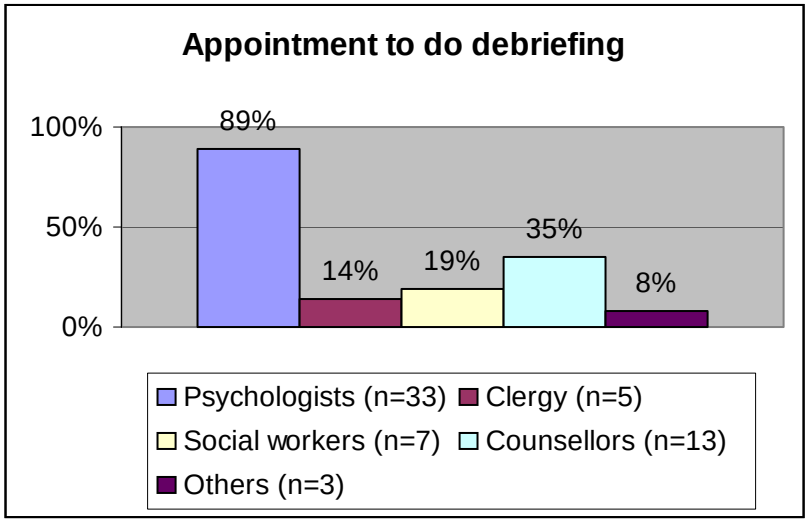

Figure 4.17

Appointment to do debriefing

Of the participants, 89% (n=33) were of the opinion that debriefing should be rendered by psychologists; 35% (n=13) felt that counsellors should do debriefing; 19% (7) felt that social workers should do it; 14% (5) indicated that clergy and 8% (n=3) indicated that others, such as nurses and psychiatrists, should be appointed to do debriefing. However, Mitchell and Everly (1994:168) found that nurses were more accepting of nurses (their peers) as debriefers than mental health professionals or clergy. This finding may be attributed to the fact that the participants were mental health nurses who were knowledgeable about the role of psychologists in debriefing.

4.3.5.6 Support systems to limit or prevent psychological trauma

Table 4.10 reflects the respondents' views on what support systems could be applied to limit or prevent psychological trauma in nurses in order of importance.

Table 4.10 Support systems to limit or prevent psychological trauma

	Most important	Important	Least important	Not important
Better salaries	57%	30%	3%	8%
Better working conditions	86%	11%	-	-
Support with transport	30%	24%	27%	16%
Debriefing	59%	32%	5%	-
Sensitivity by non-mental health colleagues	59%	35%	-	3%
Support from management	84%	8%	3%	-
Other: Independent Counselling and Advisory Services	3%			

Of the respondents, 86% (n=33) felt better working conditions and 84% (n=31) felt support from management would assist them in limiting or preventing psychological trauma. ka Mzolo (2004/2005:46) found that the extra workload that nurses carry because of short staff results in them experiencing high levels of stress. Enslin (2005: 33) states that nothing seems to be done about the unacceptable working conditions of South African nurses. Geyer (2001:22) is of the opinion that management and the employer have a responsibility to ensure that the workplace remains a healthy and supportive environment. Furthermore, Georgiou (1997:81) states that decreased job satisfaction is a by-product of the traumatic stress individuals experience because they do not have support systems they can rely on to help them deal with their problems. Of the respondents, 59% (n=22) indicated debriefing; 59% (n=22) indicated sensitivity from non-mental health colleagues, and 57% (n=21) indicated better salaries as most important supports to limit or prevent psychological trauma in nurses.

4.4 CONCLUSION

This chapter discussed the data analysis and findings, using tables, percentages and graphs, where possible. The findings were also discussed with reference to the literature reviewed. Chapter 5 concludes the study, briefly discusses its limitations, and makes recommendations for practice and further research.

CHAPTER 5

Conclusions and recommendations

5.1 INTRODUCTION

This chapter concludes the study by summarising the research process and findings, briefly discussing its limitations, and making recommendations for future research.

5.2 THE RESEARCH PROCESS

According to the literature reviewed, vicarious trauma is an occupational hazard for those who treat the traumatised. The overall aim of this study was to describe the effects, namely vicarious trauma, experienced by nurses who render psychological care to trauma victims at community health centres.

The specific objectives of the study were to

- explore the prevalence of vicarious trauma in nurses who render a mental health service at community health centres
- explore to what extent nurses' personal trauma history is associated with vicarious trauma
- describe the work-related aspects that create vicarious trauma in nurses
- describe the support systems for nurses who work in community mental health care services.

The design selected for this research was quantitative, exploratory and descriptive in order to understand the phenomenon being studied. This study falls into the category of applied research as the knowledge generated could directly affect the quality of support received by nurses to limit vicarious trauma. The purpose of applied research is "to solve problems, make decisions or control outcomes in real-life situations" (Polit et al 2001:38).

The sample selected comprised 37 nurses who rendered mental health and psychiatric services to the population of the Cape Metropole. Seven nurses rendering a mental health and psychiatric service to the population of the surrounding rural areas were invited to participate in the study and two responded. The participants were chosen according to the following eligibility criteria:

- Participants had to be registered nurses with an additional qualification in psychiatric nursing science rendering a mental health service to the population of the Cape Metropolitan area.
- Had to be employed on a full-time or part-time basis by the Department of Health of the Western Cape Province.
- Had to be directly involved in counselling victims of psychological trauma; for example, people with HIV-positive status, other debilitating disease or terminal illness, such cancer, and victims of violence, namely rape, attempted murder, indecent assault, kidnapping, abduction and carjacking.
- Had to work at a community health centre or a local authority clinic in the Cape Metropolitan area.

The data-collection instrument was a structured questionnaire, which included an existing questionnaire, namely the TSI Belief Scale (Section B) in addition to 20 other questions to gather the desired responses from the 37 nurses. The questionnaire was developed after the literature review and in consultation with the research supervisors and a statistician. The researcher personally delivered and collected the completed questionnaires from the participants to maintain confidentiality and the ethical considerations discussed. In addition, the information was protected with a secret password to which only the researcher had access.

5.3 FINDINGS

The study contributed to identifying the effects of vicarious trauma with reference to the ten subscales identified in the CSDT. Predictor variables, such as age, personal trauma history, workload, and career longevity, were correlated with the ten subscales for vicarious trauma.

Support systems for nurses working with the traumatized were also addressed. This report will make the Department of Health and the authorities aware of the psychological needs of nurses to prevent the adverse effects of psychological trauma. In addition, the study should contribute to an awareness of the support needs of nurses in the clinical field. The findings should facilitate future planning of additional support that could be rendered to nurses in the areas where they work with violence and diseases, such as HIV/AIDS, in the community health centres.

The researcher's conclusions were based on the objectives and research questions (see chapter 1).

5.3.1 What is the prevalence of vicarious trauma experienced by nurses who render a mental health service to victims of trauma?

Ten subscales were created from the TSI Belief Scale to measure disruptions in the psychological need areas of safety, esteem, trust, intimacy and control. The distributions appeared normal for these subscales. All correlations except trust vs other-trust were significant at the 5% level. There was a strong positive relationship between other-intimacy and control.

5.3.2 Is personal trauma history associated with vicarious trauma?

Personal trauma history was present in 89% (n=33) of the participants. The Mann-Whitney statistical test showed that there was no relationship between the respondents' personal trauma history and vicarious trauma as measured by the TSI Belief Scale

5.3.3 What work-related aspects create vicarious trauma in nurses?

The mean ranks for years of experience as a registered nurse differed significantly for the subscales other-safety, other-esteem, other-trust and other-control. The mean ranks for years of experience in community mental health services differed significantly for the subscale other-esteem. There was no relationship between workload and vicarious trauma in the nurses rendering a mental health service to the traumatised.

5.3.4 What support systems are there for nurses who work in community mental health care services?

Of the participants, 76% (n=28) felt supported by psychiatrists and 62% (n=23) by psychologists. Support from family and friends accounted for 76% (n=28) of support systems that nurses use to deal with trauma. Furthermore 62% (n=23) knew about the debriefing services available for staff to utilise whilst 51% (n=19) found the debriefing services helpful in dealing with trauma. A further 86% (n=32) of the participants felt that better working conditions would minimise vicarious trauma in nurses whilst 84% (n=31) felt support from management would prevent vicarious trauma in nurses.

5.4 RECOMMENDATIONS

Based on the findings, the researcher makes the following recommendations for organisational support, self-care and future research.

5.4.1 Organisational support

Supervision should be made compulsory for all nurses who treat the traumatised. Young, inexperienced nurses who are recruited to work in the mental health service should be orientated and have open channels of communication with the supervisor for support. Buddy systems between nurses should be implemented whereby nurses have telephonic or personal contact with colleagues for support. Team building exercises are vital to improve communication between the various categories of staff.

Staff shortages should be addressed promptly as this has negative implications for working conditions. Nurses recruited to work in mental health should be informed of the potential risk of developing symptoms related to vicarious trauma.

Educational programmes for nurses on vicarious trauma, triggers, symptoms and coping strategies need to be developed. Opportunities for further studies should be created and nurses should be encouraged to ascribe to the concept of lifelong learning.

The employer needs to take cognisance of the fact that vicarious traumatisation of nurses who work with the traumatised is a potential work hazard.

Caring for the carer should be included in the organisations strategic plan as a key focus area in order that the most valuable asset, the human resources, are retained and feel valued.

5.4.2 Self-care

Nurses should be encouraged to use existing support services to help them deal with their own and patients' trauma.
Nurses should know their own "triggers" and vulnerable areas and learn to defuse or avoid them.
Nurses should allow themselves to grieve when bad things happen to others.
There should be a balance between professional and personal activities that provides opportunities for self-growth.
Nurses should be encouraged to attend personal development courses such as stress management, time management and conflict resolution courses to acquire skills to deal with challenges in life.
The use of self reflective diaries can aid in giving the nurses life perspective by reflecting on the traumatic events that have transpired in own and patients lives. Reflection is important as it allows one to analyse challenges and to seek new ways of dealing with them.
Participation in social events outside of the work environment aids in creating a balance between work and personal life.
Exercise, hobbies and taking of regular leave should be encouraged to promote physical and emotional well being.

5.4.3 Future research

Further research should be conducted on the following topics or areas:

- The relationship between the positive and negative effects of working with the traumatised

- The refinement of instruments used to measure vicarious trauma so they capture the effects of vicarious trauma and not the perception of vicarious trauma as appears to be the case in the TSI Belief Scale
- A study on nurses who work in the trauma units at community health centres to establish whether treating patients with physical injuries has the same psychological effects as counselling trauma victims
- How working with families of traumatised patients influences nurses' experiences of vicarious trauma.
- A qualitative study on the internal processes related to understanding the cognitive effects that nurses experience when working with traumatised individuals
-

5.5 LIMITATIONS

The researcher found the following limitations in this study:

- The study was conducted by obtaining information from nurses working in community health centres in the Cape Metropole where caseloads varied, as nine centres offered 24-hour services while the rest were 8-hour facilities. Furthermore, nurses working in surrounding rural areas were also invited to participate in this study, of which only two responded.
- Other factors such as the nurses' personality and coping styles, which could have an effect on the cognitive schemas of the participants, were not measured.
- The findings of this study must be treated with caution because of the small sample size.
- Generalisation of these findings is limited because of the small sample drawn from the Metropole and rural area.
- The poor quality of data reflected by the missing values made analysis difficult.
- The length of the questionnaire, namely 100 questions, may have attributed to the poor quality of data collected.

5.5 CONCLUSION

This study explored and described the effects nurses experienced when working with traumatized individuals, namely vicarious trauma. No relationship was found between the predictor variables of personal trauma history and workload, and vicarious traumatisation. There was a relationship between vicarious trauma, age and career longevity.

Support systems were alluded to in addition recommendations were made with regards to organisational support, self care and future research.

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List of Annexures **Page**

Annexure A

115 Dennegeur Avenue
Strandfontein
7798
…….

The Director
Metro District Health Services
P/Bag
Woodstock

Dear Sir/Madam

Permission to conduct a study

This is to request permission to carry out a study on community mental health nurses employed by the Metro District Health Services. I am a registered nurse employed in the capacity of mental health nurse. I am a part-time post-graduate student at the University of South Africa (UNISA) currently working on a dissertation, which is in partial fulfilment of the MA (Cur) Programme.

The research focuses on an investigation into the effects of vicarious traumatisation that may be experienced by mental health nurses in the line of duty. These nurses treat patients who are victims of trauma and may themselves be at risk of developing signs and symptoms similar to their patients. I hope that the results of the study will inform planning for the supervision, training and support of nurses rendering a service to victims of trauma.

Participation in the study is voluntary. Questionnaires will be distributed to the selected participants after their written consent has been obtained.

Yours faithfully

……

PD Martin
RN. BACur (Unisa)

CONSENT TO BE A RESEARCH PARTICIPANT

Dear Colleague

I am a registered nurse currently studying with UNISA as an MA (Cur) student conducting research on the effects of vicarious traumatisation experienced by mental health nurses working with victims of trauma.

At the moment there appears to be limited information of the effects of vicarious traumatisation experienced by people working with victims of trauma in South Africa and local studies have focused primarily on emergency personnel and the police services. You are invited to participate in this study as the first contact person at primary health care level for victims of trauma. It is hoped that the results of this study will influence the needs around supervision, training and support for mental health nurses rendering a service to victims of trauma.

If you agree to participate in the study, you will be given a questionnaire to complete. Please note that all information obtained will be confidential and no names are required.

Circle one:

I (AGREE) / (DO NOT AGREE) to participate in this study.

I understand that I will not be paid for my participation. The study may produce information that is useful in the planning for supervision, training and support of nurses working with victims of trauma in the Western Cape Metropole.

I have the right to refuse to participate or to withdraw from the study at any time. Refusing to participate will not adversely affect my work at Metro District Health Services.

Participant's signature:……..

Date: ……...

Researcher's signature:……...

Annexure D

CREATION OF SUBSCALES

The individual items B1, B2…B80 were not used but ten subscales were created. However, before creating any subscales, negative items were converted into positive items. This was done using the formula: Positive item = (n+1)-Negative item =7-value for negative item. A ‘P’ was added to indicate change of an observed item from negative to positive.

The ten sub-scales were created as follows:

Safety = B1+B4P+B15+B28+B33+B45P

Other-Safety = B9+B19P+B40+B61+B27P+B73P+B79P

Esteem = B5P+B8P+B17P+B18+B23P+B27+B32+B34+B44P+B51P

Other-Esteem = B2+B10P+B20P+B26+B31P+B35+B56P+B63P

Trust = B6+B13P+B70+B77

Other-Trust = B14P+B16P+B22P+B29+B36+B47+B50+B64P+B66P+B71P+B78P

Control = B25P+B37P+B43P+B48P+B52P+B62P+B69P

Other-Control =B24P+B38P+B54+B59P+B60P+B65P+B67P

Intimacy = B3+B7P+B12+B21P+B30P+B53+B58+B80P

Other-Intimacy = B11P+B39P+B41P+B42P+B46P+B49P+B55P+B57+B68P