

EXPLORING THE
PSYCHOLOGICAL EFFECTS OF
TRAUMA COUNSELLING ON
NOVICE TRAUMA COUNSELLORS

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EXPLORING THE PSYCHOLOGICAL EFFECTS OF
TRAUMA COUNSELLING ON NOVICE TRAUMA
COUNSELLORS

by

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I declare that “Exploring the Psychological Effects of Trauma Counselling on Novice Trauma Counsellors” is my own work and that all sources I have used or quoted have been indicated and acknowledged by means of complete references.

(Ms N.Rughoo)

DATE

To My Mother

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Abstract

South African society has been affected either directly or indirectly by some degree of trauma. Therefore the presence of a trauma unit within a hospital created the ideal opportunity for novice trauma counsellors to have practical experience.

The present research is an exploratory study, designed in accordance with ethnographic principles in order to understand the psychological effects of trauma on novice trauma counsellors. It focuses on themes that reverberate throughout the participants narratives. Vicarious trauma and compassion fatigue are two such effects that were explored in this study. Research into compassion fatigue and vicarious trauma span over several decades and researchers have moved from merely describing the symptoms of secondary traumatic stress to explaining it in terms of models that highlight the role of various factors that contribute vicarious trauma or compassion fatigue.

This study concludes with recommendations to counter the effects of experiencing secondary trauma.

Key words: trauma counselling, secondary trauma, vicarious trauma, compassion fatigue, narrative, qualitative research, ethnographic research, wholistic functioning, life experience, training, self care, resilience.

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Chapter 1

Rationale for the Study

Faith is taking the first step even when you don't see the whole staircase.

Martin Luther King, Jr

1.1 Introduction

Post Apartheid South Africa has been overwhelmed with an increase in traumatized individuals. The casualties from the apartheid era as well as the present infrastructure has been instrumental in creating a platform for criminally induced trauma. South Africa is one of the few countries in the world that is not overtly affected by natural disasters, floods, tsunamis or earthquakes. Nevertheless the covert infiltration of trauma has permeated all echelons of society.

The social and political climate has changed significantly and this has led to traumatization on different levels for many individuals. Hijacking, rape, murder, domestic violence, child abuse, human trafficking and other forms of natural and unnatural disasters have permeated South African society on a national level (Harinarain, 2007). The culture of violence has become an almost acceptable norm in South Africa rather than the exception. Therefore traumatization takes place both directly and indirectly. It has become part of

the global perception of South Africa.

The violence in South Africa has reached escalating peaks and there is very little evidence to suggest that this trend is going to change soon. The casualties of this type of culture often exhibit signs of vicarious traumatization. According to the statistics from the Centre for the Study of Violence and Reconciliation (2008), South Africa ranks as having the second highest per capita murders in the world. There has been a lot of literature highlighting the plight of traumatized individuals and the crucial need for trauma counsellors (Harinarain, 2007).

This now leads us to a different level of trauma. Trauma that is experienced due to the novice therapists personal history, applied experience level and trauma-specific training. Vicarious trauma and compassion fatigue are two specific areas that are most prominently highlighted in previous research (McCann and Pearlman, 1990). The secondary trauma and trauma upon trauma has articulated a need for responding to the physical, emotional and mental aberrations that have overwhelmed the trauma counsellors. Research has suggested that vicarious exposure to trauma via work with traumatized clients can lead to trauma symptomatology within mental health professionals (Summer and Cox, 2005). The symptoms of vicarious traumatization in counsellors is often very similar to the Post Traumatic Stress Disorder, experienced by their clients.

According to Adams and Shelley (2008) the history, personal trauma and experience level play an important role in trauma counselling. This is also supported by Pearlman and Saakvitne (1995b) who indicate that there is a need for trauma specific training in order to reduce the impact of vicarious trauma and compassion fatigue. Adams and Shelley (2008) reiterate that novice therapists are vulnerable to confusion and potential hazards of the work. The current research aims to highlight this salient point. This is very much in line with my belief that the ecosystemic background of a trauma counsellor should be addressed prior to training. This type of intervention is aimed at enhanc-

ing the counsellor's effectiveness both personally and professionally. Adams and Shelley (2008) have also expounded on the mounting evidence of empirical studies that have strongly highlighted the negative psychological effects of trauma, especially vicarious traumatization. Several reports have maintained that there are possible associations between secondary trauma symptoms and personal history as well as level of experience (Chrestman, 1995; Pearlman and MacIan, 1995).

1.2 My Narrative

My personal experience as a trauma counsellor is one of the perspectives that is central to the present study. My personal relationship to this investigation aims to provide a more comprehensive understanding of the origin, focus and the purpose of this investigation. Prior to commencing my masters degree, I worked as a trauma counsellor at a trauma unit in a local hospital. The requirements for becoming a registered trauma counsellor entailed, registering for the course at a South African University, and this included being registered with the Health Professionals Council of South Africa as an intern trauma counsellor. In order to successfully complete and register as a trauma counsellor, I had to work in the trauma and other units of the hospital (under supervision), submit fortnightly reports to my supervisor (a clinical psychologist), present and discuss these cases. My supervisor and the supervisor at the hospital prepared two reports each, with regard to my placement and performance which was then submitted to the Health Professionals Council of South Africa via the university. This enabled me to write the National Board Exam for registration after twelve months internship.

In terms of training and reading material, this had to be acquired during the internship. If I found my knowledge lacking in a particular field, I would then read up and clarify salient points with my supervisor if I was uncertain about an issue. The experience was beneficial because I had a pool of knowledge at my disposal since the permanent trauma staff were extremely conversant

in this language. They also offered emotional support but not once during my internship did I ever hear them mention the effects of vicarious trauma or compassion fatigue in any context. They would reassure me that certain of my feelings were normal as they had experienced these effects in the past and although it was still present it was not as intense as in the beginning. These interactions occurred in a social milieu. There was very little structure in terms of counsellor support, debriefing, knowledge and on site supervision. In terms of individual supervision, I received emotional support and structure from my supervisors. I found this to be very useful in understanding the emotions I was experiencing. The disadvantage was that these supervision sessions were every two weeks and I felt it should have been more often.

When I first entered the trauma unit, I was a blank slate. I had no knowledge of counselling techniques or interviewing skills and a sketchy theoretical background. All I had was myself. I was the tool. I was able to empathize with people because I was really interested in their narratives and I could connect with them because my interest in their welfare was genuine. There was no time-limit to their lives and I persevered with even the most difficult cases. I would always return for a continuation of their narratives. This was all I could do well. I listened and supported them during their stay at the hospital. I was not counselling or advising them and this felt very limiting to me. I often questioned myself during the first few weeks, whether my presence was a hindrance or beneficial. I persisted on intuition and the rate of my clients physical improvement. This was my indicative barometer. I still felt the need to define a comfortable style of communication and I achieved this with the help of my clients and supervisors. They helped me to define a way of interacting and engaging in a beneficial conversation.

Nothing prepares one better for trauma counselling than to be thrown into the deep end. The only life vest is your knowledge, your personal history and your intention to survive. This I learned the difficult way. I was always convinced that although this technique toughened future trauma counsellors, it failed to address the humanness of the trauma counsellor. As a novice counsellor, I was

plagued by certain issues that cropped up during sessions. I am generally very guarded with my feelings and it never dawned on me to express myself to a colleague. I would only do so during supervision. It was still difficult to fully disclose and explore those effects as I would gloss over the feelings and focus on the content. I would often see an average of eight trauma cases per day and this continued for the better part of my intern year. I did not know when to slow down, take a break or listen to my body. This was one of the most potent effects of vicarious trauma and compassion fatigue. It was the first warning sign that appeared on my personal radar and I ignored it.

Although the literature in terms of compassion fatigue and vicarious trauma had been available for a long time, I was oblivious to the potency of this research, until four months into my training, I left work to fetch my children from school and I failed to stop at the stop street. My brain was telling my legs to apply brakes but my legs felt leaden and refused to obey. Luckily the road was quiet. This was the first indication that something was amiss. The mental exhaustion and physical unresponsiveness was a communication to me, to step back and evaluate these bold impact messages.

I had experienced immense mental and emotional fatigue, flashbacks and nightmares. There was a time that I felt heavy and the thought of another day at the hospital, filled me with dread. I often experienced a depressed immune system and bodily aches and pains after a few months. My enthusiasm was low, my energy was almost non-existent and my performance was significantly deteriorating. I decided at that stage to step back, and take a break. I knew that working in the hospital did expose me to a number of diseases and illnesses. This was definitely more than fatigue, errant viruses and the cold. I started reading about these effects. I was startled by the volume of literature published about secondary trauma. There was more material covering my experience than I expected. I could not understand the reason for this material not being incorporated into the structure of the course. Much of these symptoms that I was experiencing suggested a post traumatic stress disorder (American Psychiatric Association, 2000). These prodromal symptoms began

during the first six months of trauma counselling. Additional research led me to the concepts of vicarious trauma and compassion fatigue. These concepts were more relative to my experiences and I began expanding my exploration of these fields.

When the trauma unit was operationalized at a local public hospital in South Africa four years ago, there were two full-time lay counsellors. They did not have the benefit of supervision or adequate information about trauma counselling. The unit was functional twenty four hours a day, seven days a week. After three months, the counsellors began presenting with symptoms of flat affect, diminished interest in previously enjoyed activities, wanting to be isolated, avoiding social networks and depressed mood nearly everyday. They also experienced sleep problems, difficulty concentrating, intense anger and irritability. Eventually these symptoms began to manifest themselves into psychological distress in terms of depression and somatic problems in terms of bronchitis and depressed immune system. This is not uncommon among trauma counsellors and is not unique to this situation nor to South Africa (American Psychiatric Association, 2000).

The investigation, on behaviour and the patterns of trauma counsellors, has identified that the above mentioned behaviour was the result of vicarious trauma defined as a cumulative transformative effect upon the trauma therapist as a result of working with survivors of traumatic life events (Pearlman and Saakvitne, 1995b). Similarly compassion fatigue as iterated by Figley (1995b) is the natural consequence of caring intensely for another .

As a trauma counsellor in 2007, I observed that the system had changed considerably in terms of offering more support and assistance to the counsellors. There was also more information available on dealing with different types of trauma. However, I still felt the effects of vicarious trauma and compassionate fatigue.

1.3 Discussion

Currently there has been more support systems in place at the hospital, as well as more structured environment with report writings and trauma information. There are also weekly debriefing sessions and individual counselling sessions with the counsellors. The manifestation of vicarious trauma and compassion fatigue is also mentioned during the initial interviews conducted.

There has been considerable research generated in highlighting the themes of vicarious trauma, compassion fatigue, counsellor feelings, the helpful qualities of supervision and organizational structure (Summer and Cox, 2005). Research suggests that there are different facets to understanding vicarious trauma and compassion fatigue and they have endeavored to identify possible variables that underly these themes. Much research and implications have been implemented to minimize the effects of vicarious trauma and compassion fatigue. Early interventions actually facilitate the initial phases of the process of dealing with the traumatic event so that later psychological intervention will be less likely (Friedman and Ortlepp, 2002)

Trauma counsellors are still experiencing vicarious trauma and compassion-fatigue despite having more structure, education and support available to them. I would therefore like to explore the effects of secondary trauma effects on novice counsellors within the present framework. Previous research has concentrated on identifying the different effects of trauma and possible preventative methods according to a linear model. Recent findings have touched on the ecosystemic framework. This research has sought to explain preventative methods of vicarious trauma and compassion fatigue, from an ecological perspective. My interest is to relate the lived experiences of novice trauma counsellors from an ethnographic perspective.

1.4 Conclusion

This research study provides a rostrum for novice trauma counsellors to share and explore their experiences. My aim is to interpretively understand and explain the ecological model as an accompanying preventative model for vicarious trauma and compassion fatigue. The counselling division of the hospital presents a few workshops to the novice counsellors and this is the perfect forum for such discussions. It is something I am very interested in exploring in order to prevent my experience from recurring as intensely to other counsellors. At the very least equipping future trauma counsellors with a handbook on this reality of trauma counselling.

Research has shown that blurring of boundaries, unethical conduct, blatant exploitation of clients and institutional conflicts were observed (Gachutha, 2006). These transgressions were also observed at the trauma unit. Failure to recognize possible counsellor burnout at the unit, created some structural disturbance. The lack of research regarding the organizational responses towards trauma counsellors was the purpose of a research conducted by Geldenhuys (2005).

Trauma counsellors are exposed to the first hand experience of their client's narratives through short-term counselling. They need to be educationally equipped to deal with any case of any intensity. The challenge here is to understand the effects these narratives have on the counsellor and the level of intensity needs to be acknowledged. People become trauma counsellors to satisfy some personal need. In my case, I had this void that was fulfilled by making a real difference. It was the feeling of relatedness that existed when dealing with other people. It was a good method of reminding me of my humanness and mortality.

1.5 Presentation

The terms caregiver, counsellor, trauma counsellor and therapist occur frequently in this study. It is important to distinguish between these terms in order to facilitate clarity of these different vocations. A caregiver is someone who provides physical and emotional support to patients. They are responsible for assisting client's and attending to their basic needs, emotional and physical. However the training is very basic and addresses the sole needs of the individual.

A counsellor is any individual who undergoes more advanced training in responding to the emotional needs of individuals. However they have a limited scope of practice. The trauma counsellor specializes in attending to people who have been victims of a violent or tragic incident. They are trained to deal with the immediate trauma of their clients. If a trauma provokes symptoms of a client's previous history or psychiatric illness, the trauma counsellor is trained to spot these signs and symptoms and refer the clients to a specialist. Trauma counsellors have to undergo intensive training before writing a board examination that would enable them to practice as trauma counsellors. They need to be registered with the Health Professionals Council of South Africa. The rules and regulations are stringent for counsellors. A therapist is someone who has the relevant qualifications and is registered to practice in specialized fields of psychology. They have undergone intense training and are equipped with information that allows them to see their clients as individual parts that function within a whole system.

The most essential difference between these various titles involves the scope of practice relevant to each field. The rules and limitations vary from one field to the next.

The following chapters will address:

Chapter 2 : Literature Review and Theoretical Background

Chapter 3 : Research Methodology

Chapter 4 : Hope's Story

Chapter 5 : Alice's Story

Chapter 6 : Brett's Story

Chapter 7 : Conclusion and Recommendations

Chapter 2

Literature Review and Theoretical Background

The tendency of the casual mind is to pick out or stumble upon a sample which supports or defies its prejudices, then to make it the representative of a whole class.

Walter J. Lippmann

2.1 Introduction

This chapter consists of a literature review and theoretical background. It is presented in terms of past research conducted and its relevance to the present research. The research has been consistent over the past two decades and the evolution of coping techniques and preventative measures are highlighted in this chapter.

The literature review will also explore the impact of interacting with traumatized people and its effect on mental health workers. It will provide a background and history for the concepts of compassion fatigue and vicarious trauma, which served as a cornerstone for the current study. These concepts recur throughout a multitude of spectrums and resonate the seriousness and impact of these variables on other mental health professions. Although re-

search in the field of its effect on novice trauma counsellors is relatively new, vicarious trauma and compassion fatigue are not new concepts.

The literature review also serves to identify important threads and themes that are consistent with the current theme. The identification of the secondary trauma effects spans over at least four decades. Although the initial publications were few and tentative, they formed the foundation for future research in this field. An analysis of different approaches and models will be presented and critiqued where relevant. Previous research will serve as a foundation for exploring these approaches and noting its effects in this study.

In accordance with the notion of vicarious trauma and compassion fatigue, this chapter will explore the different facets of these phenomena. The risk of vulnerability and susceptibility to the psychological effects of secondary trauma will be explored according to past research and the present study. The various roles of the ecological, compassion fatigue and vicarious trauma models will also be highlighted.

The concept and components of resilience will also be explored in this chapter. Research has unearthed a number of functional models that are conducive to understanding and dealing with vicarious trauma and compassion fatigue.

2.2 The Psychological Effects of Secondary Trauma

While counselling invites trauma workers to participate with their clients in their process of growth and healing, it may also threaten their well-being through exposure to their client's trauma and its painful consequences. Research is beginning to show that for some individuals, working with trauma survivors may have physical, emotional and cognitive negative effects. The research literature describes the adverse impact of working with clients who have a history of trauma under a variety of terms, namely, vicarious traumatization

(VT), secondary traumatic stress (STS), burnout and compassion fatigue (CF) (Stamm, 1997).

When a caregiver begins to experience increasing levels of stress, the health and well-being of both the caregiver and the primary victim are at risk. For these reasons, it is particularly important to understand the factors that may protect caregivers from becoming secondarily traumatized. There is a cost to caring. Working with an individual, as a professional or volunteer, who had experienced some form of trauma, may result in the caregiver not only experiencing increased levels of stress, but also mild to profound changes in their worldview leading to questions regarding justice and meaning in life. Shifts of meaning in life can be quite difficult to navigate, and may lead to high rates of change in staffing for both volunteer and professional positions (Hope, 2006).

Figley (1999) cogitates that individuals could be traumatized without actually being physically harmed or threatened with harm. Learning about a traumatic event carries traumatic potential and he believes that the indirect victims are the family members, friends, neighbours, lawyers and counsellors. Research done a few years later by Figley (2002), reveals that traumatic exposure is indirect and secondary traumatic stress is nearly identical to posttraumatic stress including symptoms associated with posttraumatic stress disorder (PTSD) such as intrusive imagery, avoidance, hyperarousal, distressing emotions, cognitive changes, and functional impairment (American Psychiatric Association, 2000). Chrestman (1999) stresses that psychologically distressed professionals are more vulnerable to developing compassion fatigue-like symptoms due to personally experienced trauma as well as from the interactions and type of trauma cases that the novice counsellors experienced with clients.

Counsellors may also experience symptoms of post-traumatic stress disorder (PTSD) as a result of their work with survivors. These symptoms could include intrusive thoughts as well as emotional reactions such as anxiety and anger (McCann and Pearlman, 1990). McCann and Pearlman (1990) also sug-

gest that these disturbances could affect all aspects of a counsellor's life and could be permanent. This is consistent with their research where they argue that experiencing negative effects is an unavoidable result of trauma work. Furthermore the capacity to empathize, to feel with another person, is central to the process of therapy (McCann and Pearlman, 1990).

A different perspective on the effects of trauma by Neumann and Gamble (1995), explore the affective states of therapists in response to trauma. They documented the affective states of therapists in response to their client's narratives. As therapists listened to the experiences of survivors, affective responses similar to those experienced in a traumatic situation could be stirred. The therapist's beliefs and attitudes were repeatedly challenged as they heard in detail about exploitation, sadism, abandonment, and betrayal. Over time, the therapist began to view the world through a trauma lens. The sound of a child's cry at the grocery store evoked images of a client's brutal narrative describing childhood abuse. The therapist was filled with grief, anger, and a sense of helplessness. Higher levels of fearfulness, vulnerability and concern may be ways in which this disruption in safety needs is manifested. This was revealed by Neumann and Gamble (1995) in their study.

Pearlman and Saakvitne (1995b) iterated that it is not uncommon for survivor therapists to hear a client's experience and relive memories and feelings associated with their own traumatic experience. Trauma therapists who have gone through similar experiences as their clients may begin to dissociate during sessions, causing serious disruption in the therapeutic process. It is also fairly common for therapists to experience strange, painful, or unfamiliar physical sensations, such as numbing or sharp pains in certain body parts. Certain noises or smells may also trigger intrusive imagery in the therapist (Pearlman and Saakvitne, 1995b). The therapist's personal history appeared to influence the intensity of the psychological effects of trauma. Research suggest that highly stressful events affected people in a myriad of ways. Some people experience no change and some develop severe psychological difficulties. Findings have shown that trauma workers with a history of personal trauma are at risk

of developing secondary traumatic stress (Cornille and Meyers, 1999; Williams and Sommer, 1995).

Rodrigo (2002) echoed the above sentiments by stating that trauma work has the ability to reawaken a personal history of trauma along with badly healed wounds and therapists may find themselves emotionally drained or wounded anew in the context of their work, as reflected in cases of compassion fatigue or vicarious trauma. He reiterates that exposure to clients narratives may sometimes overwhelm the therapist's capacity to safely absorb and handle the information in therapeutic ways (Rodrigo, 2002). Trauma workers who became overloaded by the traumatic material are, at best ineffective and, at worst, place survivors in a position of taking care of the helper (Collins and Long, 2003b).

Although the traumatic exposure is indirect according to Figley (2002), secondary traumatic stress is nearly identical to posttraumatic stress including symptoms associated with posttraumatic stress disorder (PTSD) such as intrusive imagery, avoidance, hyperarousal, distressing emotions, cognitive changes, and functional impairment (Figley, 1995b, 2002). Figley's (1995b,2002) work has been dedicated to researching the effects of secondary trauma and creating awareness and programmes for combating the adverse effects of trauma work. Research literature describes the adverse impact of working with clients who have a history of trauma under a variety of terms. Vicarious traumatization (VT), counter transference (CT), secondary traumatic stress (STS) and compassion fatigue (CF) are not new concepts but prevalent issues that still predominate current research. Arguably in the field of trauma both individual characteristics and environmental factors play a role in the development of compassion fatigue. Therefore the level of exposure would include previous trauma history, the nature of the traumatic incident (i.e. the type of trauma and the severity of the traumatic experience) and the frequency of exposure to traumatic material (Boscarino, Figley and Adams, 2004).

In effect a relatively large volume of information has been generated about the psychological effects of trauma on counsellors and therapists and a solid foundation has been created to expand on this phenomena. A number of articles and books were written during the nineties, pertaining specifically to the adverse effects of trauma. Serendipitously, the lack of information on the effects of working with survivors, facilitated the process of obtaining qualitative data from counselors regarding their own perceptions of the effects of working with survivors. This data formed the basis for future work on vicarious trauma, thereby helping to ensure that we assess the full range of potential effects in future research (Schauben and Frazier, 1995).

2.2.1 Indicators of Psychological Distress

Model Figure 2.1 is specific to trauma counsellors and it depicts cognitive elements and elements of the counsellor's personality. The ecological framework of trauma integrates potent aspects of Figley's trauma transmission model.

Furthermore Dutton and Rubinstein (1995) have categorized the reactions of trauma workers into three domains. The symptoms of psychological distress, such as avoidance behaviour, intrusive imagery, somatic complaints or physiological numbing, represented in Figure 2.1, represent the first domain of trauma effects (Dutton and Rubinstein, 1995).

The second domain represents shifts in assumptions and beliefs about the world (Janoff-Bulman, 1992). Exposure to trauma deflates an individual's life goals and aspirations. This culminates either directly or indirectly into psychological stress and symptom formation.

The third aspect of the Figure 2.1 represents the relational disturbances that may occur within a counselling relationship as a consequence of mistrust between the client and the counsellor. The secondary exposure experienced by the trauma counsellor, may result in distorted relationships on personal and professional levels. Past history or similar occurrences in their personal lives

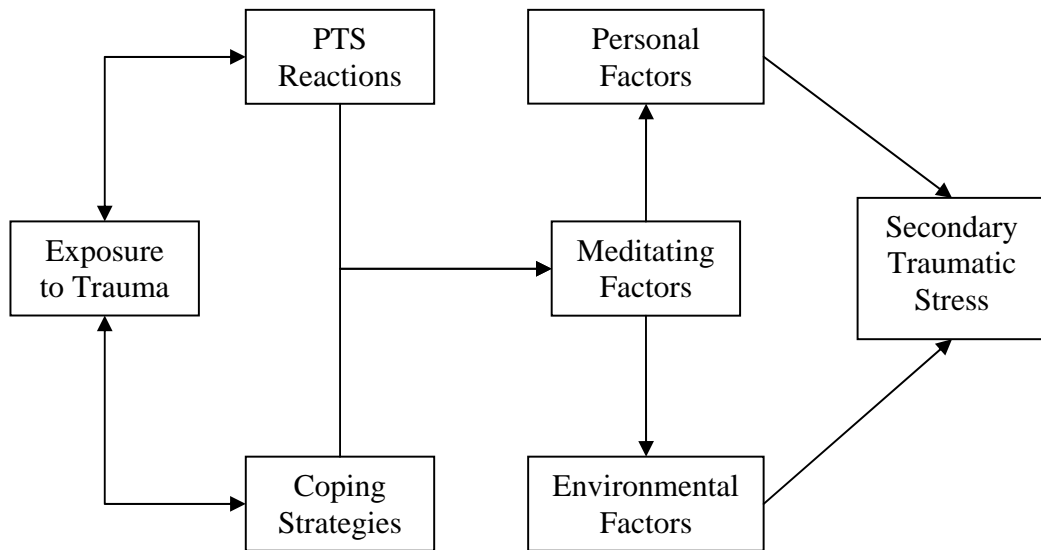


Figure 2.1: *Ecological Model of Trauma (Dutton and Rubinstein, 1995)*

may cause difficulties in their relationships and they may isolate themselves in the workplace (Dutton and Rubinstein, 1995).

In summation, Figure 2.1 depicts the four components of a secondary traumatic stress model. These components are the traumatic event to which the trauma counsellor is exposed; trauma counsellors coping strategies; the trauma counsellors post traumatic stress reactions and personal and environmental factors.

Since exposure to traumatic material is unique for every trauma counsellor, the traumatic material differs in intensity from one client to another (Dutton and Rubinstein, 1995). Often the trauma counsellor exposed to traumatic material as well as the emotions that the client experiences in relation to the event. The counsellor is vulnerable to re-victimization of their client, due to social systems. The counsellor's cognitive beliefs are challenged and the counsellor may have to deal with the clients previous trauma which may resurface (Dutton and Rubinstein, 1995).

According Dutton and Rubinstein (1995), the second component of the model identifies coping strategies that affect the development and course of compassion fatigue. Subsequently, the personal and professional strategies indicate

links and connectedness to a persons social support network.

Furthermore individual and environmental factors may be mediators of the effects of trauma. The individual factors include the trauma workers inner strengths, resources, vulnerabilities and their level of satisfaction with both their personal and professional life. Environmental factors such as social support, an organization's response to the counsellor, the context within which the counsellor works and lives and social and cultural factors are important variables in influencing the counsellor's reactions to traumatic material (Dutton and Rubinstein, 1995).

Psychological distress manifests itself in different forms. The literature review has highlighted some salient indicators of psychological distress that are listed below.

- Distressing emotions, including sadness or grief, depression, anxiety, dread and horror, fear, rage, or shame (McCann and Pearlman, 1990).
- Intensive imagery by the trauma worker of the client's traumatic material, such as nightmares, flashbacks and images (McCann and Pearlman, 1990; Herman, 1992; Figley, 1995b).
- Numbing or avoidance of efforts to elicit or work with traumatic material from the client (McCann and Pearlman, 1990; Herman, 1992; Figley, 1995b).
- Somatic complaints, including sleep difficulty, headaches or gastrointestinal distress (Herman, 1992; Figley, 1995b).
- Addiction or compulsive behaviours, including substance abuse, workaholism and compulsive eating (Dutton and Rubinstein, 1995).
- Physiological arousal, such as palpitations and hypervigilance (Clark and Gioro, 1998).
- Impairment of day-to-day functioning in social and personal roles, including missed or cancelled appointments, decreased use of supervision,

chronic lateness, and feelings of isolation, alienation, or lack of appreciation (Dutton and Rubinstein, 1995).

2.3 Vicarious Trauma

Vicarious trauma is expressed as ‘feeling heavy’ or when work gets inside you. The experience of vicarious trauma may differ for different people, again making it seem as if it is a personal issue, rather than a normal and expected reaction to repeated exposure to traumatic material. Vicarious traumatization is a normal response to repeated exposure to traumatic material (Morrison, 2007).

There is also a stigma attached to the experience of vicarious traumatization, as an interviewee in the current research mentioned, ‘it is as bad as having AIDS’. Although recognition of vicarious traumatization and other associated issues has increased, it can still be difficult to acknowledge, disclose and address (Morrison, 2007).

Brescher (2004) iterates that attaching stigma to vicarious trauma has impacted negatively on a persons ability to access necessary assistance to recover. Therefore it is important to detach stigma from the experience of vicarious trauma. He further recommends that one should locate the ‘cause of vicarious trauma with trauma itself, and its social causes, rather than with the individual workers and organizations who must deal with these issues. Addressing vicarious trauma appropriately, without stigma, means that workers are able to continue to support victim/survivors, and enjoy their important role (Morrison, 2007).

2.3.1 Genesis of Vicarious Trauma

The effects of trauma exposure on professionals were first observed formally in the late 1970s in emergency and rescue workers who displayed symptoms

similar to the trauma victims they were helping. Therefore an investigation of other people working with victims in various capacities, such as disaster relief workers, nurses, and crisis and hotline workers, ensued (Mouldern and Firestone, 2007).

According to McCann and Pearlman (1990), vicarious traumatization is a transformation of cognitive schemas and belief systems that form empathic engagement with the client's traumatic experiences and may have resulted in significant disruptions in one's sense of meaning, connection, identity, and world view, as well as in one's affect tolerance, psychological needs, beliefs about self and other, interpersonal relationships, and sensory memory (Pearlman and Saakvitne, 1995b). The term "vicarious trauma" was created by McCann and Pearlman (1990), and it is, perchance, the term that is most widely referred to in much of the literature on this topic, with some even arguing that it is the most appropriate term (Dunkley and Whelan, 2007).

This concept of vicarious trauma is embedded in constructivist self-development theory and a developmental interpersonal theory explicating the impact on an individual's psychological development, adaptation and identity (Pearlman and Saakvitne, 1995b). The interactive constructivist self development theory, focuses on the complex interaction between the individual and the environment. The constructivist self development theory is based on constructivism, the self, traumatic memories and the adaptation to trauma. According to these aspects, individuals construct their own realities. The self is the seat of the individual's identity and inner life, which encompasses the four interrelated aspects of self-esteem, ego resources, psychological needs and cognitive schemas. Retrospectively, traumatic experiences are encoded in the verbal and imagery systems of the memory. This adaptation to trauma reflects an interaction between life experiences and the self (McCann and Pearlman, 1990).

McCann and Pearlman (1990) describe vicarious trauma as the transformation in the inner experience of the therapist that ensues as a result of empathetic engagement with clients' trauma material. This is reiterated by Pearlman and

Saakvitne (1995b), five years later. They refer to vicarious traumatization and its cumulative effect of working with survivors of traumatic life events. They further state that anyone who engages empathetically with victims or survivors is vulnerable to secondary stress.

New therapists exposed to the graphic material of trauma clients may be dismayed and surprised to find themselves becoming more suspicious of others, increasingly worried about personal safety and despairing about the violence and cruelty in our society. Trauma therapy challenges the helper identities of all therapists. Doing trauma-oriented therapy provokes the new therapist to reflect on his or her own personal history. It is advocated by several researchers that all new therapists need to be informed that vicarious traumatization is an occupational hazard of trauma work so that they can predict, recognize, and name the distressing effects of immersion in the psychic worlds of traumatized individuals. They also need to be reassured that vicarious trauma is modifiable (Neumann and Gamble, 1995).

2.3.2 Definition

Pearlman and Saakvitne (1995b) define vicarious trauma, as the inner transformation that occurs in the inner experience of the therapist or other professional that comes about as a result of empathic engagement with clients' trauma material. Their definition of vicarious trauma is a process through which the therapist in her experience is negatively transformed through empathic engagement with the client's trauma material; that is, that vicarious traumatization focuses specifically on the negative aspects of the worker as a witness to clients trauma through their vivid description of the traumatic events, their reports of intentional cruelty and abuse, and their experiences of reliving their terror, grief and yearning.

Vicarious trauma is a psychological term which refers to changes in a person that can occur when they are repeatedly exposed to traumatic material (Morrison, 2007). The worker is both a witness and a participant in the traumatic

re-enactment within and outside of the therapeutic relationship.

Vicarious trauma results from psychological and spiritual disruptions that affect the way we see ourselves, the world, and what matters most to us. This leads to physical, psychological, spiritual, relational, and behavioral signs of vicarious trauma.

2.3.3 Symptoms of Vicarious Trauma

Vicarious traumatization involves physiological symptoms, changes in a person's views about themselves in the world, and potentially other adverse effects. Symptoms may be similar to the primary trauma survivors with whom the professional is working (Morrison, 2007).

Hesse (2002) narrated her experience after she succeeded in processing the situation with her field instructor, that had traumatized her. The following major schema were identified as those most prone to being altered by experiences with trauma: frame of reference about the self and the world; trust; safety; power and control; independence; esteem; and intimacy.

Vicarious traumatization can lead to a person experiencing the symptoms of post-traumatic stress disorder (PTSD). While the symptoms of trauma need to be recognized as culturally diverse and specific (Wasco, 2003), trauma reactions are generally divided into three categories. These are intrusive reactions which culminate in the form of dreams or nightmares, flashbacks, obsessive thoughts, physiological reactions and other persistent re-experiencing of the traumatic event. Avoidant reactions are general numbing in responsiveness and avoidance of things related to the traumatic material. Finally, hyper-arousal reactions include being hyper-vigilant and having difficulty concentrating.

Trauma counsellors may also experience anxiety, depression, de-personalization, feeling overwhelmed by emotions such as anger, fear, grief, despair, shame, guilt, increased irritability, feeling of reduced personal accomplishment, procrastination, low self-esteem, having no time or energy for self or others, in-

creased feelings of cynicism, sadness or seriousness, an increased sensitivity to violence and other forms of abuse, avoiding situations perceived as potentially dangerous, feeling profoundly distrustful of other people and the world in general, disruptions in interpersonal relationships, sleeping problems and substance abuse (Morrison, 2007).

Posttraumatic symptoms typically assessed by researchers to determine the presence of vicarious traumatization include suspiciousness, anxiety, depression/sadness, somatic symptoms, intrusive thoughts and feelings, avoidance, emotional numbing and flooding, and increased feelings of personal vulnerability (Neumann and Gamble, 1995; Pearlman and MacIan, 1995; Steed and Downing, 1998).

This is also highlighted in research conducted by Pearlman (1999). He observed that counsellors experiencing vicarious trauma may become hypervigilant with regard to personal and family safety. The consequences of these disruptions in terms of intimacy, were feelings of emptiness when alone, difficulty enjoying time alone, intense need to fill time, avoidance and withdrawal from others. Studies have shown that survivor therapists were at a higher risk for vicarious traumatization. Trauma appeared to be an intimate, personal experience whose intensity was appraised individually and subjectively (Pearlman and MacIan, 1995).

Trippany, Kress and Wilcoxon(2004) postulate that such vicarious traumatization could alter the counsellors basic psychological needs, such as those of safety, trust in self and others, esteem for self and others, intimacy and control. Such drastic changes in one's view of the world were related to the counsellor's existential and spiritual beliefs and traumatization could have devastating effects upon the foundation of one's life. They indicated that without a sense of meaning, counsellors may become cynical, nihilistic, withdrawn, emotionally numb, hopeless and outraged (Trippany et al., 2004).

Furthermore, connected to these experiences, vicarious traumatization may also involve a change in a person's beliefs about themselves, the world, and

other people within it. This is known in the psychological field as changes in their cognitive schema, and may involve the following: feeling that the world is no longer a safe place for themselves or others, feeling helpless in regard to field of sexual assault sets them apart from others (Morrison, 2007).

The signs and symptoms of vicarious trauma are transcribed below (Headington Institute, 2009):

- Changes in spirituality, beliefs regarding meaning, purpose, causality, connection, hope, and faith. This often takes the form of questioning prior beliefs and the meaning and purpose in life. This can be connected to a sense of loss of purpose, hopelessness, and cynicism.
- Changes in identity, in the way one practices or thinks about important identities as a professional, friend, or family member. Most of one's time and energy is spent in a professional role because one feels disconnected from or uncomfortable in one's other roles or identities.
- Changes in beliefs related to major psychological needs and beliefs regarding safety, control, trust, esteem, and intimacy. Changes in vulnerability for self and others that you care about. These beliefs can influence one's thoughts, worrying about safety issues, mistrust of strangers, and actions, being more protective towards your children.
- Hyperarousal symptoms are; nightmares, difficulty concentrating being easily startled and sleep difficulties.
- Repeated thoughts or images regarding traumatic events, especially when trying not to think about it.
- Feeling numb.
- Feeling unable to tolerate strong emotions.
- Increased sensitivity to violence.
- A feeling of cynicism.

- A feeling of generalized despair, hopelessness and loss of idealism.
- Survival guilt.
- A feeling of anger, disgust and fear.
- Difficulty setting boundaries and separating work from personal life.
- Feeling like you never have time or energy for yourself.
- Feeling disconnected from loved ones, even when communicating with them.
- Increased conflict in relationships.
- General social withdrawal.
- Experiencing the “silencing response”, finding yourself unable to pay attention to others distressing stories because they seem overwhelming and incomprehensible and directing people to talk about less distressing material.
- Decreased interest in activities that used to bring pleasure, enjoyment, or relaxation.
- Feelings of irritability, intolerance, agitation, impatience, neediness, and moodiness.
- Increased dependencies or addictions involving nicotine, alcohol, food, sex, shopping, internet, and other substances.
- Experiencing sexual difficulties.
- Feelings of impulsivity.

This is supported by research conducted by Summer and Cox (2005). They postulate that exposure to life threatening situations via work with traumatized clients could lead to trauma symptomatology within mental health professionals. Negative symptoms of vicarious traumatization could affect the

counsellors personal and professional lives and limit the counsellors ability to provide quality client services. Supervisors should be aware of any changes in the counsellors behaviour, intrusions of client's stories in counsellors lives, feelings of being overwhelmed and symptoms of withdrawal within the counselling or supervisory relationships.

2.3.4 Causes of Vicarious Trauma

McCann and Pearlman (1990) suggest that vicarious traumatization could occur as a result of working with trauma survivors. They further assert that long-term exposure to the traumatic experiences of clients who had been victimized could result in disturbances in the counselor's basic schemas about the world, such as the belief that the world is safe and that people generally could be trusted. An individual's frame of reference refers to his or her identity, world view, and spirituality. Vicarious traumatization caused trauma therapists to question their own identity, role, and self worth (Hesse, 2002).

The researchers also state that vicarious traumatization refers to the cumulative effect of doing trauma work with clients and to its pervasive impact on the self and can thus result in profound disruption in the worker's frame of reference, that is, basic sense of identity, world view and spirituality. Multiple aspects of his life are affected including affect tolerance, fundamental psychological need, deeply held beliefs about the self and other interpersonal relationships, internal imagery and experiences of his body and physical presence in the world. They also state that vicarious traumatization refers to the cumulative effect of doing trauma work with clients and to its pervasive impact on the self and can thus result in profound disruption in the worker's frame of reference, that is, basic sense of identity, world view and spirituality. Multiple aspects of his life are affected including affect tolerance, fundamental psychological need, deeply held beliefs about the self and other interpersonal relationships, internal imagery and experiences of his body and physical presence in the world (Pearlman and Saakvitne, 1995b).

Vicarious traumatization is predicted by the extent of exposure to trauma. It may also be influenced by the level of experience. Personal abuse history may be related to the experience of vicarious traumatization. Needless to say, vicarious traumatization also relates to a separate trauma of its own (Morrison, 2007).

Schauben and Frazier (1995) reveal that counselors with a history of victimization are not more distressed by seeing survivors than were counselors without a history of victimization. The data suggested that counselors who worked with a higher percentage of survivors reported more disrupted beliefs about themselves and others, more PTSD-related symptoms, and more vicarious trauma than counselors who saw fewer survivors. It was important to note that the counselors' experiences of sexual violence-related symptoms did appear to be vicarious. Their symptomatology was related to the percentage of sexual violence survivors in their case load, but not to their own history of sexual victimization (Schauben and Frazier, 1995).

2.3.5 The Effects of Vicarious Trauma

Pearlman and Saakvitne (1995b) further iterate that given our understanding of psychological trauma and the self and of the interpersonal therapeutic process from a theoretical perspective, vicarious traumatization is inevitable. It is unique to trauma work and its effects are specific, pervasive, and predictable according to its theoretical foundation and the psychology of the individual therapist. The effects are widespread, its costs are immeasurable. It will inevitably affect all of our relationships; therapeutic, collegial and personal.

2.3.6 Models of Vicarious Trauma

Adams and Shelley (2008) explored vicarious trauma among trainee therapists relative to history of trauma, experience level, trauma specific training and defense styles. In a cumbersome effort to garner all aspects of trauma

and construct it into a model framework, this study established a pertinent foundation for future research. Although this was an exploratory study with several limitations, the study extended the literature on vicarious trauma. It highlighted salient issues pertaining to the personal history, experience and education of the trainee therapists relative to its impact on trauma counselling. This literature has been important in pursuing the psychological effects of trauma on novice trauma counsellors.

Self-care models refer to proactive strategies or routines that professionals use to offset the negative aspects of working with trauma victims and to promote their own wellbeing. This involves creating a context to think about changing their cognitions, using body and senses, relying on their religious beliefs or spirituality, using friends, family or creative recreational activities as outlets and verbalizing the painful details and intense feelings that they experience (Campbell, 2002).

According to Brescher (2004) the following strategies are necessary to facilitate self-care: taking breaks at work, and from work, when needed; taking up opportunities for debriefing and other therapeutic support; maintaining professional connections; maintaining connections with others outside the field; accepting support and positive feedback when it is offered; giving support and positive feedback to others; treating themselves particularly well, consciously focusing on their own self-care; physical activity and other bodily self-care, spiritual engagement; humor; identifying successes and reminding themselves of successes.

2.4 Compassion Fatigue

Compassion Fatigue is a syndrome which consists of various symptoms that mirror Post Traumatic Stress Disorder (PTSD). Post Traumatic Stress Disorder affects people who have experienced extreme traumatic or violent events in their lives (American Psychiatric Association, 2000). People who have been

in severe car accidents, plane crashes, earthquakes or other natural disasters; victims of violent crimes, domestic violence, child sexual or physical abuse. People who develop the disorder report episodes of fear, depression, confusion, helplessness, hopelessness, feeling out of control, extreme mood swings and avoidance behaviors. It is a natural occurrence as the result of a life threatening event for most people. People who develop Compassion Fatigue have not been direct victims of trauma, but have associated with people who have been (Figley, 2002).

Compassion fatigue can emerge suddenly and is associated with feelings of hopelessness and confusion. Compassion fatigue is an alternative term for secondary traumatic stress (Geldenhuys, 2005).

Secondary traumatic stress and compassion fatigue are conceptually different from vicarious trauma, they have their foundation in a symptom-based diagnosis, and thus focus primarily on a constellation of symptoms. Since vicarious traumatization has its foundation in a constructivist personality theory, it emphasizes the role of meaning and adaptation rather than symptoms (Pearlman and Saakvitne, 1995b). The researchers further iterated that given our understanding of psychological trauma and the self, and of the interpersonal therapeutic process from a theoretical perspective, vicarious traumatization is inevitable. It is unique to trauma work and its effects are specific, pervasive, and predictable according to its theoretical foundation and the psychology of the individual therapist. The effects are widespread, its costs are immeasurable. It will inevitably affect all of our relationships; therapeutic, collegial and personal.

2.4.1 Genesis of Compassion Fatigue

One of the first earliest references in the scientific literature regarding this cost of caring comes from Jung (1974). Jung (1974) discusses the challenges of countertransference and the therapists conscious and unconscious reactions to the patient in the therapeutic situation, as well as the particular countertrans-

ference difficulties analysts encounter when working with psychotic patients. He boldly prescribed a treatment stance in which the therapist participates in the delusional fantasies and hallucinations with the patient. Nevertheless, he warns that this participation in the patients darkly painful fantasy world of traumatic images has significant deleterious effects for the therapist, especially the therapist who has not resolved his/her own developmental and traumatic issues (Jung, 1974).

Figley (1995b) espoused that counsellors were vulnerable to experiencing stress yet very few studies could identify the active ingredients that were connected to their job related stress. The lack of empirical research concerning trauma counsellors identified a gap in the trauma literature and provided sufficient incentive for the current research. As a psychologist and a pioneer in trauma science, he used the term compassion fatigue to signify too much compassion and fatigue from empathic overwork (Figley, 1995b).

In accordance with the above research, Canfield (2005) suggested that therapists went through an internal process as they tried to consolidate both the stories they heard from clients, and to integrate those stories into their own existing cognitive schemas. During this process of integration, trauma therapists often experience secondary traumatic stress reactions that negatively impact the treatment process, as well as their own experiences of self. The therapist needs to attend to the balance in his or her own professional and personal life, and attend to personal needs. In addition to suffering vicarious symptoms of traumatic stress, trauma therapists have to struggle with the same disruptions in relationships as their patients. Repeated exposure to stories of human cruelty inevitably challenged therapists in the areas of their basic faith and sense of vulnerability (Canfield, 2005).

2.4.2 Definition of Compassion Fatigue

Figley (1995b) defines secondary traumatization as the natural consequent behaviours and emotions which result from knowing about a traumatizing

event experienced by a significant other and the stress resulting from helping or wanting to help the traumatized or suffering person. Furthermore compassion fatigue is defined as the natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other, the stress resulting from helping or wanting to help a traumatized or suffering person.

Compassion fatigue is described by Figley (1995b) as a state of tension and preoccupation with the individual or cumulative trauma of clients manifested in one or more ways: that of re-experiencing the traumatic event, avoiding, numbing or reminders of the traumatic event and through persistent arousal. He also points out that when the professional is suffering trauma, as opposed to burnout, he usually experiences a faster onset of symptoms and faster recovery from the symptoms.

Compassion fatigue is a state of exhaustion and dysfunction; biologically, psychologically and socially. It is a result of prolonged exposure to compassion stress (Figley, 1995b).

2.4.3 Secondary Traumatic Stress and Burnout

Secondary traumatic stress and burnout are two components of compassion fatigue.

Secondary traumatic stress was renamed compassion fatigue by Figley (1995b). This indicated the natural occupational hazard for trauma workers and mental health professionals. Jenkins and Baird (2002) explain that this term is preferable as it is less stigmatizing. Furthermore the stress and fatigue of compassion in the line of duty better describes the causes and signs of their duty related experiences. Figley (1995b) considered compassion fatigue to be identical to secondary traumatic stress disorder and to be an equivalent of post traumatic stress disorder.

Secondary traumatic stress may be categorized according to three descrip-

tive areas; indicators of psychological distress (sadness, depression or grief), changes in cognitive schema (dependency, safety, power, esteem, intimacy, and frames of reference), and relational disturbances (lack of trust and dysfunctional relations in personal life) (Dutton and Rubinstein, 1995).

Secondary traumatic stress, as described, must not be confused with burnout. Burnout is a reaction to a stressful work situation and appears to consist of three stages. The first stage involves an imbalance between resources and demand. The second stage is the immediate and short-term reaction to the imbalance. Accompanied feelings with the second stage may include anxiety, tension, fatigue and exhaustion. The last stage consists of changes in attitude and behaviour. These changes include detached and mechanical involvement in clients. A transactional process could describe burnout due to the factors like job stress, work strain and psychological accommodation (Cherniss, 1980).

Burnout is characterized by physical depletion, feelings of helplessness and hopelessness, emotional drain and by the development of negative self concept and negative attitudes towards work, life and other people, that is caused by intense involvement in emotionally demanding situations (Pines and Aronson, 1989).

Burnout is defined as exhaustion of physical or emotional strength or motivation usually as a result of prolonged stress or frustration. It is something that gradually builds to a breaking point and the stress and frustration comes from all types of work-related sources (Merriam-Webster's Collegiate Dictionary, 2003).

Three components of the burnout syndrome were identified by Maslach and Jackson (1981) as: emotional exhaustion, depersonalization and a reduced sense of accomplishment. The authors indicated that emotional exhaustion occurs as a result of emotional overload in interpersonal contact situations. There is an increased demand for high levels of affect which results in lower affectual responses, concern, trust, interest and motivation. Depersonalization manifests as the psychological distancing of oneself.

Four primary differences between burnout and compassion fatigue are identified by Figley (1995b). The first difference stipulate that burnout emerges over time whereas compassion fatigue symptoms may emerge more suddenly. The second difference between these symptoms is that compassion fatigue may result in a greater sense of helplessness, confusion and isolation. Consequently, compassion fatigue is likely to be disconnected from the real cause whereas an individual experiencing burnout is more likely to be able to identify the cause of the symptoms. The fourth difference is that individuals are likely to recover more quickly from compassion fatigue than from burnout.

The symptoms of secondary traumatic stress, burnout and compassion fatigue are very similar. It is therefore not uncommon for any individual working in the field of trauma, to experience all these states at some stage of their lives (Figley, 1999).

2.4.4 Symptoms of Compassion Fatigue

Figley (1995b) believe that the ability to empathize is a key personality characteristic for effective counselling, but it also plays a vital role in the development of compassion fatigue. He asserts that empathy presents us with a paradox: it is required by counsellors to provide care and support to clients, however by having an emotional connection to someone increases the counsellor's vulnerabilities to symptoms of compassion fatigue.

Herman (1992), describes a type of victim-blaming that sometimes occurred in trauma workers because they themselves felt victimized by their clients whom they perceived to be threatening, manipulative, or exploitative. Clearly, this will have had detrimental effects on the therapeutic process. Crothers (1995) supported this debate by reiterating the responses of staff who worked with survivors of trauma, anger, sadness, caution, vigilance, sleeplessness, intolerance, nightmares, compassion, irritability, sensitivity, denial and understanding formed part of the spectrum of responses that was explored.

A sense of helplessness, confusion and isolation from supporters ensues. A pattern of tiredness and emotional depletion from too much caring and too little self-caring, emerge. The symptoms are often disconnected from real causes and the symptoms triggered by past or current traumatic experiences. The symptoms of compassion fatigue comprise seven categories: emotional, cognitive, behavioural, spiritual, personal relations, somatic and work performance (Figley, 1995b).

The following are some of the signs and symptoms that have been documented from research (Panos, 2008):

- Feeling estranged from others (having difficulty sharing or describing feelings with others)
- Difficulty falling or staying asleep.
- Outbursts of anger or irritability with little provocation.
- Startling easily while working with a victim thinking about violence or retribution against the person or persons who were victimized.
- Flashbacks connected to clients and families.
- Needing more close friends. Feeling there is no one to talk with about highly stressful experiences.
- Working too hard.
- Frightened of things that traumatized people and their family had mentioned.
- Experience troubling dreams similar to the clients and their families.
- Experienced intrusive thoughts of sessions with especially difficult clients and their families.
- Suddenly and involuntarily recalled a frightening experience while working with a client or their family.

- Preoccupied with a client or their family.
- Losing sleep over a client and their family's traumatic experiences.
- Feeling trapped by trauma work.
- Feeling a sense of hopelessness associated with working with clients and their families.
- Feeling weak, tired, rundown as a result of work.
- Feeling depressed as a result of work.
- Trauma counsellors are unsuccessful at separating work from personal life.
- Feel little compassion toward most of their co-workers.
- Thoughts that one is not succeeding at achieving one's life goals.
- Feel I am working more for the money than for personal fulfillment.
- Finding it difficult to separate personal life from work life.
- A sense of worthlessness/disillusionment/resentment associated with work.

2.4.5 Causes of Compassion Fatigue

A key variable in the development of compassion fatigue is the counsellor's level of exposure to traumatic material. This phenomena was explored by Dutton and Rubinstein (1995). They further expounded that the novice trauma worker may have felt especially guilty when the survivor re-experienced the trauma through necessary interviews or therapeutic intervention procedures (Dutton and Rubinstein, 1995). Pearlman and Saakvitne (1995a) assert that the cumulative effect of story after story, client after client, day after day can become a chronic condition. According to Figley (2002), the best counsellors are the most likely victims. Figley's experience with compassion fatigue emerged during his acquaintance with war veterans and the experience left an indelible

impression on him. Furthermore he felt incapacitated at times. He experienced intensive nightmares and became obsessed by them. This led to feelings of anger and frustration over his client's experience. This experience sparked his entry into the research and development of models in the field of compassion fatigue. Since he endured the effects from an ethnographic assimilation of the traumatic effects in his life, through secondary traumatization.

Compassion fatigue develops as a result of the caregiver's exposure to the patients' experiences combined with their empathy for their patients. Compassion fatigue is sudden and acute. These findings, following the Omagh bombings, revealed that in the first year (August 1998 to August 1999) there were increases in compassion fatigue scores. The researchers concluded that many of the strategies used by the mental health workers, were the same sort of strategies recommended for clients. This involved taking care of oneself through exercise and healthy living, expressing emotions and getting support (Collins and Long, 2003a).

Subsequently, in order for trauma treatment to be effective, the counsellor responsible for helping the client through this process needed to re-experience the traumatic incident with the client. This process of repeated exposure to the trauma involved an intrinsic risk of emotional, cognitive and behavioural changes in the clinician (Bride, Radey and Figley, 2007). The risk of compassion fatigue was one of the residual effects of working in a trauma unit, that is highlighted in future chapters.

The vulnerability to compassion fatigue is attributed to the fact that therapists and trauma workers are constantly surrounded by traumatized individuals and trauma (Figley, 1995b). According to Figley (1995b), empathy is one of the major resources for trauma workers to help clients. It is also the key variable in the transference of traumatic material from the client to the therapist. Furthermore most trauma workers experienced a traumatic event in their lives. Peeke, Moletsane, Tshivhula and Keel (1998) substantiated this statement by highlighting the plight of the social workers who live and work in a traumatic

environment and are constantly exposed to some aspect of trauma directly and indirectly. Unresolved traumatic experiences may be activated by similar experiences of clients and this is inevitable in the context of these trauma workers (Peeke et al., 1998).

2.4.6 The Effects of Compassion Fatigue

In the aftermath of the 9/11 terror attacks in the United States of America, psychologists and other helpers were forced to balance demands placed on them in their work with patients and clients against the demands in their own lives. There was a national feeling of fear, vulnerability, and uncertainty (Saakvitne, Stamm and Barbanel, 2001). The counsellors and psychologists found their own anxieties mirrored or increased by the concerns and feelings they heard, expressed by their patients or clients and this contributed to feelings of apprehension and their own mortality.

All of the following are normal responses to exposure from secondary trauma and can influence professional work. It is therefore necessary to recognize and understand them in order to address these issues constructively. Absences from clinical practice for personal need or professional demands, which can increase the stress of clinical work, intrusive imagery such as reactions to the sound of planes or to the sight of towers are common responses after a traumatic event. Emotional reactivity involving more or stronger feelings and unexpected emotions or reactions; fear and anxiety were personal reactions to terror and threats that distract or inhibits one; fatigue in terms of emotional and physical exhaustion or weariness; and sadness, grief, or depression were acknowledged in the research as being potent effects of compassion fatigue (Saakvitne et al., 2001).

According to Figley (2002), hearing about past trauma can trigger haunting memories from a therapist's own past. A clinician whom he worked with, related an incident of becoming angry with a client who was an adult survivor of childhood sexual abuse. The provider was surprised by those feelings, but

as she considered them she realized that the therapy had forced to the surface her own buried anger towards an adult relative who had once fondled her when she was a child (Figley, 2002).

Figley (2002) bases his research on his experience with treating mental health professionals. He believes that the providers more likely to suffer from compassion fatigue are those who are caring and empathetic. The stigma attached to too much empathy, caring and compassion prevent many professionals from seeking help (Morrison, 2007).

2.4.7 Figley’s Model of Compassion Fatigue

Figure 2.2 highlights the process of compassion fatigue.

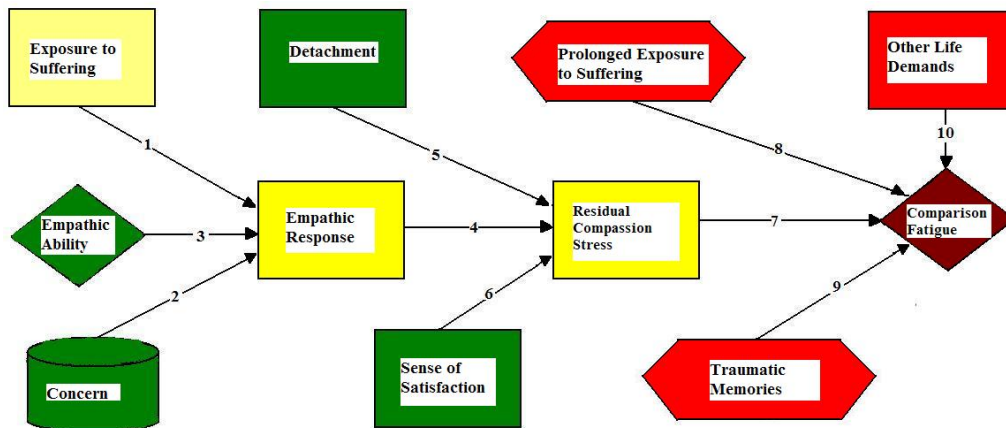


Figure 2.2: *The Compassion Fatigue Process (Figley, 2001)*

Exposure to suffering, empathic responses and concern snowball towards the first stage of compassion fatigue, which represents Empathic Response. In the next step empathic response together with detachment and a sense of satisfaction escalate into Residual Compassion Stress. As the effects of a traumatic event gain momentum, residual compassion stress together with prolonged exposure to suffering, traumatic memories and other life demands culminate into Compassion Fatigue (Figley, 2001).

The process of compassion fatigue is not clusters of isolated events but it is a blend of all the categories and effects as well as its impact on these categories. It is a recursive process and information is continuously being fed into the individual's system. This form of negentropy helps to create a context for the individual to think about a change in the system.

According to Figure 2.3, prolonged exposure to traumatic material leads to secondary traumatic stress and this is a recursive process. Secondary traumatic stress can also prolong the exposure to traumatic events and this would then result in compassion fatigue. The single criticism that I have with this model is that it moves in a single direction, the arrows should be bi-directional as information is continuously been fed into the system in order to culminate into compassion fatigue.

Furthermore secondary traumatic stress can lead to traumatic recollections in a bi-directional route. The cause and effect of secondary traumatic stress and traumatic recollections are reflective of the intensity of each component and they can lead to or be the effects of compassion fatigue as depicted in Figure 2.3.

The unidirectional arrow in Figure 2.3, from degree of life disruption to compassion fatigue should also be bi-directional. Thus far all the literature reviewed in this study have highlighted the recursive nature of compassion fatigue and vicarious trauma on the effects of novice counsellors. Even novice counsellors have a background and personal history that reflects or deflects the psychological effects of trauma.

2.5 Preventing Secondary Trauma

Bearing witness to trauma stories can evoke in clinicians the confusion and emotional turmoil their clients experience, known as secondary trauma. Given the complexities of trauma work, practitioners need help to clarify issues and feel more effective (Geller, Madsen and Ohrenstein, 2004).

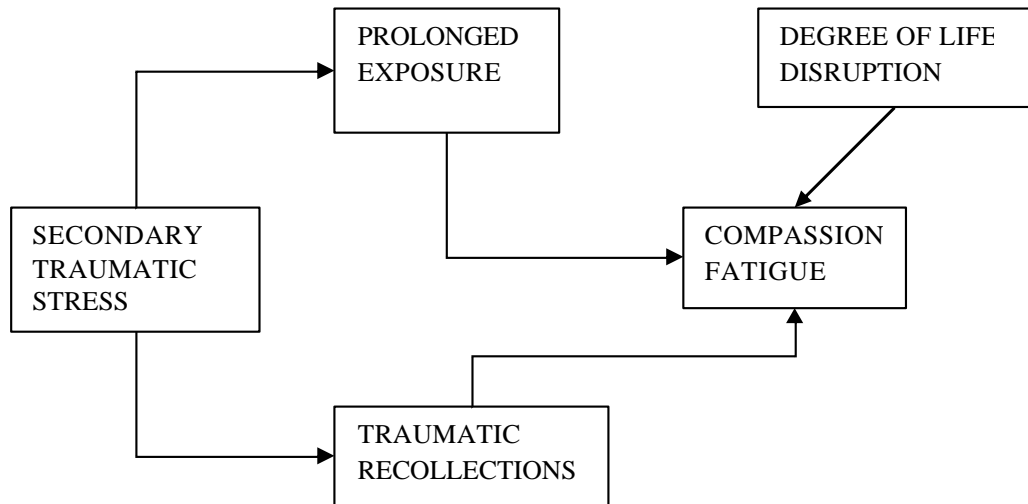


Figure 2.3: *Compassion Fatigue Model (Figley, 1995a)*

Like primary trauma reactions, secondary trauma may disturb the counsellor's ability to think clearly and to modulate their emotions in order to feel effective or to maintain hope. Yet hope is an essential component of doing the work. If the clinician is overwhelmed, they may feel inclined to withdraw from potential sources of support. Practitioners may react defensively, by avoiding such cases, denying their seriousness, or possibly by rationalizing their destructive impact. Alternatively, defensive reactions might take the form of over-involvement and rescue efforts that can undermine the clients potential strengths. These factors hinder the counsellors ability to sustain a hopeful and effective stance (Geller et al., 2004).

2.5.1 A Model for Preventing Secondary Trauma

Personal trauma had been considered by some to be more harmful to the counsellor's psychological well-being than work related trauma, and its effects may lead to compassion fatigue symptoms being experienced (Yassen, 1995). Subsequently a multi-dimensional framework based on the ecological model of Yassen (1995) indicate primary, secondary and tertiary intervention to be implemented by organizations to comprehensively address compassion fatigue

and burnout in trauma counsellors.

In relation to an ecological approach, primary interventions have a long term social change when implemented resulting in elimination of the root causes. Secondary interventions consisted of environmental and personal planning for the preparation in coping with the impact of secondary traumatic stress. Tertiary interventions were crisis interventions for individuals and their communities in order to reduce the long term effect (Geldenhuys, 2005). However in order for an ecological model (Yassen, 1995) to be effective, it must be consistently maintained on a primary, secondary and tertiary level.

2.5.2 Training

Campbell, Raja and Grining (1999) postulates that training is an essential tool in trauma counselling. The mental health system is one of the primary support structures for victims of intimate violence (sexual assault, domestic violence, childhood sexual abuse, sexual harassment and incest). Since counsellors form an integral part of the victim's recovery process, it is imperative that trainee counsellors have adequate training in order to address the victim's needs. Training should also aim to minimize the effects of vicarious trauma and compassion fatigue.

Dunbar-Krige and Fritz (2006) stipulate that the compilation of portfolios and reflective writing are crucial for counsellor awareness. Reflection is defined as a cognitive, affective and conative process that involves active engagement by the trainee. It results in the integration of new understanding into one's experiences and becomes part of the novice counsellors development. Supervision facilitates this reflective process, which is slow and frustrating process, because of the barriers built up within the individual over a period of time.

According to research conducted by Friedman and Ortlepp (2002), a selection criterion could be issues related to whether counselors have been exposed to other traumatic incidents in their lives. The focus should be on how counselors

have coped with these incidents. To this end, the selection procedure should take into account coping mechanisms as a decision-making criterion. It would seem important to explore prospective trauma counselors' work and nonwork resources available to them since the research findings indicated that these were related to the ability to withstand the potential experience of traumatic stress. It is imperative that the trauma program coordinator, in consultation with experts in the field, monitor the effectiveness of the skills training provided to trauma counselors on a regular basis (Friedman and Ortlepp, 2002).

Clinicians affected by secondary trauma need to talk about their experience and concerns in a safe context that is validating and non-judgmental, offers empathic connection, and supports clear thinking toward effective action (Geller et al., 2004). The premise that supportive collegial groups can offer workers such a context to better understand both their own reactions and their traumatized clients, was highlighted by Rudolph and Stamm (1999). The authors Geller et al. (2004) developed a model for conferencing trauma cases, called Clinical Risk Management Team (CRMT).

This model has two components. The first component is the structured protocol for case discussion, this helps to organize and counterbalance the impact of trauma on complex cognition. The aim is to support and facilitate thorough and careful thinking that may be lost in the intensity and confusion of trauma stories. The second component is a collegial team that provides a safe context in which to reflect on the work, offering support and connection to the trauma counsellor or clinician in response to the potentially isolating effects of trauma (Geller et al., 2004).

The aim of this model is to facilitate a reflective process that enables staff to express their feelings about trauma cases in an atmosphere that is validating, normalizing, and safe. Research has shown that when one is enhanced by structure and support of colleagues, clinicians are able to work more effectively with traumatized clients (Geller et al., 2004).

Figure 2.4 represents the different levels of exposure and vulnerability to sec-

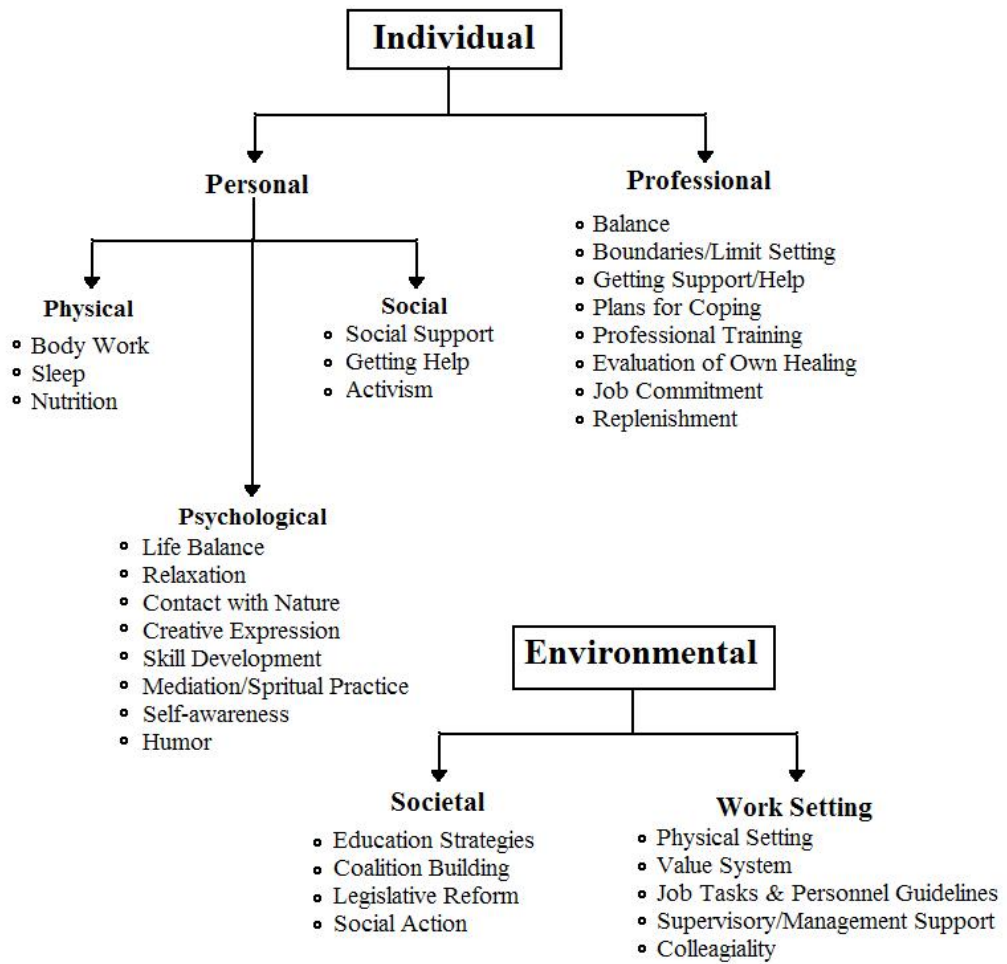


Figure 2.4: *Ecological Model for the Prevention of Secondary Traumatic Stress Disorder (Figley, 1995a)*

ondary traumatic stress. The individual category has two components: personal and professional levels. This model highlights intervention strategies at each of these levels and within these levels. These strategies prevail to facilitate the prevention of secondary traumatic stress. Compassion fatigue and vicarious trauma are also units of secondary traumatic stress disorder. The methods presented in Figure 2.3, can also be effectively applied to preventing compassion fatigue and vicarious trauma before it results in secondary traumatic stress disorder.

The personal domain consists of the physical dimension which includes well-being and self-care suggestions for the individual; social dimension includes support, help and activism and psychological dimension life balance, relaxation, contact with nature, creative expression, skills development, mediation, spiritual practice, self-awareness and humor (Figley, 1995a).

The professional domain consists of balance, boundaries, getting support, coping strategies, professional training, self evaluation, job commitment and replenishment (Figley, 1995a). These self-care strategies are recommended for a professional context to facilitate preventative measures.

The environmental category in Figure 2.4, shows preventative methods within the individual's environment that can help to regulate and install methods for preventing or diminishing the effects of secondary traumatic stress (Figley, 1995a). The societal structure includes societal reform, educational strategies, legislative reform and coalition building. The work setting involves the physical setting, value system, job tasks, supervisory support and collegiality. These sub-components of the societal structure and work setting indicate preventative methods that can be introduced to keep secondary traumatic stress from reaching mammoth proportions (Figley, 1995a).

Figley has dedicated his research to finding new and innovative ways of preventing the identified psychological effects of trauma and his models are flexible enough to be applied to any context. This forms a strategic basis for the development of future research and preventative models.

2.5.3 Resilience

In times of national crisis and disaster, therapists need to be more resilient than their clients. They need to be able to facilitate a healing process and provide a context for the healing to be regulated.

Resilience is the ability to adapt to difficult, challenging, stressful, or traumatic life experiences that can be particularly important for the psychologist. It is an ongoing process that can be learned and developed. Resilience can be enhanced by available social supports, self-awareness, the ability to provide self-care, and an ability to connect to something larger than themselves. This could include religious or spiritual activities, or an affirmation of humanitarian values (Saakvitne et al., 2001).

Resilience can be achieved by the following (Saakvitne et al., 2001):

- Self-assessment. The therapist must indulge in self-reflections and discussions of the effects of the experience with their colleagues, supervisors or family.
- Self - Protection. The counsellors must be aware of their vulnerability and the negative consequences of their work. They must strive for balance and maintain connection with others.
- Address the stress of your work. Practice self-care, nurture oneself by focusing on sources of pleasure and joy, and allowing for escape when necessary.
- Transform the negative impact of the work. Focus on finding meaning in their work and day-to-day activities, challenge negativity, participate in community building activities and join with others around a common purpose or value.
- Connect with yourself and with others. Pay attention to your inner experience, talk about it with others, do not work alone, and most importantly, ask for support as well as offering it to others.

2.6 Conclusion

The history of trauma can be documented from the beginning of time. As long as there was life, there was some degree of trauma. A qualitative understanding of this phenomena has been used to create awareness and preventative methods for this phenomena. The literature review on the current status of present research about the psychological effects of trauma on mental health workers has consistently reflected the intensity of the impact of trauma on mental health professionals.

South Africa is still recovering from the lingering effects of the post -apartheid era. The social workers often emerge from a violent society and are affected by the brutality and violence, and this fuels the issue of the traumatized counselling the traumatized. The personal history of the counsellor plays a significant role in secondary exposure to trauma, especially if it has been unresolved and there is no mechanism in place to provide adequate support, training and supervision (Peeke et al., 1998).

Macliam (2003) reiterates that trauma counsellors are at great risk of assimilating the effects of trauma. Since the repercussion of the relatively high levels of crime in South Africa create the possibility of survivors being re-traumatized thereby generating the need for trauma counselling. In this process the trauma counsellors are inevitably at risk of being directly exposed to non-work related trauma and the trauma counsellor may feel helpless in protecting their clients and keeping them safe (Macliam, 2003).

Although the effects of psychological distress is not a new field of research, it is very much a tentative field. A sense of hesitancy prevails when unveiling this information. This field of research seems to be wrapped in a shroud of vulnerability and mortality. The early research focused on identifying the signs and symptoms of vicarious trauma and compassion fatigue. Present studies have enhanced this whirlpool by identifying and designing models and programmes to educate, prevent and facilitate the healing of secondary traumatic stress

disorders.

Despite the limitations, the findings have important implications for counselors who work with trauma survivors. The findings reveal that working with sexual violence survivors is associated with changes in beliefs about the world, PTSD symptoms, and self-reported vicarious trauma. Just as PTSD is a normal response to victimization, vicarious trauma may be a normal response to trauma counseling. Counselors should therefore be encouraged to acknowledge and work through whatever effects they may be experiencing and agencies should provide the time and resources for this healing to take place (Schauben and Frazier, 1995).

Since countertransference is often present in all therapeutic relationships with dynamics unique to each therapist-client dyad, vicarious traumatization is a cumulative consequence not specific to any one client, which can be lasting and linked to multiple aspects of the therapist's personal and professional life. The psychological effects can interfere with the therapist's adaptive assumptions, thereby increasing the likelihood of a protective numbing reaction to feelings of pain and loss (Saakvitne, 1996). It is very convenient for trauma workers, to try and deny the impact of the effects by rationalizing their behaviour or by becoming defensive. These factors can influence the effectiveness of the trauma services (Geller et al., 2004).

Chapter 3

Research Methodology

Dig where gold is . . . unless you just need some exercise.

John M. Capozzi

3.1 Introduction

The present study is based on a multi-method research paradigm. Multiple operationalism is a measurement and construct validation technique that is used to enhance research validity and reliability (Johnson, Onwuegbuzie and Turner, 2007). The aim of qualitative research is to study human action from the perspective of the social factors (Babbie and Mouton, 2001). The focus is on the process rather than the outcome of the study, it is conducted in a natural setting and the primary aim is to gain rich, thick descriptions and understandings of actions and events (Babbie and Mouton, 2001). This exploratory study is conducted to satisfy the researchers curiosity and desire for a better understanding of the psychological phenomena of traumatic effects and to explicate the central concepts and constructs of the study (Babbie and Mouton, 2001).

The ethnographic design ensued because the information was derived from direct observation of behaviour and the subjective experiences of the researcher

(Babbie and Mouton, 2001). A particular culture is being explored from a native's perspective and learning of the experiences on other members of the same culture ensues. The method of triangulation is used to consolidate all the information obtained during the research process. The aim is to enhance validity and reliability of this study (Babbie and Mouton, 2001).

3.2 Qualitative Research

Qualitative research is used to gain insight into people's attitudes, behaviours, value systems, concerns, motivations, aspirations, culture or lifestyles. It is used to inform communication and research. In-depth interviews, content analysis, ethnography, evaluation and semiotics are among the many formal approaches that are used, but qualitative research also involves the analysis of any unstructured material, including naturalistic observations and subjective experiences.

The qualitative perspective is a reasonable approach when the researcher knows in advance about the important variables (TerreBlanche, Durrheim and Painter, 1999). The ontological approach facilitates the interaction between people and their experiences in order to subjectively appreciate the nuances in their narratives. Their epistemology informs our methods of data collection and analysis. Most of the research pertaining to the psychological effects of trauma on health care professionals, have been conducted through qualitative analysis. This is an interesting approach as it facilitates the extraction of rich descriptions and subjective experiences of the individuals, without prescribing a rigid structure of interaction. The method used to conduct research plays an important role in addressing the issue of secondary trauma. If research was conducive to the client's best interest, then a harmonic resonance between the story of the participant and the life experiences of the researcher can facilitate self-care for the researcher when researching trauma (Connolly and Reilly, 2007).

In fact, qualitative research is more than just a method, it is a particular

approach to inquiry that is based on a particular set of assumptions about how knowledge is produced and about the nature of the reality itself. Qualitative research takes the position that it is less important to discover what is “real” (in the sense of objectively verifiable truth) than it is to understand what contributes to people’s subjective understanding of reality. For this reason, the qualitative research aims to build an understanding of people’s “lived” experience, discovering how people interpret the world around them and how this influences their actions (Connolly and Reilly, 2007).

The principle of contextual understanding facilitates a vivid impression of social interaction undertaken by individuals. In order to understand human phenomena in this context, the application of qualitative methodology is the most appropriate for the present research (TerreBlanche et al., 1999). In order for qualitative researchers to understand their participants perspective, they need to embrace the reality of their participants. The content obtained from the contextual setting of the participants provides for a comprehensive description for interpretation and analysis.

In qualitative research the researcher acts as the research instrument, and data are typically viewed through the lens of both the study participant contributing the data and the researcher analyzing the data (Connolly and Reilly, 2007). Risks are inevitable for the researcher and this is supported by a number of studies. Undertaking research can pose risks to researchers as well, therefore a grounded theory study involving a range of researchers who had undertaken qualitative health research on a sensitive topic was completed (Dickson-Swift, James, Kippen and Liamputtong, 2008)(Dickson-Swift et al., 2008). Training, preparation, and supervision must be taken into account so that the risk to researchers can be minimized.

3.3 Ethnographic Study of the Effects of Trauma

The ethnographic approach examines behaviour that takes place within specific social situations, including behaviour that is shaped and constrained by these situations. People's understanding and interpretation of their experiences are contextually explored (Wilson and Chaddha, 2009). Since theory plays an inductive role in ethnographic research, the theoretical insights inform the interpretation of data uncovered in the context of discovery. In the process the ethnographer integrates new empirical findings with theoretical arguments not by testing prior theoretically driven hypotheses but in using his or her theoretical knowledge to make sense of the data uncovered in the field research (Wilson and Chaddha, 2009). Some ethnographic studies that incorporate theory into research are neither purely deductive nor inductive, but combine elements of both.

James (1897) stated that we live in 'a pluralistic restless universe in which no single point of view can ever take in the whole scene'. Consequently our world exhibits an 'impressive and irresistible mixture of sufficiencies, tight completeness, order, recurrences which make possible prediction and control, and singularities, ambiguities, uncertain possibilities, processes going on to consequences yet indeterminate' (Dewey, 1958).

3.3.1 Introduction and Genesis of Ethnographic Research

Ethnography has its roots in anthropology and sociology. Ethnography is a social science research approach. It relies heavily on up-close, personal experience and possible participation and not just observation by researchers. The ethnographic focal point may include intensive language and culture learning, intensive study of a single field or domain, and a blend of historical, observational, and interview methods. Typical ethnographic research employs three kinds of data collection: interviews, observation, and documents. This in turn produces three kinds of data: quotations, descriptions, and excerpts of doc-

uments, resulting in one product: narrative description. This narrative often includes charts, diagrams and additional artifacts that help to tell the story (Harris and Johnson, 2000). Ethnographic methods can give shape to new constructs or paradigms.

There has been a shift in the application of ethnographic studies. Presently ethnographic studies are also conducted in organizations and communities of all kinds. Ethnographers study schooling, public health, rural and urban development, consumers and consumer goods and any human arena. Although it is particularly suited to exploratory research, ethnography also draws on a wide range of both qualitative and quantitative methodologies, moving from “learning” to “testing” while research problems, perspectives, and theories emerge and shift (Agar, 1996).

Ethnography is a descriptive study of a particular human society. Contemporary ethnography is based almost entirely on fieldwork. The ethnographer lives among the people who are the subject of study for a year or more, learning the local language and participating in everyday life while striving to maintain a degree of objective detachment. He or she usually cultivates close relationships with informants who can provide specific information on aspects of cultural life. While detailed written notes are the mainstay of fieldwork, ethnographers may also use tape recorders, cameras, or video recorders. Contemporary ethnographies have both influenced and been influenced by literary theory (Britannica Concise Encyclopedia, 2009).

Ethnography is charged with the ability to bridge structure and agency by infusing abstract categorizations with individual meaning and placing the individual action within its larger social and cultural milieu (Kelemen, 2007). Since the ethnographer is able to provide rich descriptions which can lead to a fuller understanding of differences and similarities within any context of study.

In line with the process oriented participatory research, the ethnographers closeness to the empirical world via observation and triangulation of subjective experiences, sources and methods is a way to counteract an overemphasis on

what people say (Kelemen, 2007).

3.3.2 Triangulation

Triangulation is a combination of different methods used to collect data. The combination of different methods would give us a clearer picture of the individual's life and behaviour. Thereby enabling the researcher to observe a respondent's behaviour and make notes about it using a form of participant observation. The researcher could also question the interviewee about their actions and behaviour in certain contextual situations (Olsen, 2009) .

Triangulation is derived from a technique used by surveyors in their work. The researcher takes on the role of a surveyor in an attempt to validate the respondents responses (Olsen, 2009):

- If a respondent claims they always do something in a given situation, we have to take this on trust.
- If we could observe them this would give us a way of checking the accuracy of their claim. Whilst this is not as reliable a way of measuring the accuracy of something as the technique used by a surveyor, it does give us some measure of control over the accuracy of the data we collect.

The concept of triangulation can be applied to both (i) the way we use various different methods in the research process, methodological triangulation and (ii) the way we can combine various theoretical perspectives in our research, theoretical triangulation (Olsen, 2004).

In the present research, triangulation was achieved through two routes. The first route entailed gathering collaborative information from past research and exploring the effects of vicarious trauma and compassion fatigue in the present study. The second route involved using personal, subjective experiences together with the experiences of the interviewees in an attempt to gain a thick description of the psychological effects of trauma.

3.4 Research Approach

3.4.1 Introduction

The psychological effects of working with traumatized clients have been observed over time. The main focus of most research centered on counsellors working with victims of natural disasters, wars and sexual abuse. These studies have focused on the direct victims of trauma and with less attention paid to trauma counsellors, who work with these victims. The effects of psychological distress on novice trauma counsellors has created a need for further investigation. The exploration of the vulnerability to secondary traumatic stress, experienced by this category of health professionals is relatively new.

The key variables and contributory factors of vicarious trauma and compassion fatigue have been highlighted to be significant in the development of compassion fatigue. According to research these variables are exposure to traumatic material, personal history and empathy. Since this is an exploratory study based on ethnographic principles, I intend to explore the effects of psychological trauma and its role in the development of vicarious trauma and compassion fatigue in novice trauma counsellors. Hence, this study seeks to understand the effects of trauma within the culture of a trauma unit, and to also contribute to a further refinement of the theoretical understanding of the exposure of trauma and the susceptibility to developing vicarious trauma and compassion fatigue.

This chapter focuses on exploring the psychological effects of trauma from an ethnographic paradigm. This is an exploratory study that is triangulated against my experiences (as I was once a part of the trauma team), previous research and narrative experiences of the participants.

3.4.2 Aims of the Study

This study focuses on novice trauma counsellors and their experiences of trauma. The study aims to explore the effects of vicarious trauma and compassion fatigue within the culture of a trauma unit. I want to explore the interrelationship within the complex network of the trauma unit. The study attempts to relate experiences and the effects of secondary trauma from a native's perspective, thereby applying an ethnographic modality of relatedness. The research design for the study will be based on ethnography and exploration of narratives. The emergence of themes during the narratives will provide rich descriptions of subjective experiences.

3.4.3 Selection of Participants

The selection of the participants will be purposive, keeping in line with qualitative research. The participants have to be able to provide clear descriptions of their experiences and be willing to reflect on and delve into their past, thereby revealing sensitive and personal information in the process.

I have approached the trauma counselling unit at a local hospital in order to obtain permission to recruit novice trauma counsellors to participate in this exploratory study. As I have completed my trauma counselling internship with this trauma team, I have developed trust with the gatekeepers of the hospital and access to this organization will not present difficulties, as the supervisor is familiar with me.

The training programme that I participated in, was instituted at a government hospital in Pretoria, Gauteng and it offered an internship programme for registering as a trauma counsellor or pastoral counsellor. The internship programme lasts between six months and eighteen months. The students need to complete forty hours per week, full time training or the compulsory nine hundred and sixty hours need to be completed over the course of a year. Often the programme runs for a longer period, depending on the intern's emotional

and psychological functioning. The internship programme is very flexible and is tailored to suit every intern's needs.

In accordance with the above purpose of the study, the following criteria will be used for selecting participants for the research:

- Two novice counsellors and one experienced counsellor will be approached and asked if they would be willing to participate in this study.
- The novice counsellors must still be in training or just completed training, not longer than six months prior to being interviewed.
- They must be completing their internship in trauma counselling in the trauma unit.
- They must have completed over eight hundred hours of counselling.

I will contact each of the prospective participants in order to arrange for a suitable time and place to conduct the interviews. The purpose of the research and the nature of the investigation will then be explained to the participant. Permission will be solicited from the participants to use the interview for research purposes. A written consent will be obtained from the participants and they will be reassured that their identities will remain confidential. Permission to tape the session will also be acquired. These authorization forms will also be filed in a safe place.

3.4.4 Research Design

Since I was also a part of this particular culture for two years, the interviews will be conducted in accordance with the training of this system. In-depth interviews will be the data collection tool used to procure and capture the clients narratives and translate it within the ethnographic framework of my experience. The interviews will be conducted in the form of a conversation

between peers rather than a structured and formal exchange of questions and answers. It will be a dialogue of shared experiences.

I will start the interview with the following invitation:

- *Perhaps we can talk about your background and previous vocation.*

This can then lead up to probes such as:

- *What sparked your interest in trauma counselling?*
- *How did you hear about the training and this institution?*
- *Have you been exposed to trauma counselling in the past?*
- *How do you feel about being part of this research?*
- *What does this interview mean to you?*
- *Are you able to describe your feelings after a counselling session?*
- *Perhaps you can depict any particular category of cases, you avoid or are attracted to?*
- *Can you illustrate any particular incident that made you question your choice of trauma counselling?*
- *Have you ever taken leave for an extended period of time?*
- *Can you illustrate the effects of your experiences with trauma?*
- *Can we explore the events that necessitated the break from counselling?*
- *Can you describe any unusual incidences (unusual for you), that occurred before you decided to take leave?*
- *Can we explore your support systems?*
- *What meaning do you attach to support systems?*

- *How do you feel about availability or lack thereof support systems?*
- *What role does your supervisor play in your experiences?*
- *What is your impression of the current training?*
- *What are the differences you have noted in yourself?*
- *What meaning do you attach your changes, if any?*

As the interview progresses, I will use statements, questions and descriptions to clarify any discrepancies and uncertainties, in order to provoke the participant to elaborate on their depictions and provide a richer narration.

The aim is to elicit a sufficiently rich archive of experiences and history acquired in this particular culture. This will facilitate exposure of the psychological effects within the field of trauma counselling, and provide a basis for future enhancements of present systems in place. The purpose of this research is to provide a platform for further development in highlighting the consequences of being continuously exposed to trauma, as well as incorporating and implementing training and resilient programs on a regular basis.

3.4.5 Data Analysis

This section of the research has to conform to the process of content, context, structure and meaning to be imposed on the data collected during the research. Data will be analyzed in terms of interviews, observations and documents. This information will be triangulated together with my personal experiences in order to provide a rich understanding of the narratives in this particular culture.

The following principles of ethnography will be adhered to:

- Naturalism is the view that social research is to capture the character of naturally occurring human behavior. This can only be achieved by

first-hand contact with it, not by inferences from what people do in artificial settings like experiments. Therefore ethnographers carry out their research in “natural” settings, settings that exist independently of the research process, rather than in those set up specifically for the purposes of research. This research and interview processes were conducted at the trauma unit in the hospital. The importance of this implication is that in studying in the natural settings of this is to increase the chances that what is discovered in this setting suggest what occurs in similar settings that have not been researched. The notion of naturalism implies that social events and processes must be explained in terms of their relationship to the context in which they occur.

- Understanding is central to the argument that human actions differ from the behaviour of physical objects. They do not constitute simply of fixed responses or even of learned responses to stimuli, but involve interpretation of stimuli and the construction of responses. This argument can reflect a complete rejection of the concept of causality, and an insistence on the freely constructed character of human actions and institutions. This research attempts to explore human actions within a specific culture of trauma and gain an understanding of the cultural perspectives on which they are based. When a setting is familiar the danger of misunderstanding is especially high. However we cannot assume that we already know others’ perspectives, even in our own society, because particular groups and individuals develop distinctive worldviews. This is especially true in complex multi-cultural societies. Therefore it is necessary to learn the culture of the group one is studying before one can produce valid explanations for the behaviour of its members. This is the reason for the centrality of participant’s observation and unstructured interviewing to ethnographic method.
- Discovery is a feature of ethnographic thinking. The research process is inductive or discovery-based; rather than limited by explicit testing of hypotheses. Often if one approaches a phenomenon with a set of hypotheses

one may fail to discover the true nature of that phenomenon. The focus of the research will be tapered, honed and perhaps even changed substantially, as it proceeds. Theoretical ideas that will frame descriptions and explanations of what is observed will develop during the research. These themes will be regarded as valuable outcomes of, not a precondition for, research.

In doing my research, I will adhere to the following dictum an ethnographic study:

- People’s behavior is studied in everyday contexts, rather than under experimental conditions created by the researcher.
- Data are gathered from a range of sources, but observation and/or relatively informal conversations are usually the main ones.
- The approach to data collection is “unstructured” in the sense that it does not involve following through a detailed plan set up at the beginning; nor are the categories used for interpreting what people say and do pre-given or fixed. This does not mean that the research is unsystematic, simply that initially the data are collected in as raw a form, and on as wide a front, as feasible.
- The focus is usually a single setting or group, of relatively small scale.

Ethnography is not far removed from the sort of approach that we all use in everyday life to make sense of our surroundings. It is less specialized and technically sophisticated than approaches like the experiment or the social survey. Historical origins in the ways in which human beings gain information about their world in everyday life is incorporated.

The analysis of the data in ethnography involves interpretation of the meanings and functions of human actions. This is achieved by verbal descriptions and explanations, with quantification and statistical analysis playing a subordinate role at most.

Field notes and previous research will also be used in order to provide a comprehensive account of the phenomenon being investigated. These notes and research will guide me during the interviewing process and prevent salient information from being lost during the session.

The role of the researcher is more of an ecological detective. I will look for themes, patterns, changes and a time frame that produced the psychological effects. The process of analysis will involve in-depth analysis, creative insight and the focus of the research. The analysis and interpretation processes are separate practices.

The analysis phase involves gathering all the raw material in order to get an impression of the whole process. I will try to cover the entire process on the continuum from the analysis to interpretation. Analysis involves bringing order to the data, organizing the information into patterns, categories, and basic descriptive units. The analysis process involves consideration of words, tone, context, non-verbals, internal consistency, frequency, extensiveness, intensity, specificity of responses and big ideas. It is important to use data reduction strategies in order to make sense of all the information present.

Qualitative methods will be used to amass a great deal of pure description of the experiences of people in the research environment. This description allows the reader access into the environment under observation, the participants' perspective and information on particular events or activities in the environment. Field notes and interviews will enable me to search for the data necessary for presentation as pure description in the research report. An entire activity may be reported in detail and depth because it represents a typical experience. These descriptions are written in narrative form to provide a holistic picture of what has happened in the reported activity or event.

Interpretation involves attaching meaning and significance to the analysis, explaining the descriptive patterns, and looking for relationships and connectedness among descriptive dimensions. Once these processes have been completed I can then report the interpretations and conclusions of the research.

The interpretive approach referred to as hermeneutics was selected in order to understand the participants worldview. Hermeneutics involves the process of engaging with all the information, in an attempt to discover embedded meaning (Neumann and Gamble, 1995). In accordance with the research modality, hermeneutics will be used to understand and interpret the participants experiences without abstracting or categorizing it.

The principles of hermeneutics are in synchrony with the ethnographic paradigm, on which this study is based. The process of interpretation is informed by my values and experiences. This process will allow me to obtain and discover meaning and achieve understanding through the participants' experiences and textual content. The object of this is to ensure that the researcher and participant are in a relationship that fosters the discovery of shared common practices and experiences.

The following sequences for conducting the research will be applied to this study:

- Phase One

Permission will be obtained from the supervisors and gatekeepers of the trauma unit and the religious organization, that will form an integral part of the study.

- Phase Two

The interviews will be tape recorded. Written permission will be attained from the participants, prior to the interviewing process.

- Phase Three

The taped interviews will be transcribed.

- Phase Four

I will read the transcripts and listen to the taped information, simultaneously, to ensure consistency and validity of the obtained information.

- Phase Five

I will read the narratives several times in an attempt to understand the participants' perspectives and worldviews.

- Phase Six

The interpretation will be discussed with each participant in order to gain collaboration.

- Phase Seven

I will record themes and patterns as they emerge from each of the original texts. I will also use extracts from the original text in support of the emerging themes. The participants' stories will evolve around the identified themes.

- Phase Eight

The themes that are common to all three participants and me will be ascertained and integrated with findings from previous research in an attempt to consolidate the exploratory study in this research.

I will approach the research from an open and curious angle. The final conclusions will only be made once the data collection has been completed.

The process of research is linguistically, a circular exercise. The relationship between the narratives and me are interrelated. This research will expose a more complex set of interactions between the content, context and the emerging processes into a multifaceted representation of the individual.

3.5 Conclusion

I will attempt to elicit information from this study in order to gain a deeper understanding of the subjective experiences of each trauma counsellor. Their

resilience, experiences and decisions to join this branch of mental health professionals and remain in this vocation will contribute to a greater understanding of this growing field of interest.

The significance of this research is embedded in the descriptions to represent an expanded understanding of the pentagon of illustrated viewpoints manifested as single narratives. This study does not aim to simplify or quantify the participants' experiences. The purpose of this study is to provide a platform for the exploration of subjective experiences and open up a dialogue for talking about the traumatic effects.

The sensitive nature of the information shared by the participants' need to be respectfully acknowledged. The beauty of ethnographic studies is that it does not allow any researcher to impose reductionistic techniques on the participant's narrative, but to embrace this information in a humane and exploratory manner. Thereby ensuring that the dignity, encapsulated in the shared information, is maintained.

Chapter 4

Hope: A Leap Of Faith

Prospecting is not what it once was. Unless you want to walk the same ground and not find anything either, you have to be prepared to prospect differently than the Old-Timers did.

Clyde H. Spencer

4.1 Introduction

Hope is a young female of twenty two years, who hails from Polokwane. She first came across psychology during her undergraduate years. Subsequently she developed a passion for the subject. She completed her BA degree in 2007 and went on to complete a post graduate degree in Psychology at the University of Limpopo in 2008. Hope realized that she loved working with people and she thought that psychology would be a good choice for her. However she was never interested in completing masters in clinical psychology, she was more inclined towards industrial psychology. Since this was not an option at the University of Limpopo, she completed a general qualification in psychology.

On completion of her postgraduate degree, Hope was despondent, as the options to practice in the field of psychology, were limited. She heard about the registered counselor programme, from a master's student at the University, and decided that this might be a good option for her to pursue. She had obtained

all the information about the internship from the student, and embarked on her journey of trauma counseling. She contacted the relevant departments at the university and hospital and once she was accepted in the one year training programme, Hope relocated to Pretoria.

Hope had never been exposed to any form of trauma in her life. The introduction into the trauma unit was a reality call for her and the turmoil of emotions that she experienced during this period will be highlighted later in the chapter. As a novice counselor, with no prior history of counseling, Hope was yanked out of her protected womb and thrown to the harsh realities of life.

Hope started the internship training in 2009. When she joined the trauma unit, she had to take a course in trauma counseling and pastoral care. This course helped her to become familiar with the rules and regulations of the hospital, as well as counseling etiquette and responsibilities. It provided a framework for her to structure her approach to trauma counseling. The course required that Hope had to find a personal supervisor to aide and guide her through the internship process. However when she started the course, she did not have a personal supervisor to help her through the process. She was totally dependent on the in vivo supervision provided by the trainers in the course.

Hope was not only a novice counselor but she was also in an intensive training programme. This pushed all her boundaries and made her more aware of herself in relation to the system. Rodrigo (2002) reiterated that exposure to clients narratives may sometimes overwhelm the therapist's capacity to safely absorb and handle the information in therapeutic ways. Hope's supervisor helped her immensely to move forward in the course. Since she had reached a stage, during the training where she began to manifest symptoms of secondary trauma. She became overwhelmed by the pressures and stress associated with the intensity of the training and extent of traumatic incidents that she was exposed to on a regular basis.

These effects are also documented by the following researchers who reiterate that exposure to trauma deflates an individual's life goals and aspirations. This

culminates either directly or indirectly as psychological stress and symptom formation (Janoff-Bulman, 1992). Furthermore trauma therapists who have gone through similar experiences as their clients may begin to dissociate during sessions, causing serious disruption in the therapeutic process (Pearlman and Saakvitne, 1995a). According to Morrison (2007) trauma counsellors may also experience anxiety, depression, de-personalization, feeling overwhelmed by emotions such as anger, fear, grief, despair, increased irritability, feeling of reduced personal accomplishment and having no time or energy for self or others. Therefore by being a novice counselor, in the same trauma unit, a few years ago, I could identify with the demands of the trauma unit and the dangers associated with having too much sympathy and not enough empathy.

This chapter will discuss the effects of trauma counseling on Hope as well as my impressions, perceptions and reflections of the interview process and Hope. It will highlight the relationship between Hope and myself, as well as the information derived from direct observation of Hope's behavior and my subjective experiences. This particular culture of trauma is being explored from a current and previous native's perspective and learning of the experiences on other members of the same culture ensues. The method of triangulation is used to consolidate all the information obtained during the research process. The aim is to enhance validity and reliability of this study (Babbie and Mouton, 2001). My beliefs and attitudes were also challenged. This forced me to reflect on my process during the session. The effect of the narrative on me will be shared at the end of this chapter. Hope will also share her experience of the interview process.

4.2 My Experience of Hope

Hope is an unassuming and quiet person. She has a friendly disposition and an engaging smile that had a calming effect on me. I sensed that she was a reserved and shy person. On further enquiry Hope disclosed that the trauma counselling internship was out of her comfort zone. Everything she observed

was a novelty and it took a lot of effort for her to muster up enough courage just to speak to people. Furthermore she divulged that it was a slow and sometimes painful process for her. My impression of Hope was that, she had limited life experiences and until the point of entrance into the internship programme, she had led a fairly sheltered life.

We shared similar experiences in the trauma unit and the wards. She mentioned that this was the first time she had the space to discuss exactly how difficult her initiation into the programme was. I experienced Hope has a bubbling cauldron of heightened emotions, ready to disgorge during the session. I asked her about her supervisor, close friends, family and support systems. According to Hope she could not really talk to them about everything she was going through because she did not want to be stigmatized. She had this fear that others may think that she was incompetent and until this point, Hope had always been successful in all her endeavors. She did not want this façade to be shattered. There is also a stigma attached to trauma work and vicarious traumatization, as an interviewee mentioned, ‘It is as bad as having AIDS’ (Morrison, 2007). Although recognition of vicarious traumatization and other associated issues have increased, it can still be difficult to acknowledge, disclose and address the issues associated with trauma.

4.3 Hope’s Experiences as a Novice Trauma Counsellor

When Hope joined the hospital, she was in awe of the trauma unit and the hospital and the rapid pace of response expected from the trauma counsellors. Hope did not have any counselling experience. She attended the trauma counselling and pastoral courses provided by the hospital. It was her first introduction into the rules and regulations of the hospital as well as hospital procedure and etiquette. The training was very basic and focused more on how the novice counsellor should present themselves in their capacity. Hope

was immediately exposed to the trauma unit, on completion of these courses. She was not prepared for the intensity and practical exposure to trauma.

The course did not adequately prepare her for the intense physical and emotional turmoil that she would encounter on a regular basis.

'I didn't think it was going to be like so, like I had to see dead people, go to the morgue. I didn't have time to just sit down and look at my feelings. How those things affect me personally?'

She was swept into the whirlwind of activity in the trauma unit. It did not give her much time to sit and reflect actively on the process. Hope then began to start bottling up and suppressing her emotions. Hope's responsibilities at the hospital included working in the trauma and casualty units, being on call for a week, every month, as well as visiting patients in other wards. She also had to be available for any crisis that presents itself.

Hope explained how difficult it was for her to go into a ward, introduce herself to the staff and patients before visiting with the patients. Being an extremely shy and introverted person, she felt as though she was invading the patient's privacy. She often felt as though she was imposing herself in their lives. After the pastoral care course, there was a slight shift in Hope's attitude. Although she felt uncomfortable visiting patients in the ward and asking them if they wanted to talk, it became easier when she realized the importance of the support she was offering to them. This theme of imposition resonated with many novice counselors and I could also identify with the feelings expressed by Hope and the other counselors.

When Hope began her training, she had not engaged a private supervisor prior to the onset of the programme, but she was grateful for the in vivo supervision provided by the training group in the hospital. Hope explained how she arrived at a point in her training, when things became too ambivalent for her:

'I think it was two months. I think I, sort of reached a breaking

point. It was actually too much for me, I didn't think I would do this anymore. I spent another 2 months not coming for training. I was really confused. I just needed time to myself.'

It was at this point that Hope had difficulty consolidating her feelings or actively reflecting on them. She felt isolated. The internship training was physically, mentally and emotionally draining for her. She was confronted with traumatic events on a daily basis and this manifested as helplessness and questioning of her choice of career.

Hope began to see cracks forming in her personal relationships and there was a significant drop in the quality of work that she was delivering. She began to withdraw into herself and the effects of secondary trauma began to present. Hope was beginning to manifest symptoms of physical, mental and emotional effects of trauma. Emotional exhaustion occurred as a result of emotional overload in interpersonal contact situations. There was an increased demand for high levels of affect which resulted in lower affectual responses, concern, trust, interest and motivation (Maslach and Jackson, 1981).

Hope: 'It affected my relationship with my boyfriend in a bad way because everything changed like, I was moody, I was always complaining. Um, I would always, say that his day was perfect and mine was not. I would view life as being unfair to me.'

Me: 'Unfair in terms of?'

Hope: 'In terms of I have to come here and speak to patients and do whatever, like which I don't feel like doing, like I don't connect with my patients, I don't feel like being here, I don't enjoy being here. Or else he gets up in the morning, put on his tie and goes to whatever, the corporate world and then comes back and tells me about his times and I have nothing to say. I would avoid him as well.'

Depersonalization manifests as the psychological distancing of oneself (Maslach

and Jackson, 1981). Hope had also started to break away from her parents and she avoided any contact with them. She did not return their telephone calls and she avoided talking to them. Although the effects were not profound enough to lead to burnout, in Hope's situation, it was also not recognized as possible symptoms of burnout. This is one of the many dangers that novice counsellors are exposed to.

The following themes identified throughout the conversation, also resonate with me and my perception of the effects of trauma on Hope. It also highlights Hope's emotional transition during this journey. The themes tend to have common characteristics and occur in tandem with each other.

4.4 Feelings of Ineffectiveness

At the beginning of the training, Hope went about her duties automatically. She tried to maintain a professional distance between the client and herself. This continued for the first two months. However the cracks in her persona began to show. She was having difficulty keeping up the cheerful masquerade at work. Hope began to feel alienated and alone during this time. Towards the end of the second month, her energy levels had dropped substantially; she avoided visiting her clients in the various wards. Her work production and quality began to decline significantly. Like primary trauma reactions, secondary trauma may disturb the counselor's ability to think clearly and to modulate their emotions, in order to feel effective or to maintain hope (Geller et al., 2004).

She was despondent and felt extremely incompetent and ineffective; she did not feel as though her presence made a difference. She felt sympathy for her clients, and helpless when she could not physically lessen their pain. A sense of helplessness, confusion and isolation from supporters ensues. This is followed by a pattern of tiredness and emotional depletion from too much caring and too little self-caring, emerge (Figley, 1995a).

She began to question her choice of career:

'I think having to experience emotionally the problems which people were telling you, like everything was just too much for me. I didn't know there was so much sadness and so much grief and so much pain which I had to face it every day. Feelings, I could say loneliness and alienation, like feeling like you don't belong.'

'There was this incident, I saw a little baby girl, a premature baby girl dying. While the parents were there watching. It was like, it was really, you, even though you know that it doesn't happen to you, but you can see how they are feeling. It's really, it just so hard to explain. That's the most traumatic things here for me. Having to see your loved one dying while you are watching. I felt so helpless, like, I couldn't do anything. And I felt so sad, very sad. To a point where I could just sit by myself and just start crying.'

'I remember telling my dad that, no, I can't do this anymore. Like no, it's not for me. I see dead people all the time. I am working myself up, I am tired, I didn't want to come back to the hospital. It was just too much for me. I draw a line trauma counselling is not for me.'

4.5 Effects of Trauma

Hope is in a long-term relationship. She explains how her experience with traumatized people affected her relationship with her boyfriend. Hope experienced feelings of helplessness in her personal and professional lives. She felt as though the world was crashing around her, as she could not deal with the intensity of emotions flooding her. This manifested as constant bickering, frustration, irritation directed towards her personal relationships. The symptoms are often disconnected from real causes and the symptoms triggered by past or current traumatic experiences; this is reiterated by (Figley, 1995a). These

effects of compassion fatigue were beginning to affect Hope's personal life and professional performance.

Hope felt that her training was inadequate and it was reflected in the feelings of inadequacy that she experienced. In a training session, Hope often felt inferior to the other students. She felt that they presented themselves so confidently and intellectually that it made her seem incompetent. She was reduced to a quivering bowl of jelly whenever she had to join a discussion. This increased her feelings of inadequacy and significantly reduced her self-esteem. Feelings of estrangement from others and difficulty sharing or describing feelings with others are a common side effect of compassion fatigue (Panos, 2008).

Feelings of vulnerability dominated the first few months of Hope's training. She felt exposed, and often questioned her authenticity in the counselling process. Hope was exposed to death and her own mortality for the first time in training. She was initially puzzled by the number of grief related cases that were directed towards her. She had a stint that ran for a few weeks where she was assigned a majority of death-related cases and she had to take the grieving family to visit the deceased in the mortuary. This upset Hope because she was frequently confronted with the fragility of life and it increased her vulnerability.

Past research has reiterated that anyone who engages empathetically or sympathetically with victims or survivors is vulnerable to secondary stress (Pearlman and Saakvitne, 1995a). This vulnerability is expressed as a form of dissociation. According to Neumann and Gamble (1995), vicarious traumatization is an occupational hazard. The novice counsellor needs to be made aware of its effect on their psychic worlds. Being an active participant in the re-enactment within and outside the therapeutic relationship makes the novice counsellor vulnerable to manifesting symptoms of vicarious trauma (Morrison, 2007).

Hope showed signs of vicarious trauma, this include emotional numbing, flashbacks and nightmares, recurring thoughts of a traumatic incident and disconnection were some of the effects of trauma, experienced by Hope. These often transpire as intrusive reactions which culminate in the form of dreams or

nightmares, flashbacks, obsessive thoughts, physiological reactions and other persistent re-experiencing of the traumatic event. Hope's avoidant reaction can be understood as a general numbing in responsiveness and avoidance particularly of things related to the traumatic material (Wasco, 2003).

4.6 Hope's Worldview

This theme reveals Hope's transition and how her perception has been expanded by the counseling experiences. She was exposed to her own mortality and the vulnerability of life. This ripped her out of her comfortable cocoon into a world of reality. Hope's life had been protected and she had not experienced pain, loss or trauma of this magnitude.

Hope's individual's frame of reference refers to her identity, world view, and spirituality. The effects of vicarious traumatization caused Hope to question her own identity, role, and self worth (Hesse, 2002). Her reality had changed and so had her attitude towards life and death. She experienced intense vulnerability and awareness of her daily existence. Hope was an inexperienced counselor with a restricted world view, the effects of trauma resulted in disturbances in her basic schema about the world.

'I stopped thinking about myself, like I stopped just being selfish in a way, because I thought I was always thinking of myself. I can't do this, I can't do this, so no, I'm just alone, so I'm like, I start thinking about the patients, what they actually needed. That they are the ones who are suffering too much, not me. You know, so I started having that closeness with the patients.'

Hope has become less sensitive since the beginning of the training. She is now able to actively reflect on the effects a particular incident is invoking in her. She became more skeptical and less trusting of people in general. She became more cautious about people and their motives.

'I don't feel the way that I was feeling for the first time. You know. Like I would take whatever with me at home, I would want to speak to my boyfriend . . . I no longer do that except if I saw something which was very, very disturbing. Ja, then I could just share. But now, it's just all like normal.'

There has been a significant shift in Hope's behaviour and attitude towards trauma counselling. At the beginning of the programme, Hope wanted to quit the training, this changed towards the end of the programme. When at one stage she dreaded the beginning of a day at the hospital, she now relishes the thought of returning after registering as a trauma counsellor.

4.7 The Role of Life Experience in Training

Hope's life experience was very limited. Her personal boundaries were firmly secured and she was blissfully unaware of the harsh realities of trauma. Despite her limited life experiences, Hope's experienced the same level of distress as veteran counsellors. Schauben and Frazier (1995) revealed that counsellors with a history of victimization are not more distressed by seeing survivors than were counsellors without a history of victimization. This actually made her more vulnerable to the experience.

Me: 'In terms of what were your expectations?'

Hope: 'I didn't think it was going to be like so, like I had to see dead people, go to the morgue and have to approach, like ask people if they want to speak to me. Like just talk to them, like that thing of approaching a person, hello, how are you? How are you doing today? I come from . . ., is it okay if I talk to you? Like that was really hard for me. To tell the truth. Ja, I didn't understand why I had to do that.'

Me: 'What did you expect?'

Hope: 'I don't know, maybe more structure, an office to conduct interviews, Ja like not being exposed to blood and gore all the time.'

Hope's expectations of the training fit well with her previously restricted worldview. She expected more structure and distance from her work. Her knowledge of trauma counselling was limited and this fed into her schema. Hope reflects on this fact as restricting her ability to adequately cope with the stressful and novel situations presented at the hospital. She does not feel that her incomplete life experience affected her performance, it may have withheld her from exploring other options but it also stimulated emotional growth and perseverance that she was unaware of. She felt a bit disadvantaged about leading such a sheltered life but she is also glad that her growth was able to occur in a safe and secure environment. Hope found it necessary to connect with self and with others. She had to pay attention to her inner experience, talk about it with others, not work alone, and most importantly, ask for support as well as offering it to others (Saakvitne et al., 2001).

I was impressed by Hope's ability to actively confront her fears and she used the energy to change her fears into her strengths. Hope began to look at traumatic situations from different perspectives and this showed her inner resilience and ability to assimilate herself into any situation without compromising her beliefs.

4.8 The Role of Hope's Supervisor

When Hope began her training at the hospital, she did not have a personal supervisor. As the interview progressed, Hope reiterated how much she missed having someone to talk or debrief with:

'I didn't have a supervisor. So the supervisor, it's really . . . not to have a supervisor because that is the person who can say whatever you want to say. I think, I didn't get that much support of talking

to someone, getting to let out your feelings, how are you feeling when you saw this patient and then you have to explain.'

The supervisor at the hospital provided debriefing sessions, and was available if the interns wanted to talk. Initially Hope felt uncomfortable disclosing her feelings to the trainer, but after she returned from her break, she was able to talk more freely and embraced the in vivo supervision. Once Hope acknowledged that when she began to feel the effects of secondary trauma, she looked forward to the debriefing sessions provided by the hospital. Hope admitted that it was only after the first four months into training, that she really began to connect with other people. The severance that Hope had from the trauma unit, encouraged her take the time to reflect on her life and also on how much she had matured during the training.

Her supervisor was able to help her to actively reflect on the day and also on anything that would trigger an emotional reaction within her. Supervision facilitated this reflective process, which was often slow and frustrating process, because of the barriers built up within Hope over the training period (Dunbar-Krige and Fritz, 2006). Hope admits that this process helped her to grow emotionally and develop necessary coping skills to reinstate herself after the four months of emotional turmoil.

4.9 Coping Skills and Mechanisms

Hope concurs that her coping skills were fairly limited, and she needed assistance in appreciating the complexities of trauma work. According to Hope, the supervisory sessions helped her to cope with stressful situations and it also equipped her with necessary skills required for conducting interview sessions. Self-assessment is an important criterion for the novice counselor to adhere to. Research has suggested that the counselor should indulge in self-reflections and discussions of the effects of the experience with their colleagues, supervisors or family (Saakvitne et al., 2001). This is the key to stimulating conversation

and reducing the psychological distress.

'It's not all about me but the patient, the way I had to approach them and whatever, it didn't matter what I thought was good for me but what was good for them. So I had to just put myself aside.'

This helped her to retain focus and concentration of the situation. Hope was debriefed about the effects of secondary trauma and vicarious trauma by her supervisors. This helped her to recognize the signs and symptoms and take some time off, when she felt overwhelmed. She began to understand her limitations and this mobilized her to become more effective in her personal and professional environment. Hope had to take care of self and engage in self-care management.

Hope also had organizational support from the trauma training team and the other pastoral counsellors at the hospital. She was able to form a good relationship with them. They helped to facilitate the healing process within her, and they also provided a space for her to talk about her difficulties. Her relationship between her boyfriend also improved during the course of the training. She claims it has reached a different level, instead of shutting him out from her discomfort, she shares the effects with him. This helped her immensely to reflect on and not suppress her emotions. She managed to re-establish her connection with her parents and the communication is better than before.

However Hope is wary of the intensity of the effects of trauma. The feelings of numbness, desensitization, disillusionment, lack of energy and withdrawal into her protective world make her vulnerable to developing secondary stress. She is afraid that not having necessary support structures available will hinder her management of secondary stress. Hope has achieved the realization that she needs to protect herself. According to past research counsellors need to be aware of their vulnerability and the negative consequences of their work. They must strive for balance and maintain connection with others (Saakvitne

et al., 2001). I believe that Hope has achieved this level of understanding. She has grown into her role as a trauma counsellor and this is evident in the way she presents herself.

She feels that she needs to be able to reign in her inner resources and this takes a lot of her energy. This could make her susceptible and vulnerable to compassion fatigue. She feels that her emotions are more transparent and there is a fear that it could cause her to over identify with the emotions of her clients. She is aware that she would need to be able to debrief and mobilize whatever resources is available in order to prevent a recurrence of secondary trauma. This level of awareness attests to her level of maturity and ability to grow.

4.10 The ‘AHA’ Moment for Hope

Hope experienced the effects of secondary trauma within the first two months and during the last month of her training. She attributed these effects, especially during the last month, as due to increased workload, being on call and being understaffed in the unit. She became aware of her susceptibility to the psychological effects of trauma.

When the intensity of the training threatened her emotional state, Hope decided to extricate herself from the stress of the hospital. At this point Hope made a life altering decision. She decided to leave the trauma unit. This was the point of realization for Hope. She became aware that something did not feel right in her life. She needed to take a step back and assess her position in relation to her personal and professional life.

Her feelings of ambivalence about her choice of career began to resurface with greater intensity. Hope needed to heal; she needed to get away from all the pain and sorrow attached to the trauma unit. She needed to embrace a different environment. Hope decided to return home, to Polokwane and her parents. She needed an environment conducive to healing and rejuvenation. She had

felt emotionally battered and bruised and she needed a different environment. This process of healing was essential for Hope to make an informed decision about her career and her future. She needed to understand what triggered these effects and she needed to be able to reflect deeply on the salient issues that compelled her to move away from the hospital environment.

This period of ambivalence lasted almost two months. Hope had taken leave for two months in order to recuperate from her experience. The training was very intense and draining and Hope needed time to reflect on her choice of career and personal turmoil. During her two month break, she slept for long periods of time and she spent time alone, thinking and assessing her role until this point. It was a physically and emotionally strenuous time for her but she was able to touch the core of her issues and actively confront it.

'I matured. I matured like, I matured, you know what I'm saying? Emotionally, I did grow. But now I have matured and if I have to see a patient and he tells me about his leg which is gone I can just tell him what he wants, like how is he going to use that leg which is gone? How is he going to live with it? I feel empathy, now, for them but there is nothing I can do.'

I also observed a significant shift in Hope's attitude and approach to stressful situations. She learned to become more aware of herself, and not in a selfish way as she expressed in the beginning of our conversation, but in terms of her emotional needs. It also helped her to reconnect with her spirituality and this process was enabled by the presence of pastoral counsellors, who helped her to rediscover the cure in her transition. They provided a strong support structure for her spiritual growth. Once she became secure in her beliefs, Hope was able to move forward with renewed strength and vigorous energy.

4.11 Discussion

Hope's description of the effects of the counselling experience that culminated in feelings of despondency was revealed in her analogical behaviour. She was very congruent about her feelings and the change in her attitude towards the end of the interview was revealed verbally and analogically when she expressed a desire to continue her stint at the hospital after obtaining her registration.

'Even if I have to volunteer, the experience will be beneficial'

Hope was more animated and her face lit up when she spoke about the last few months at the hospital. She also mentioned that although she had to work longer hours in the last month, she was happier and more relaxed. There was a shift in Hope's approach to counselling as it evolved during the course of training. It seemed as though she was on an emotional roller coaster and the ride never stopped.

The effects of trauma counselling on Hope manifested as:

- Feelings of inadequacy and helplessness. She often felt that her role was unimportant and she was not making a difference. She felt as though she was intruding into people's lives and it made her uncomfortable.
- She was ambivalent about pursuing a career as a trauma counsellor. Hope felt that this may be the wrong choice for her and she began questioning her abilities and her effectiveness as a trauma counsellor.
- Her personal relationships began to deteriorate. Hope began to actively withdraw from her parents and her boyfriend. She avoided talking to her boyfriend and very often she felt resentment for his occupation. She bottled up her emotions and it manifested as irritation, anger, resentment and withdrawal.
- Hope felt alienated and isolated from everyone.

The Ecological Model captures the essence of Hope's transition beautifully (Dutton and Rubinstein, 1995). This model expresses the vulnerability to secondary traumatic stress on a personal and professional level. On a professional level Hope experienced the effect of her naivety and approach to trauma counselling manifested as nightmares, flashbacks, increased vulnerability to stressors, decrease of energy, avoidance, reduced performance at work and inadequacy. Consequently this led to deterioration in personal and professional relationships, questioning of her decision to become a trauma counsellor. This culminated in an enforced leave of two months, a period that forced her to reflect deeply within her soul. She confronted her fears and became more aware about the circularity of her effect on the system and the systems effect on her. On a personal level, Hope's relationship between her parents and boyfriend suffered because she had decided to shut them out of her professional life.

The societal and environmental levels were also assimilated into Hope's self-care regimen. Supervision facilitated her process of awareness and this enabled her to return to the programme. She entered the system again but this time with the view of being a part of the system and not a temporary guest to the system. She became more aware of the environmental structures and she decided to work within these boundaries in order to develop her empathic skills.

This ecological perspective enabled Hope to gain the full benefits of the training and become proactive within the system. The system embraced this change and flexibly adapted to the needs of the counsellor. Although there are still a few glitches in training, there has been a significant shift in the attitude of the trainers and they have incorporated feedback from previous interns, in order to improve the training programme. The aim of the training team is to facilitate a reflective process that enables counsellors to express their feelings about trauma cases in an atmosphere that is validating, normalizing, and safe (Geller et al., 2004).

Hope highlighted the importance of supervision, personal and professional support for her. Hope first became aware of secondary trauma, vicarious trauma and compassion fatigue, after she had experienced the effects of it. It was addressed during the debriefing sessions provided by the training team at the hospital. According to Hope, the astuteness of the team in recognizing the signs and symptoms of possible secondary stress amazed her, because when she requested leave, it was supported by the team. They even offered further support by checking on her and offering an open-door policy if she needed to talk.

4.12 My Reflections of the Process

Hope's experiences as a novice trauma counsellor highlighted a number of areas that can make one vulnerable to developing compassion fatigue or vicarious trauma. My perspective of Hope has evolved during the course of the interview. I was able to map Hope's growth and maturity during the conversation. I often felt as though Hope was narrating my experiences as a trauma counsellor. She managed to capture the essence of my experiences and package them into neat reflections of the training process.

I was impressed by her astuteness and ability to self-reflect as this was an area that I found difficult to encapsulate within myself. It also took me longer to understand to the psychological effects of trauma. This occurred because I was operating on automatic pilot most of the time and I refused to acknowledge or succumb to the turmoil of emotions raging through me.

The effects of psychological trauma, is a topic that is very close to me. Being in the same environment, whilst conducting my interviews, evoked a myriad of emotions within me. The interview between Hope and me was very intensive for both of us. In Hope's case she found the interview very beneficial as she was able to share experiences that were similar to both of us. She felt relieved at the end of the interview and also mentioned that it made her feel good

to disclose things, that she was not comfortable revealing to her supervisors. However at the end of the interview, I felt heavy. I felt emotionally, mentally and physically depleted. The session was so intense and draining for me, that I do not remember how I drove home. I had to retreat to my place of healing in order to reflect on this process and become aware that I still needed to practice yoga, which was part of my self-care regimen. It helped me reach spiritual harmony and realign myself with the cosmic energies.

Chapter 5

Alice: A Journey Of Self

Discovery

In solving a problem of this sort, the grand thing is to be able to reason backward. This is a very useful accomplishment, and a very easy one, but people do not practise it much . . . Most people, if you describe a train of events to them, will tell you what the result would be. They can put those events together in their minds, and argue from them that something will come to pass. There are a few people, however, who, if you told them a result, would be able to evolve from their own inner consciousness what the steps were which led up to that result. This power is what I mean when I talk of reasoning backward . . .

Sherlock Holmes

5.1 Introduction

Alice is a twenty four year old unmarried female from Pretoria. She completed her Bachelor of Arts with Honours in Psychology at the University of Pretoria. On completion of her post graduate degree, she realized that there was very little that she could do with the degree. This theme reverberated amongst many postgraduate psychology students. Subsequently she did some part-time jobs that involved proof reading and editing in order to augment her income. At this stage Alice was quite despondent, as all her friends had a career and

were earning a good salary, whereas she was still studying and pursuing her dream in psychology.

Alice heard about the registered counsellor training course from the university and embarked on the twelve month trauma counselling internship training programme at the end of 2008. Alice's responsibilities included being on call for a week, every month, as well as visiting patients in orthopedics, vascular and general wards. Her duties also included working in the trauma unit, casualty wards and she had to be available for any crisis that presented itself.

Alice had never been exposed to any form of trauma counseling in her life. She recalled feeling intimidated and overwhelmed. She maintained that the exposure was daunting since she was generally a very shy person. She did not have any experience with counselling and this scared her. As a novice counsellor, with no prior history of counselling, Alice was thrown into the deep end of the trauma unit, with no formal training, except in the form of trial and error.

Alice revealed that she had no prior counselling experience and everything she learnt was from books and talking to other counsellors. However this did not frighten Alice, as she had found her niche. This was a novel experience for Alice and initially she felt really energized and enthusiastic. Conversely as time progressed, Alice began to feel the pressure and intensity of trauma work. Alice explained how she arrived at a point in her training, when things became very ambivalent for her.

She was beginning to feel the effects of secondary traumatic stress, especially the compassion fatigue syndrome. This syndrome arises not from direct being a direct victim of trauma, but having associated with people who have been victims of trauma (Figley, 2002). This is secondary trauma and it can emerge rapidly. Alice acknowledged that when she began to feel the effects of secondary trauma, she was confused and it was also a scary experience for her.

Alice began to feel these effects of compassion fatigue and it can be explained in terms of Figley's Model of Compassion Fatigue (Figley, 2001). In terms of

this model and from an ethnographic perspective, compassion fatigue does not occur in a clearly defined or structured manner. The process of compassion fatigue is not an isolated group of events but a blend of all the categories and effects as well as the impact on these categories. It is a recursive process and information is continuously being fed into the individual's system (Figley, 2001).

Alice experienced trauma upon trauma on a daily basis and this began to drain her reserve of empathy, she began to distance herself from people and isolate herself from her friends, colleagues and family. This process made her vulnerable to her memories and she began to relive past experiences. The stress of her everyday living began to impact on her professional and personal life. This culminated into compassion fatigue, as she began to function in an automated fashion. She began distancing herself from her clients and traumatic memories of her experiences. The energy expended in suppressing all these emotions, resulted in emotional and physical fatigue. Physical and emotional avoidance was articulated by the demands of her environment. Research also supports the culmination of these effects as the vulnerability of workers with a history of personal trauma to be at a risk of developing secondary traumatic stress (Cornille and Meyers, 1999; Williams and Sommer, 1995).

She had already engaged a personal clinical psychologist as her supervisor on admission into the programme. However Alice experienced difficulties discussing the turmoil of her emotions. She believed that the role of a supervisor was to help her gain a broader theoretical knowledge of the course, equip her with the necessary tools of the trade and listen to her case presentations in order to provide concrete direction and therapeutic techniques to resolve the client's dilemma. Contrary to these expectations, Alice experienced difficulty establishing a baseline relationship with her supervisor. As she found that her supervisor's style of interaction was personally intrusive.

This chapter will highlight the effects of trauma counselling on Alice as well as my impressions, perceptions and reflections of the interview process and

Alice. It will highlight the relationship between Alice and myself, as well as the information derived from direct observation of Alice's behavior and my subjective experiences of her. This method of triangulation is used to consolidate all the information obtained during the research process. The aim is to enhance validity and reliability of this study (Babbie and Mouton, 2001). This forced me to reflect on my process during the session. The effect of the narrative on me will be shared at the end of this chapter. Alice will also share her experience of the interview process.

5.2 My Experience of Alice

Alice appeared to be a shy and quiet person. She was very cautious about what she disclosed and this was evident throughout the interview. I sensed that she liked to be in control of the situation. On further enquiry Alice disclosed that she was used to structure and being in control of her feelings and emotions. Alice's reserved style of interaction often hindered her ability to be proactive and initiate conversations with the patients and their families. This proved to be a very slow and painful process for her, as it really pushed her personal boundaries.

Although it may appear as though Alice has limited life experiences, my experience of her hints at some personal incident in her past that has forced Alice to become closed off and guarded. Initially I found it very difficult to connect with Alice and this forced me to self-reflect on my style of interaction. At times I felt as though Alice wanted to reveal more of herself during the interview, but something was hindering this process. Her tone was very controlled and she shared little emotion.

It almost felt that Alice was being consumed by some inner-conflict that restricted her from connecting with me. She was afraid to reveal too much of herself, hence the cautious approach to the interview and counselling process. As it has been documented, the effects of a traumatic event gain momentum

and the residual compassion stress together with prolonged exposure to suffering, traumatic memories and other life demands culminate into compassion fatigue (Figley, 2001). I felt that these suppressed emotions, analogically communicated by Alice, were enslaving and preventing her from performing at her best.

5.3 Alice's Experiences as a Novice Trauma Counsellor

Alice attended the trauma counselling and pastoral courses provided by the hospital. It was her first introduction into the rules and regulations of the hospital as well as hospital procedure and etiquette. The training was very basic and focused more on how novice counsellor should present themselves. Alice engaged a private supervisor when she initially started the programme, but she was more grateful for the in vivo supervision provided by the training group in the hospital.

Alice initially felt that some of the duties she had to perform in the training were unnecessary. She felt strongly about doing ward rounds. She felt that she was being intrusive when she went into a ward. In her opinion, she felt that she was an imposition on the patient as the patient did not really have a choice. She felt as though she was taking advantage of the patient's predicament in order to strengthen her counselling skills. This made her feel very guilty and also helpless. This seemed to change after a few weeks. A new realization dawned on her:

'I realized, maybe it made their day, maybe no-one comes to visit them, those things often make sense but . . . talking to people, wow, I can do that at home but you realize the impact you have on someone and that made me feel good, that made me more motivated.'

This energized and renewed her passion for trauma work. She reframed the

process in terms of trauma existing beyond the trauma unit. Once she made this transition, her purpose became more defined. She was able to enjoy the benefits of the training. She encountered a number of hitches during the programme but this tapped into her psychic framework and presented opportunities for self-reflection.

She felt that the introductory course did not adequately prepare her for the intense personal physical and emotional turmoil that she would encounter on a regular basis. I perceived this as Alice's avoidance of her own feelings as she was trying to function on a superficial level, but the intensity of the training did not allow this:

'Too much people dying and blood and gore and you get sensitive for those if you are busy and tired. You get very sensitive and then if someone says a wrong word to you, you take it personally.'

When Alice began the training she was excited and enthusiastic about the course. She had many expectations about the programme and when it failed to materialize at her pace, she became despondent. This culminated in compassion fatigue:

'About two months, two to three months into the training, I was just like, I kept feeling like alone and isolated. I mean you listen to a few people, but who helps you? Who listens to you? I needed someone to listen to me, I know it sounds selfish, but it's how I felt.'

Although she did have a supervisor, she did not feel comfortable discussing her personal journey and this created a lot of tension in her relationships with her family and boyfriend.

'I was very moody, very, very irritated. I don't want people around me, you know, I used to go out once or twice a week with my

friends, I didn't want to do that. You know, here comes another person with a problem. Let's just talk about everything and nothing at the same time.'

It almost seems as though Alice had created a protective wall around her in an attempt to shield others and herself from the ongoing mayhem in her professional environment. She struggled to keep her professional life separate from her personal life and the effect of this resulted in isolation:

'I don't know why but for some reason I got a point where I didn't want to speak to anyone, where I didn't want to see anyone at all. So I, not hid, made myself scarce and just talked to like one or two people a day. I didn't want to talk to them.'

She began to distance and isolate herself from family, friends and colleagues and this self-imposed alienation led to feelings of despair, hopelessness, helplessness and failure.

'Problems, problems, problems. I feel helpless, what can I do and I don't feel that there is anyone that I can talk to about it, it's because they don't understand. It seems like this was the first time that I was failing at something and it frightened me.'

Pearlman and Saakvitne (1995a) asserted that the cumulative effect of story after story, client after client, day after day can become a chronic condition. According to Figley (2002), even the best counsellors are the most likely victims. Alice appeared to be experiencing these symptoms:

'It got too much and I just needed that break so I made my own break.'

Alice used this break to try out different career choices. However there was something about trauma work that pulled her back into the programme. Alice did not want to elaborate on her reflections but she mentioned that:

'I actually got excited again when I got to casualty last year and it was fun and then I started with the emergency unit and it was fast and exciting.'

However this feeling of euphoria only lasted a few months. It seemed as though Alice did not acknowledge the initial impact of trauma work adequately and her time in the hospital was suppressed. When she returned to the stressful environment, she underestimated her ability to cope with the harsh realities of trauma:

'And then at the end of last year I got totally numb. I realized that, no, I can't do anymore I got cynical. I just needed a break.'

It seems as though there was a manifestation of vicarious trauma in Alice. Her feelings of cynicism, increased irritability, reduced personal accomplishment and disruptions in interpersonal relationships were in line with other trauma therapists who had gone through similar experiences as their clients and may begin to dissociate during sessions, thereby causing serious disruption in the therapeutic process. It was also fairly common for therapists to experience strange, painful, or unfamiliar physical sensations, such as numbing or sharp pains in certain body parts (Pearlman and Saakvitne, 1995a).

The trauma unit seemed to bring Alice closer to her suppressed emotions. At times it overflowed into her personal life and manifested as intense irritation and frustration. This is also in accordance with Figley's (2002) research where he states that hearing about past trauma can trigger haunting memories from a therapist's own past. This appeared to be happening to Alice. There was also a time when Alice subjectively experienced rejection from a patient as racism:

'Sometimes it was the culture differences, I tried to overcome that I tried to speak their language, just be there for them. They blatantly ignore me and they just don't want me there ... and then I feel,

wow I have driven here, not myself but someone drove me here, I was sleeping and then I hear from you and you guys don't want me here. I felt so demotivated.'

Alice refused to discuss any emotions and feelings, with her supervisor, family or boyfriend. Furthermore Alice confessed that she would have preferred everything to be objective and structured, so that she could deal with it out there and not really have to get into the emotional charge attached to the patient's narratives. She found the training to be very intensive and personal. She would have preferred more distance and objectivity during the training phase.

The themes identified throughout the conversation, highlight my perception of the effects of trauma on Alice. It also tracks Alice's emotional transition during this journey. The themes tend to have a single common thread that reverberates within each other. Although Alice is not yet a victim of burnout, she is very susceptible to it. If Alice fails to acknowledge her repressed emotions they will continue to resurface and make her vulnerable to burnout.

5.4 Feeling's of Ineffectiveness

At the beginning of the training, Alice went about her duties with much excitement and enthusiasm. She enjoyed being in the midst of the trauma unit and she tried to maintain a professional distance between her client's and herself. This continued for the first two to three months.

'I don't know why but for some reason I got to a point where I didn't want to speak to anyone, where I didn't want to see anyone at all. So I, not hid, made myself scarce and just talked to like one or two people a day. I didn't want to talk to them. I was just like, I kept feeling like You listen to a few people, but who helps you? I feel so helpless.'

She felt alienated and alone during this time. Towards the end of the third month, her energy levels had dropped substantially and she avoided visiting her client's in the various wards. The quality of her work declined substantially and she decided to leave. She was despondent and felt extremely incompetent and ineffective. She did not feel as though her presence made a difference.

'Ja, I just felt helpless, completely. I am person that likes to be in control. I was afraid to fail but I didn't want to do it. I'll just leave it then, but I didn't quit.'

This period of ambivalence lasted almost two months. Alice had taken leave for one month in order to recuperate from her experience. The training was very intense and draining and Alice needed time to reflect on her choice of career and personal turmoil. The one month break stirred something within Alice but she was not comfortable disclosing the content. However it seems like she also denied these emotions and spent a lot of time and energy trying to forget the impact of the training on her.

'I could see the quality of my work falling; I could see my energy level just trying to suppress these personal issues. It was too much, you become so overwhelmed that it is actually quite laughable now that when I look back at it that, why was I suppressing that, it wasn't such a big deal really. It's over and done with.'

5.5 Effects on Personal Relationships

Alice is in a long-term relationship. She explains how her experience with traumatized people affected her relationship with her boyfriend and her family.

'Then I just stay quiet, and they start nagging me and then I get irritated. I just wanted to be alone, ... I just think there wasn't a

net in place for us because you can't go every single day ... you have to just take it a bit and then do something else. My family could not understand it when I wanted to just be quiet and that really frustrated me.'

However her relationship with her boyfriend was more solid, she was able to talk to him and tell him about the effects of the day without fear of being judged. However the following statement is ambiguous but this could also be Alice's style of interacting with people close to her:

'I really think they should prepare us in the university for some this. Because I feel so helpless.'

There seems to be a fear of rejection looming over Alice's head. She appears to be afraid of criticisms from her parents and though she reiterates that her family gives her the space to grow and experience life, there is some ambivalence about her statements:

Alice: 'I'm a weird with my family; I don't open up very much in front of them. I want to not distance myself but be less emotional ... I don't like to talk about emotion. It's difficult to explain. I don't think I have that relationship with anyone yet ...'

Me: 'Has this always been the case or has it just been recent?'

Alice: 'No, it's always like that but I don't think it's wrong. You know. No, I don't talk to them at all. I talk to my boyfriend, my fiancé'

Alice's relationship with her friends began to deteriorate considerably because she felt that they did not take her seriously and in a way they were rejecting her. This caused her to break away from them. She felt that they were not supportive of her career choice and were undermining her chosen profession. This increased her distance between them and she found it difficult to connect with them.

‘That’s my greatest fear ...rejection and ...control. Those are my two big things, which you can relate almost everything to those two.’

I noted at this stage that this revelation was a real breakthrough for Alice. She had finally let her guard down and was more approachable and amenable to the interview process. Although Alice had willingly consented to the interview, she expected it to be more structured and sterile. Her responses indicated that she was often uncomfortable sharing subjective experiences and feelings.

Alice experienced feelings of helplessness, inadequacy, ineffectiveness, vulnerability, moodiness, irritability, frustration, fear, cynicism, emotional numbing and failure to connect with patients and other interns. She hints at the possibility of recurring thoughts of a traumatic incident but does not elaborate on the process. Trauma appeared to be an intimate, personal experience whose intensity was appraised individually and subjectively (Pearlman and MacIan, 1995). Furthermore vicarious traumatization could alter the counsellors basic psychological needs, such as those of safety, trust in self and others, esteem for self and others, intimacy and control. Alice also experienced becoming cynical, nihilistic, withdrawn, emotionally numb, hopeless and outraged as postulated by Trippany et al. (2004).

Alice experienced these effects during the first three months and midway through her training. She attributed these effects, during the last month to the increased rate of mortality cases that she had to handle. She felt unappreciated and ineffective in offering support to the bereaved families.

5.6 Alice’s Worldview

This theme reveals Alice’s release from emotional bondage. Her self-perception was challenged and she was confronted with racial, cultural and religious issues. Her counselling abilities were tested and she was forced to actively confront

issues that she had suppressed for a long time. She was exposed to her own mortality and the vulnerability of life. She experienced intense emotional vulnerability and awareness of her daily existence. Alice wanted to run away from her emotions and her life experience that kept rearing itself during her counselling sessions. Alice encountered difficulty probing into her client's past, it seemed as though she did not want to pry too deeply on an emotional level.

'I think if I knew I had tried my best and I couldn't persuade the person then ... it's not my problem, I tried my best. Then I will just leave it I think. I'm very good at leaving things and personal things, I try to separate it. Although it is difficult. You try to help but you can't help everyone, you have to let go at some stage. But the people that you do help, I would focus more on that ... I think.'

There seems to be an indication of avoidance. It is evident that Alice is afraid that her client's story might evoke something from her past. Her worldview is shaped by shielding herself from further harm. This is also a common tool used to suppress deep-seated emotions. She is not yet prepared to deal with these feelings but she is also afraid of being exposed as vulnerable. Her cognitive schema seems to be strengthened by negative energy from the training and she is experiencing feelings that the world is no longer a safe place for self or others', helplessness in regard to taking care of self or others, limit to personal freedom and feelings of alienation, as stated by Morrison (2007).

According to Figure 2.1, Ecological Model of Trauma (Dutton and Rubinstein, 1995), there are shifts in assumptions and beliefs about the world (Janoff-Bulman, 1992). Since exposure to trauma deflates an individual's life goals and aspirations. This culminates either directly or indirectly into psychological stress and symptom formation. The essence of this model when applied to Alice represents distortion in personal and professional relationships and changes in her worldview. Past histories or similar occurrences in their personal lives may cause difficulties in their relationships and they may isolate themselves in the workplace (Dutton and Rubinstein, 1995).

Alice has become less sensitive since the beginning of the training. She is now able to reflect on the effects a particular incident is invoking in her. Although she has not yet reached the point where she can fully divulge these effects to anyone, she is considering the possibility of seeking therapy.

Me: 'Did you feel that you are not in a good position to deal with other issues?'

Do you think these other personal issues that you have may be impacting on your performance?'

Alice: 'Definitely but it is something that . . . that is the reason why I don't go to lectures for educational psychology. Because of my personal choice. But it's fine I want to deal with it but not now. But I know I'm making the issue worse. You know, it's difficult because you really have to do through soul searching process, but, no, just focus now and be . . . that first step very difficult. But I have to do it. It is obviously very important but I will do it. My supervisor, I don't think she is the most appropriate choice. I'll get another psychologist.'

There has been a significant shift in Alice's behaviour and attitude towards trauma counselling. Her worldview was forced to integrate the effects of trauma into her cognitive schema. Although the experience pushed her deeper into the fissure of her past and enforced her negative beliefs, it also subjected her to active engagement with her unconscious. She was forced to reflect and she used a lot of energy suppressing these reflective actions. It has dawned on her that she needs to engage more with herself and this has been a tremendous leap for her. The reason I chose to conduct an ethnographic study was because of my own subjective experiences in the trauma context. I also observed the amount of unusual occurrences in the natural settings of the trauma unit. The trauma unit could not be inflexible it had to be able to accommodate requests from doctors, nurses and grieving family members. Trauma counsellors had to be flexible as well. They had to be available for all types of requests and

this was bound to place a huge amount of physical and emotional stress on the counsellor, especially since they were still in the process of training.

This journey encouraged her to embark on a journey of active self-reflection. Although she tried very hard to hold onto her old schemas, she was compelled to let go of certain beliefs. She is still trying very hard to negate the impact of her internship training on her personal history. A lot of effort needs to be made in order to consolidate these two areas of her life. She appears to be ready to embark on this leg of her journey.

5.7 The Role of the Supervisor

When Alice began her training at the hospital, she had already engaged a personal clinical psychologist as her supervisor. Alice had clearly delineated the role of her supervisor and someone she needed to debrief with. In her mind they were not the same person. As the interview progressed, Alice reiterated how much she missed having someone to talk or debrief with, she was ambiguous at this stage because she wanted to talk to someone but she was also very cautious about whom this person should be:

'It's difficult because I am not a person that, because she want to go into it in more personal issues. So it got to the point where the more we talk about work, work, work, but you see . . . I don't think our relationship is going to get any deeper, if I can put it like that because I have issues. But I don't want to deal with it, so leave me alone and stop pushing me. You just go through it and then you hold on it will get better, it can't get worse.'

Alice had a complex relationship with her supervisor. It seems as though she had a difficult time connecting with her supervisor. It seems as though Alice was blocking the therapist's efforts by being evasive and concrete in her approach to supervision. It seems as if Alice was sabotaging her own

process. According to Dunbar-Krige and Fritz (2006), supervision facilitates the reflective process, which is slow and frustrating process, because of the barriers built up within the individual over a period of time. Consequently Alice was adamant about changing her style of interaction and this hindered the supervision process.

The supervisor at the hospital provided debriefing sessions, and was available if the interns wanted to talk. Alice felt uncomfortable disclosing her feelings to the trainer, but she used the in vivo supervision to sharpen her counselling skills. She admits that she did not take full advantage of the in vivo supervision provided by the hospital trauma unit. Alice had difficulty disclosing her feelings with her supervisor, but she was less closed than before. She has become more aware of the emotional triggers. Alice admits that this process helped her to facilitate cognitive growth and emotional.

5.8 Coping Skills and Mechanisms

Alice agreed that she needed assistance in appreciating the complexities of trauma work and would have benefitted from more structured counselling courses. According to Alice, the supervisory sessions really triggered painful emotions, emotions that she was not ready to confront but it also equipped her with essential skills required for conducting interview sessions.

‘Ja, it’s difficult but it’s weird how when you work with people how the things they make you feel. You have to be strong I think, but also not too strong. You have to, not depend on other people, but you have to, how can I put it, not share what you’ve learned here but you have to go home with it, you have to say how was your day to another person. I try to do that at least, without breaking confidentiality but just talking to someone just to get it off you.’

This helped her to retain focus and concentration of the situation. Alice attended debriefing sessions, and also conducted some as part of the training, about the effects of secondary trauma and vicarious trauma by her supervisors. This helped her to recognize the signs and symptoms and take some time off, when she felt overwhelmed. She has become more aware of herself, her limitations and this has mobilized her to become more effective in her personal and professional environments.

Alice always had organizational support from the trauma training team and the other pastoral counsellors at the hospital. However in the past she was unable to form a relationship with them but this changed, towards the end, when she realized the benefits of peer support, especially in this field. They helped to facilitate the healing process within her, and they also provided a space for her to talk about her difficulties. Her relationship with her boyfriend became stronger during the course of the training. This helped her immensely to reflect on her emotions. She had decided to let go of friends that were dominating her and to re-establish her connection with people who could understand her and the intensity of trauma counselling.

However Alice is wary of the intensity of the effects of trauma. The feelings of numbness, desensitization, disillusionment, lack of energy, cynicism and her life experiences make her vulnerable to developing vicarious trauma. She is aware that not having necessary support structures available will hinder her management of secondary stress. She feels that she needs to be able to deal with her unresolved emotions in order to reign in her inner resources and this takes a lot of her energy. This could make her susceptible and vulnerable to vicarious trauma. She feels that she has more difficulty suppressing her emotions and she is afraid of losing control of her emotions and rejection.

5.9 The Role of Life Experience in Training

Alice's life experience is very intense. Her personal boundaries are firmly secured and she has created a protective wall around her that prevents anyone from accessing her emotions. She underestimated the intensity of the training.

Me: 'In terms of what were your expectations?'

Alice: 'I could see the quality of my work falling; I could see my energy level just trying to suppress these personal issues. It was too much, you become so overwhelmed that it is actually quite laughable now that when I look back at it that, why was I suppressing that, it wasn't such a big deal really. It's over and done with. I did not expect myself to be exposed on a daily basis. I know all this stuff. I know everything that's wrong with me, not wrong with me but I'm not sure . . . inside obviously why I do the things I do I know I have to get to the root problem but, I know it but it's difficult.'

Me: 'What did you expect?'

Alice: 'Ja, I think there is a huge need for boundaries but it's not that. I think the structure is important, reflection didn't work. So well, because that's what's missing, structure. I would have preferred more structure, impersonality and objectivity.'

Alice's expectations of the training challenged her world view. She expected more structure and objectivity. Her knowledge of trauma counselling was limited and this misled her into the training process. Alice reflects on the fact that her suppressed emotions kept interfering with her counselling sessions. She is aware that she needs a safe, confidential and secure environment to be able to divulge more of her emotions. She has already taken the first difficult step by acknowledging the need for seeking psychotherapy.

'I know all this stuff. I know everything that's wrong with me, not wrong with me but I'm not self reflective, inside. It's obviously why

I do the things I do. I know I have to get to the root problem but, I know it's difficult.'

5.10 The 'Aha' Moment

Alice's experiences as a novice trauma counsellor highlighted a number of areas that can make one vulnerable to developing compassion fatigue or vicarious trauma. I encountered cautious responses from Alice. It was initially difficult for me to connect with Alice and this made me also reflect on this process.

There was an interactive process unfolding and I had to directly confront Alice about the effect she was having on me, and I had to check in with Alice if she experienced anything. This was a turning point in the interview as Alice now began to disclose more of her feelings and emotional turmoil. Her description of the effects of the counselling experience became an exploratory journey of her effect on others and their response to her. It was during this interview that Alice experienced moments of realization and awareness of her own problem. This helped facilitate the interview process.

She became more aware of her blind spots, and for her the defining moment occurred when she realized that she would benefit from further therapy. Initially Alice was very focused on going into the training, with the aim of performing her duties objectively and then leaving the trauma behind at the unit. When she realized that this was not her reality, she began to question the effectiveness of the training programme. She found the lack of structure and control daunting and this amplified her fear of rejection and failure. She experienced in terms of people not accepting her support and ignoring her. This was devastating to her.

The effect of her naivety and approach to trauma counselling manifested as irritation, frustration, lack of self confidence, increased vulnerability, decrease of energy, avoidance, reduced performance at work and inadequacy, consequently this led to deterioration in personal and professional relationships.

The suppression of her emotions, forced her to take a month's break in order to consolidate her emotions. She realized that her biggest fears were failure and inability to control her emotions. This caused Alice to put up higher barriers to protect her from her own emotions. It took a lot of energy and she finally realized it.

Supervision facilitated this process of awareness and Alice strongly resented the probing of the effects of the training on her. She did not understand the reason for the supervisor discussing her feelings and emotions. In this relationship, as well, she expected supervision based on objectively presented cases and she expected sterile feedback and ways to improve her counselling techniques she did not bargain for in depth analysis into her soul.

When Alice entered the system again after her break, her focus was clearer and she was aware that her emotions were going to hinder her training. She addressed her emotions but did not adequately reflect on and acknowledge their presence instead she spent a lot of energy suppressing or bottling up her emotions. Alice is still undergoing a painful process of allowing herself to be exposed to traumatic incidences, especially since she has unresolved incidences in her life. She has come a long way by taking the first step to acknowledge that these emotions would be potential hindrances in her growth process.

Alice highlighted the importance of personal and professional support for her. Alice first became aware of secondary trauma, vicarious trauma and compassion fatigue, after she had experienced the effects of it. It was addressed during the debriefing sessions provided by the training team at the hospital. Her life experiences feature significantly in her training and the effects of certain incidences in her life need to be addressed in order for Alice to become more flexible.

5.11 Discussion

At the beginning of the programme, Alice was excited and full of energy, then there was a significant decline in her energy levels during the training but this changed again towards the end of the programme. This is consistent with the culture of the trauma counsellor subsystem at the hospital. I also worked in the trauma unit at the same hospital as Alice and I have also been aware of the trauma counsellor's culture in this hospital setting. The culture of the trauma counsellor focuses on crisis intervention, trauma debriefing and providing support for the patient and their families.

Alice did not anticipate the intensity of the training programme. Her vulnerability was exposed by the exposure to trauma upon trauma in the hospital. At times she felt stifled and overwhelmed by the magnitude of the trauma she witnessed on a daily basis. These incidences regurgitated latent emotions within her, and she expended a lot of energy trying to suppress and ignore these feelings. However it eventually left her physically and emotionally drained and she needed to take a break from the hospital in order reflect on the effects she was experiencing.

Alice's experiences of the trauma unit was also echoed by Stamm (1997) who described the adverse impact of working with clients who had a history of trauma under a variety of terms, namely, vicarious traumatization , secondary traumatic stress, burnout and compassion fatigue. He further postulated that since counselling invites trauma workers to participate with their clients in their process of growth and healing, it may also threaten their well-being through exposure to their client's trauma and its painful consequences. There is always the threat of the counsellor's history being unfolded or exposed in a client's narrative.

The Compassion Fatigue Model (Figley, 1995a), depicts Alice's process through the trauma counselling internship. It skillfully encapsulates her vulnerability towards succumbing to compassion fatigue. This model highlights areas of

susceptibility for developing compassion fatigue. Alice experienced intense feelings of sympathy towards her clients and she began to identify with the pain experienced by her clients. The energy required to suppress her emotions, left her emotionally and mentally drained. This led towards serious disruptions in her personal and professional life.

The effects of trauma counselling on Alice manifested as:

- Feelings of inadequacy and helplessness. She felt as though she was intruding into people's lives and it made her uncomfortable. She felt that it did not matter how much she did, it was not enough and this began to discourage her. She felt that her support was inadequate and lacking in empathy.
- Her personal relationships began to deteriorate. Alice began to actively withdraw from her parents. She avoided talking to her family. She bottled up her emotions and it manifested as irritation, anger, frustration and withdrawal.
- She felt disconnected from her friends and decided to abandon friendships that she felt was damaging her confidence and self-esteem.
- Alice felt alienated and isolated from everyone.
- Her life experiences and suppressed emotions were bubbling to the surface and interfering with her training and counselling sessions.

'It's a rollercoaster ride of emotions and feelings.'

The trauma internship was an overwhelming experience for Alice. There was a huge shift in Alice's behaviour from the beginning of the internship. The last few months of the internship showed Alice's growth and maturation. As we neared the end of the interview, I saw instances of self-reflection and flexibility in Alice's attitude. She was no longer closed to the experience and I felt myself connecting with her on a different level. I concur that there is the possibility

that Alice was mirroring my feelings and apprehension about being back in the trauma unit. This particular interview drained me emotionally and physically.

Chapter 6

Brett: A Passion for Healing

Errors using inadequate data are much less than those using no data at all.

Charles Babbage

6.1 Introduction

Brett is a thirty two year old single male. He is currently completing his undergraduate degree in Psychology at the University of South Africa. Brett had been approached by the pastor of his church to complete a theoretical course in trauma counselling. As the field of trauma counselling was relatively new for him he realized that he needed practical experience. However, during his studies, he was also teaching full-time and had not had the opportunity to complete the practical requirements for the pastoral counselling course. When Brett decided to complete his training, he approached a hospital in Pretoria and requested practical training, his placement was approved and he became a volunteer counsellor at the hospital for a year.

After his first introduction into the trauma unit, Brett felt alive. It felt like a 'homecoming'. He initially felt scared because of the cases in the trauma unit. Brett had never experienced anyone die in front of him and this was his first experience on the first day of his training. He learned a lot about offering

support and comfort to the bereaved families from his mentor at the hospital. Brett was in awe of his mentor's approach to caring and dealing with victims of trauma. This enabled him to gain valuable experience from just observing and learning. His listening skills improved immensely and he learnt to be patient and enduring with people.

Brett was never introduced to any form of trauma counseling in his life. The first time Brett encountered death, was on his first tour of the trauma unit and he recalls feeling scared. As he had never seen someone pass away in front of him. As a novice counselor in 2004, with no prior history of counseling, Brett was thrown into the deep end of trauma, with no exposure to practical training.

When Brett was invited to join the trauma unit at the hospital, he was exposed to a new transition. The old hospital building, where he was initially based, was moving to the newly built hospital next to the old building. He became actively involved in helping to move equipment from the old wards to the new wards. He was now an active member of the trauma training unit, and it was becoming increasingly busy because of the change. The merging of different departments created chaos, conflict and emotional stress for the health care providers. The trauma counseling unit became a pivotal place for restoring some semblance of integration and 'normalcy' to the hospital culture.

As the popularity of an in-hospital trauma counseling unit increased, it became necessary to train volunteers and pastoral workers in crisis intervention and trauma counseling techniques. Since 2004 he provided training to prospective pastoral and trauma counselors. The trauma unit facilitated a process of interaction between the universities, the Health Professional council of South Africa and students wishing to pursue a career as a registered or pastoral counselor.

Brett's responsibilities included being available to the intern students, providing debriefing sessions to the students and staff at the hospital, workshops, supervision, as well as being on call, providing individual counseling sessions

and visiting patients in other wards. He also had to work in the trauma unit, casualty wards and be available for any crisis that presented itself.

Brett's introduction into the field of counseling was marked by enthusiasm:

'I can say that I was bitten by the bug of doing trauma work and just being in the casualty unit, I really attached to it as a volunteer. I really felt alive, that's the only way I can describe it. Sort of a homecoming, that kind of thing.'

When Brett started work at the hospital, the hospital was undergoing a major transition. He was immediately thrown into the chaos of counseling not only the patients but also the staff. The merging of departments and units within the hospital caused an escalation in stress amongst the new and old staff members. Trauma counseling had to be conducted next to the patient's bed in the same room as operations being performed. There was no privacy for the patients. Furthermore Brett was one of two fulltime counselors at the trauma unit in the new hospital and he was still a novice counselor as he did not have the necessary practical training:

'Only two people trying to provide a 24 hour counselling service. And immediately the whole hospital got into this so we not only provided the counselling service for the casualty unit but for all trauma cases throughout the whole hospital.'

Brett acknowledged that when he began to feel the effects of secondary trauma.

'What literally happened was within the period of 3 months we burned ourselves totally out. So we were literally working shifts. I would work the morning or a day shift and he a nightshift and then we will switch. Then we tried okay I would work morning and he afternoon and then between us one of us. I was out sick with bronchitis so I was out for a month to 2 months almost. And then from then what I did was now, okay, this is crazy I need to break.'

According to Brett the break that he took, was very beneficial. It renewed his spirit and his enthusiasm for working in such a highly stressful environment. However he had to also rethink his work strategy and put new measures in place.

6.2 My Experience of Brett

Brett is a huge and intimidating individual. Initially I was in awe of him as his presence filled the entire room. However after engaging him in a conversation, I was impressed by the warmth, humility and peacefulness that emanated from him. He was passionate about his job and he was open about his experiences and the emotional turmoil he still experiences when he encounters secondary traumatic exposure.

Brett entered the field of trauma counselling without many expectations. He was aware of the lack of structure and counselling rooms. However he did not anticipate the influx of cases at such an early stage in his training. Brett is a very flexible individual and despite being a staunch Christian, he embraced other religions and respected the teachings of other schools of thought. This showed me that Brett was mature beyond his years and his willingness to learn made him more accessible to staff and students alike.

I found that Brett was committed to his career as a trauma counsellor, but I also detected a hint of frustration regarding the limitations of the training programme. He also expressed annoyance at the restrictions imposed by the professional body with regard the scope of practice of the registered counsellor. He had the qualities of a trauma counsellor that made him susceptible to vicarious trauma and compassion fatigue. Being at the helm of trauma unit he was diplomatic, compassionate, empathic, non-judgemental and respectful. His passion for caring for all, emanated from him and because he was so congruent, I experienced him as genuine.

6.3 Brett's Entrance Into Trauma Counselling and his Impressions of the Internship Programme

When Brett started the practical training at the hospital, there were very limited support systems in place and he did not have a supervisor. His knowledge of trauma was learnt at the hospital. There was no exposure to trauma workshops or counselling courses except the hospital based Pastoral course.

The course did not adequately prepare him for the intense physical and emotional turmoil that he would encounter on a regular basis. I perceived this as Brett's limited exposure to life experience. He tried to maintain a professional level by suppressing his emotions but this manifested as physical illness and mental exhaustion:

'I really totally isolated myself at that point. There would literally be sometimes where I have sat in a conversation where I felt, I don't know what they are talking about because you really isolate yourself, and not by choice, it's just work.'

Brett openly discussed these emotions and feelings that were stirred within him, with his psychologist. Furthermore Brett confessed that he did not expect counselling to be so intense. He would have preferred more distance, even after all this time, so that he could deal more objectively with certain cases and not be lured by the emotional charge attached to the patient's narratives. He found the experience to be very intensive and personal.

At this stage the directors of the trauma unit decided to introduce a more structured approach to training. They decided to provide a space for students to be able to complete an internship programme in trauma or pastoral counselling before becoming registered counsellors.

'We would be able to provide only for our counselling service for

the whole hospital and the community at large. And it seemed the trauma centre and there should be an academic training where psychology students should be trained in trauma or whatever you want to call it in the end. It needed skills or whatever, how to facilitate people that had been traumatized effectively.'

Five years ago the internship programme for registered counsellors was initiated into the trauma unit of the hospital. It provided students and volunteers' access to patients, staff and anyone who required pastoral or trauma counselling. It also enabled the students to become familiar with the logistics of working within an organization. Students were provided with support from other departments. They were also exposed to in vivo supervision, workshops and debriefing sessions.

6.4 The Effects of Trauma

Brett was exposed to trauma counseling, at a time when this field of registration was still relatively new. The themes identified during my conversation with Brett, resonate with the themes expressed by the other counselors. The difference between their experience and Brett's shows an evolution in the training programme.

Brett had been in a long-term relationship for four years prior to the training and he expressed feelings of isolation and frustration of going home and being forced to engage in a normal routine of social interaction. He began to find a number of things to be meaningless and felt that people around him were insensitive towards his work at the hospital. They expected him to switch off from work mode to social mode on cue and this began to create a number of rifts in his relationships between his friends, family and girlfriend.

'Each time when I went home it was like wow there's a world outside, what's happening and my family and my friends and my girl-

friend had to inform me what's happening and there would literally be sometimes where I have sat in a conversation where I felt, I don't know what they are talking about because you really isolate yourself, and not by choice, it's just work.'

However his relationship with his girlfriend was also vulnerable. He was unable to talk to her and tell her about the effects of the day without fear of being judged. Perhaps this was too much for his girlfriend as eventually she broke off the relationship.

'We lived our lives totally different and that our goals in life were different but I can definitely say those 2 years working in the casualty unit day and night, non-stop, did it for us. We barely saw each other and maybe if things were different, it would have survived. The other factor was that we were growing in different directions and this was bound to happen.'

According to Brett his personal relationship was not the only one that suffered. He also found it difficult to connect with his friends and relax in their company. He always found himself avoiding meeting new people. He did not believe that he could really voice his feelings and emotions, and this created a lot of inner turmoil for him.

Me: 'In terms of your relationship, what can you draw from it?'

Brett: 'My girlfriend used to say, you are so distant. You are not communicating with me. In three years I had not had a Christmas with my family.'

Me: 'How did missing special occasions impact on you?'

Brett: 'There were a lot of fights in my family, because I'd often also miss Sunday lunch/dinner. My family was becoming frustrated and angry with me and they could not understand my predicament. This really angered me.'

Me: 'Did your trauma work impact on your social interaction?'

Brett: 'Definitely, I mean, trauma work is not ideal dinner table conversation. This really irked me, because I felt that my work was very relevant and yet it was being ignored. After sometime it just became difficult attending family affairs. I started to deliberately avoid such gatherings as it was too stressful for me.'

Brett was also experiencing some feelings of ambivalence about his career choice. According to Brett, being a trauma counsellor was not a normal career choice for Afrikaner men. Although his parents were very supportive, he always wondered if he had disappointed them by choosing this career.

'They might respect me as a person. They might respect my knowledge about the other stuff. And they might love me and whatever, but that part of me that's doing that in my occupation. I don't always think that people will respect that. Does it take intelligence to do that, or think like that?'

Brett had this idea that people in his culture would only respect him if he had a particular profession. He began to devalue his work and at a point he even became embarrassed about it. He eventually learned that he needed to respect his choice before expecting others to.

The Compassion Fatigue Model (Figley, 1995a), highlights the effects of prolonged exposure to trauma on a counselor's life. This model shows Brett's experiences in terms of irritation, frustration, fatigue and restlessness that were projected towards his family and friends. He experienced emotional reactivity involving more or stronger feelings and unexpected emotions or reactions. Fear and anxiety which were personal reactions to terror and threats that distract or inhibits one; fatigue in terms of emotional and physical exhaustion or weariness; and sadness, grief, or depression were acknowledged in the research as being potent effects of compassion fatigue (Saakvitne et al., 2001).

According to Figley (1995a), the ability to empathize is a key personality characteristic for effective counseling; however it is also the key affect that predisposes one towards experiencing compassion fatigue. A pattern of tiredness and emotional depletion from too much caring and too little self-caring emerge (Figley, 1995a), are some of the effects that were experienced by Brett. He did not have adequate theoretical or practical exposure that would have informed him about the psychological effects of trauma.

6.5 Feeling's of Overwhelmedness

Brett felt that he had finally found his niche. This was something he really wanted to pursue and he was very passionate about his work in the unit. However he underestimated the intensity and influx of traumatic incidences that resulted from the merger and transition within the organizational structure of the hospital.

'We totally underestimated, not only us, the sisters and the doctors as well because how things turn out now it's a whole triage area that we are having where walk-in patients come in they need to be assessed. The triage area caters for all trauma, outpatient and emergency cases. And immediately the whole hospital got into this so we not only provided the counselling service for the casualty unit but for all trauma cases throughout the whole hospital.'

He had felt alienated and alone during this time. So within 3 months he had burnt out. He started getting aches and stiffness in his muscles, flu and eventually bronchitis. He had to take two months to recover from his physical ailments. His energy levels had dropped substantially.

'I really totally isolated myself at that point. I did have a girlfriend at that point and we were together for 4 years. I had written off my

life. She forced me to acknowledge her presence, I had a girlfriend and I had to go home. I had to go and speak with this person but the effect of that was, while I am seeing my family and my friends and my girlfriend, my world became very small. You are frustrated and you want to cry.'

Brett like other novice counsellors began to distance himself from the process of interaction by referring to himself in the third person. I have found this to be a common occurrence across the participants in this study. Changes in identity, in the way one practices or thinks about important identities as a professional, friend, or family member. Most of one's time and energy is spent in a professional role because one feels disconnected from or uncomfortable in one's other roles or identities (Headington Institute, 2009). This is a recurrent effect of vicarious trauma. Counselors want to guard against the effects of secondary trauma, and it seems as though this is a protective mechanism used by the counselors.

Brett reached a point where he felt emotionally drained and could not care any longer for his patients. According to Rodrigo (2002), exposure to clients' narratives may sometimes overwhelm the therapist's capacity to safely absorb and handle the information in therapeutic ways.

'What I want to get to is it didn't affect me in any way. Even with those volunteers I was at that point I was like I'm doing a job, I'm using the skills but the patient dying here, I don't really care. That's how burnt out I was.'

I understood this statement as emotional numbing. Brett had given so much of himself that he was becoming immune to the effect he had on other people. He needed to create a safe place to acknowledge this pain and frustration. Such drastic changes in one's view of the world were related to the counselor's existential and spiritual beliefs and traumatization could have devastating effects upon the foundation of one's life (Trippany et al., 2004).

Brett experienced feelings of isolation, helplessness, inadequacy, ineffectiveness, moodiness, irritability, extreme frustration, cynicism, emotional numbing and failure to connect with patients. Although Brett experienced these effects during the first three months of his training, they were recurrent themes that reverberated throughout his career. He attributed these effects to over work, being understaffed, and intense physical and emotional drain. He began to feel really unappreciated. There was a time when Brett developed bronchitis and he was forced to stay away from work for two months. It still did not occur to him that he needed to take it easy. He felt that he was responsible for everyone and everything and towards the end of his first year of training he became physically incapacitated again. This time he had to reflect on the process. It was very difficult for him but he knew he had to do something to change his behavioural pattern.

According to Collins and Long (2003a), trauma workers who became overloaded by the traumatic material are, at best, ineffective and, at worst, place survivors in a position of taking care of the helper. This realization dawned on Brett after he began engaging with the literature on trauma. It facilitated the process of healing for him.

6.6 Brett's Worldview

Brett's worldview underwent a major transformation during his year of training. He had always been a bit rigid in his beliefs of Christianity, but this began to change. He realized that he would become irritated with the volunteer counselors who tried to convert patients to Christianity. Since he was still a novice counselor, he could not voice his displeasure and this made him more aware of how the trauma context was changing and challenging his beliefs. He was now able to fully appreciate other people's religions and culture and respect their beliefs and practices.

His self-perception evolved in his context. At times he felt vulnerable when

confronted by other pastoral workers, regarding his beliefs, but he was able to overcome these obstacles and emerge successful in his therapy. He began to appropriate counseling based on the individual and not his or her beliefs and practices. This was initially a huge challenge for him, but he was basically provoked into doing things differently. He had to learn to be congruent with himself and true to his beliefs at the same time. However this was the easy part for him. As he opened himself up to new experiences, counseling became meaningful.

‘That’s a big thing that I have learned is boundaries and to practise it. It’s a skill that you have to practice every day. I think another thing that I have learnt was to say, the job that I am doing is okay, I can, with the resources that I have, with the skills that I have at this point in time, this is the kind of quality job that I can deliver, and it’s okay.’

He also learnt that the journey of trauma, was an ongoing challenge and one could never learn everything within one year. When he entered the trauma unit, he expected to be an expert by the time his training was over. He soon realized that it was an ongoing process and he had to embrace this fact.

‘Doing trauma work is a journey for a lifetime. Skills and knowledge you gain over a lifetime. You are not going to gain it within a year. I have made peace with that because I am a very impatient person concerning stuff like that and as you have said now I go with the flow and I come to a point where I will refer to somebody I know who will solve the problem.’

Brett has also learnt to work within the confines of a multidisciplinary team. He has realized that he needed to work with other professionals in order to get the best possible care for the patient and this was the most important thing. Trauma counselling was not about him, it was about the patient. Although

he often felt he would like to do more without referring the client, he had to acknowledge his limitations. His individualistic style of thinking and behaving was slowly replaced by a team of doctors, occupational therapists, clinical psychologists and other specialists.

'I make sure that I have a list of clinical psychologists and therapists and child psychologists and whatever, and social workers and whatever, on standby I am . . . environment. Our psychology department . . . social workers at level 3, I went and made friends with them. If I have to send somebody, can I refer, and sometimes I do refer because I have made peace with the fact that I cannot handle everything, will never know everything.'

Shifts of meaning in life can be quite difficult to navigate, and may lead to high rates of change in staffing for both volunteer and professional position (Hope, 2006). This was something else that Brett experienced intensely. He began to drift away from his friends and family.

'The idea was that if something happens within the hospital, a sister that gets shot by a jealous boyfriend that walks into the hospital, then we are on the scene helping with that and the family and things like that.'

These incidences would really cause Brett to question the meaning of life and his role in life. He would often turn to his own spirituality to draw strength and understanding from such senseless acts of violence. Neumann and Gamble (1995) suggested that the therapist's beliefs and attitudes were repeatedly challenged as they heard in detail about exploitation, sadism, abandonment, and betrayal. He had reached a point where he was sickened by the stories he heard daily and he preferred his own company.

'Dealing with people so you associate giving with people so now there are other people that I have to give to and at this point you

are sick of people. You want to be in your own space, you want to be by yourself, you want to go running or cycling or go and watch a movie on my own. My favourite past time was to go and watch a movie on my own.'

Depersonalization and dissociation were common retreat mechanisms utilized by most novice counsellors and even professional therapists. It was easier to just run away and hide from the realities of life. As a counsellor, I also felt prey to these mechanisms and I can identify with Brett's need to wanting time out on his own, without having to worry about making inane conversation in social settings. Trauma counselling makes it difficult for the counsellor to hide from themselves. The concept of being alone is an illusion. The hazards of being a trauma counsellor, is the inability to watch a movie without analyzing or absorbing the effects of any trauma being played out. Brett realized that he had to be cognisant of the effects of trauma on his emotions in order to develop a sense of resilience.

6.7 The Role of Supervision

When Brett began his training at the hospital, he was unaware of the necessity of retaining a clinical psychologist as a supervisor. He did not have a clinical psychologist to supervise him and he received most of his supervision from the pastor, who had asked him to join the training programme. Brett completed his training without supervision from a clinical psychologist. Brett only started going to a clinical psychologist, two years ago. He maintains that he wished that he had gone sooner.

'At that point we were only starting out we didn't know about resistance training with volunteers or resilience building or whatever. We didn't know about that stuff, we found that out as we experienced the stuff and the pains of being a counsellor.'

Brett was also responsible for supervising new interns and volunteers in the trauma unit. He was now in the position to offer knowledge, support and training to the novice counsellors, but he often felt inadequately prepared for the position because of his own history without intensive supervision. He learnt a lot from the students and the supervisor of his unit about the benefits of clinical supervision.

‘Even with those volunteers I was at that point I was like I’m doing a job, I’m using the skills but the patient dying here, I don’t really care. That’s how burnt out I was.’

Brett felt the full effects of secondary traumatic stress on a regular basis, until he began seeing a clinical psychologist on a personal level. He realized that he was not invincible and he needed more support and training.

‘I’m at the point where what’s helping me now to stay in shape emotionally and spiritually is more the skills, life skills, that I have learnt from the therapist. And I have a date with her once a month when I go to her and I debrief. I sit down with her and I tell her, listen in this month this was the stuff that happened to me.’

He now feels more confident to approach, supervise and train future trauma counsellors.

6.8 Coping Skills and Mechanisms

Brett acknowledged the fact that he needed more assistance in appreciating the complexities of trauma work and he would have benefitted from more structured counseling courses. His assessment of the function of the trauma unit, led him to attend many courses that provided additional training for dealing with traumatic situations. He completed a six-week pilot course presented by

the South African Institute for Traumatic Stress the Center for the Study of Violence and Reconciliation. The purpose of the course was to provide educational training for trauma response teams. Brett managed to get information that helped him to better equip the trauma training unit at the hospital.

‘And I’m at the point where what’s helping me now to stay in shape emotionally and spiritually is more the skills, life skills, that I have learnt from the therapist.’

Brett also had to learn to reclaim his identity and feel comfortable in his choices. This was a painful journey for him and he often felt that the pain was devastating. He encountered a number of tribulations during his training and he realized the importance of having a safety net in his personal and professional domains.

Brett grew a lot during his training and he had to also let go of his rigid approach to therapy and personal beliefs. His worldview underwent a major transformation and this was all instigated by the way he began to develop coping strategies. He became more proactive rather than reactive and this energized him.

‘It took me 2 years to where I felt now I have been recharged. I feel okay.’

The trauma unit began to train intern counsellors and volunteers, during this period. It came as a huge relief to Brett and his other colleague, when the interns were placed to relieve the burden of the work load shouldered by the two trauma counsellors. Brett had to learn to become more resilient and responsible for his process, health and career. He realized that he needed to revisit certain areas of his life that were being neglected. Together with this realization, he began engaging in self-care behaviour. It is also something he proposes to the trainees and other volunteers.

'I had to connect my identity with my job, without confusing the roles. That's one of the hardest lessons that I had to learn was that your job did not define you as a person. And you need to separate yourself when you get home. I have a switch-off ritual, I shower. I take off, because . . . the hospital smell goes and sits in your clothes and your hair so if I from there go to a movie or whatever the smell everything still reminds me. Even if other people don't know it. Then in my mind I switch off from work mode to I am now in family mode and friends mode and that took me a year to develop that and to oh, this is a new idea, let's try it and see if it works.'

This helped him to retain focus and concentration of any situation. He had now developed a strategy to separate his personal and professional life. Since it was working well for him, he incorporated it into the training programme as a tool for building resilience.

'Once a month I am standing back with the therapist or clinical psychologist, I go and see her and she debriefs me. I think it should be standard for anybody whether you are in trauma work or not. If you are in a mental health profession. At the end of the month you see someone and they give you a different perspective. Otherwise I can promise you I would not be back, because although we have now a whole bunch of students, everything like that, and that's interesting enough we are now at the point where the dream that I have started with is now full-filled. It is in-house trauma counselling centre for the community at large, for the whole hospital, academic training institutions, psychology students, where I have been through trauma counselling techniques.'

Brett's dream which evolved over time was realized and this was one of his main motivating factors. He needed to continuously assess his mental, emotional and physical presence in order to make the unit more effective and functional.

6.9 The Role of Life Experience and Training

Since Brett had not been exposed to in vivo supervision at the hospital, he was fully aware of the benefits of a debriefing session. However when he realized the importance of organizational support and debriefing sessions, he ensured that it became an important part of the training context. He was already aware about the effects of secondary trauma and vicarious trauma from first-hand experience and he realized that some measures needed to be added into the programme. This helped him to recognize the signs and symptoms of secondary trauma in his students and he was able to suggest time off for them. He also became more aware of himself, his limitations and this mobilized him to become more effective in his personal and professional environment.

Brett always had organizational support from the pastoral counsellors, but he felt he needed something more. He also recognized the need for peer support and especially in this field. These relationships are extremely necessary for facilitating the healing processes, and they also provide a holding space for support and sharing knowledge. This process facilitates the reflection of feelings and emotions and also enables the counsellor to become more open and flexible. Often the novice counsellors decided to let go of dominating friends and to re-established connections with people who could understand the intensity of trauma counselling. It may seem as though the novice counsellors were closing themselves up from other experiences, but it was not the case. This method of creating a safe space for the counsellor to de-brief, is a way of ensuring that they are more effective in their personal environments.

Brett is wary of the intensity of the effects of trauma. The feelings of numbness, desensitization, disillusionment, lack of energy, cynicism and life experiences make the interns vulnerable to developing vicarious trauma. He is aware that not having necessary support structures available will hinder the management of secondary stress. Therefore he places a lot of emphasis on individual supervision with a clinical psychologist in order to deal with unresolved emotions in order to reign in inner resources and this takes a lot of energy. Brett had been

exposed to these effects and he is aware that he is also susceptible and vulnerable to vicarious trauma. He feels that he would encounter more difficulty suppressing his emotions and he has realized that in order to be effective, he needed to conserve his energy. Being a trauma counsellor needs a lot of energy and this puts an individual at risk for withdrawing from friends, family and important relationships.

‘The courses I attended started to give me ideas on, because they spoke a lot about self-care, having a switch-off ritual, having a life outside the hospital, things like that. So they gave me a couple of ideas there but I only really started to apply that as a total package here by the mid 2008 to the end of 2008. What happened was I took something small and started to implement it and let it run and see if it changed anything and then implement something new. So it literally built up over a while until I found out what worked for me and the unit. And now this is what I am doing and I am sticking to that and that’s helping me and working for me. You read a lot of books and out of necessity.’

Brett had very little expectations about the training culture. Being relatively new to the context, he expected the unexpected. However he did not expect the onslaught of the personal impact on his emotions. He went into the training programme with a willingness to learn and experience everything. His passion for the trauma unit grew and he immersed himself in the everyday chaos of the unit. He thrived on the experience.

‘In a certain sense that dream has been realized. The question is now, where to now? And with that, if you have that you build up a reputation. Now at this point where the family medicine department of the University of Pretoria, of the medical faculty, are using us now to teach the medical students about interviewing skills, counselling skills, stuff like that when they are interviewing a patient. And getting much more involved in projects like that. So the

demands that are being put on this unit, you as the trainer and student and the kind of depth of training that you are giving them and new models, counselling models that you teach them, because you cannot only stick to one model, you must incorporate other models as well. That is becoming more and because you have all the manpower, now the different departments of the hospital expect more in terms of employee wellness and we are branching now seriously out into employee wellness.'

6.10 The 'Aha' Moment for Brett

The turning point for Brett came from an incident that left him afraid and forced him to take a break.

'Whereas the karate class it is training how to fight, so you don't really have to talk. This guy is punching at you and you must block and you punch back and it was good for me because then I can fight this guy and get all my frustration and anger out of it. The bad part of it was that this instructor wants to stop the fight because I was losing myself in the fight and going flat-out instead of controlling my punches, I got so really into it and I was hurting the guy instead of control fighting situation.'

This made him more aware of the profound effects of secondary trauma. He began to actively reflect on his performance, which was beginning to deteriorate. He was beginning to project his frustration onto other people and in a sense making them responsible for the entire trauma he had to deal with.

'If you are burnt out, ja, you can hide for a while, you can fake it for a while, you can only fake it for a while then people will start saying you can do all the right things but . . . by not being there by the client. I knew in my heart I can perform much better.'

His second realization dawned when his girlfriend of five years decided to leave him. Brett really began to find himself disconnecting from her. Although the next step was inevitable for their relationship, he was oblivious to the impact he was having on the relationship and the break down off the relationship was a wake -up call for him to. He had to seriously reflect on this transition in his life.

It took Brett two years to feel recharged. He felt like he could now move forward. He had moved past working on automatic pilot. He was able to reconnect with his patients and other people.

6.11 Discussion

Brett's situation is different from the other novice counselors, as he was a novice trauma counselor a few years ago. When he began working in the hospital, there was no clearly assigned trauma counseling unit. He was also not expected to undergo specific internship training for trauma in order to register as a trauma counselor. The courses in trauma counseling that he attended were offered by people from other countries and only after his training, did he come into contact with South African Institutes that offered courses on trauma counseling.

Brett experienced personal and professional consequences of vicarious trauma. He began to isolate himself from friends and family, he also began avoiding the pastoral support staff at the hospital. He tried to consolidate his functioning by withdrawing into a cocoon of self-protectiveness. He created boundaries between himself and his clients. In so doing, he opened himself up for the onslaught of physical and emotional ailments. He became very ill within three months of working in the trauma unit. He was then compelled to bed rest for two months. This gave him time to reflect on his behavior.

Brett's worldview shifted significantly during his training and it made him very vulnerable to the intensity of cases in the trauma unit. The case load

was very high and there were only two trauma counselors. Brett experienced feelings of exploitation especially from the hospital staff. He also experienced feelings of redundancy and that prompted him to embark on more structured trauma training course. Although he learnt more about trauma from practical experience, this process needed to be facilitated through training courses.

Brett's journey was difficult as he had no exposure, experience or information about trauma counseling. He was literally thrown into the deep end of the hospital and he had to learn very fast about the politics of the hospital and his limitations. He did not have peer support, education or training and this made him more susceptible to the psychological effects of trauma. Herman (1992) reports that traumatic countertransference can include a range of emotional reactions to trauma survivors, such as identifying with their helplessness, grief, personal vulnerability, and rage. Unless these are understood and contained, they could lead to longer term personal, therapeutic, and professional effects. This was abated by Brett because he began to understand the importance of integrating a regular self-care routine into his personal life.

He developed incredible coping skills, like a strict self-care regime. He always felt rejuvenated and more effective once he began to exercise self-care. Spirituality featured strongly in Brett's life. He is a very spiritual person and meditation is one of his prominent tools in maintaining his peace of body, soul and mind.

Ochberg (Gentry, 2005) posits that everyone who moves toward the scene to help; comforts someone who was there; and listens closely, with sensitivity, is a potential casualty. But every one of us is also a source of comfort, information and inspiration. This was experienced by Brett especially since he had little understanding of creating boundaries between his clients and himself.

I experienced Brett's journey as unique and filled with passion and creativity. He seemed to be on a mission to improve the trauma unit and together with other key players in the hospital, they managed to acquire a room for the trauma counselors and they began to infiltrate the hospital system. The

trauma counseling unit became a personal achievement of Brett's. He ensured that students and volunteers received the basic training course in trauma counseling before embarking on the programme. He basically reigns over the trauma unit.

An exclusive quality that I picked up in Brett was his accommodating and flexible nature. He is always open to suggestions from students, staff and other members of the hospital. After two years I can see a drastic change in the trauma unit. The volunteers and interns are being cared for and supported on a different level. There are ongoing training programmes throughout the life-cycle of an intern counselor. Brett's experiences of the psychological effects of secondary trauma informed his incorporation of several prevention models in order to counter these effects for the students and hospital staff.

These inclusions support my view of Brett's flexibility and passion for healing. He is no longer confused about his identity and he has found his niche in society. Although he would like to pursue a career as a clinical psychologist at some stage, presently he is too involved in expanding and making the trauma unit better and more accessible. I felt rejuvenated after my conversation with Brett. I felt his healing spirit embalm me as well.

Chapter 7

Conclusion and Recommendation

If I have seen further than others, it is by standing upon the shoulders of giants.

Isaac Newton

7.1 Introduction

This is an exploratory study of narratives based on my subjective experience as well as the experiences of other novice counselors in the trauma unit. My narrative was also a part of this ethnographic study and it facilitated a deeper understanding of the processes observed within the organizational structure. Trauma counselling does not focus on curing the patient. The main role of the counsellor is to provide immediate intervention to the victim. The trauma counsellor's role is seen as the primary intervention in order to stabilize the victim before referring for appropriate treatment or intervention. This study enabled me to understand the complexity of simple processes within the organization.

The following concepts were used to illustrate the use of ethnography in the culture of the trauma unit within the hospital (Creswell, 1998). I used the

behaviour as the unit of analysis in order to observe, analyze and understand the intact culture-sharing group. The gatekeeper or supervisor of the trauma unit facilitated and participated in the research process. The supervisor of the unit was instrumental in assisting the data gathering process. He mobilized students to participate and he linked me up with various key personnel in order to obtain a comprehensive understanding of the mechanisms responsible for ensuring the maintenance of the trauma unit.

The intricate network involved in ensuring efficient trauma services provided to the hospital comprised of individuals responsible for organizing the smooth management and delivery of services throughout the hospital. They all formed part of the trauma culture within the hospital and they were responsible for the increasing popularity of the trauma unit. I obtained insurmountable information from the members of this organization with very little effort, the reason being that these individuals were open, accommodating and willing to share their experiences and their time. They made my entrance into this facility effortless and supportive.

Over the past decade there has been an upsurge in interest regarding the effects of secondary traumatic stress, burnout, vicarious trauma and compassion fatigue. The most important criteria that have been noted, involve countering the effects of these variables.

The research has highlighted salient advances in identifying and reducing the effects of secondary trauma. Most of the models emerged from actual traumatic situations. The survivors of the 9/11 terrorists attacks, survivors of the tsunami, bombings, and unnatural events throughout the world, served as educational grounds for identifying the effects on counsellors and creating preventative models for the variables.

7.2 Evaluation of the Study

The present chapter will be presented in terms of the themes elicited from the rich narratives obtained from the ethnographic study. The ensuing discussion will encapsulate the essence of my personal experience as well as the experience of the other novice trauma counsellors.

The aim of this research is to relate the narratives of the experiences of two novice trauma counsellors and one professional trauma counsellor. It is my belief that this task has been adequately achieved and the related narratives provide a resonant description of all the experiences. This includes the psychological effects of counseling, the role of supervision, the participants coping skills and the training programme. The research attempted to provide a platform that is often absent from more conventional approaches. These insights could help prospective applicants to make informed decisions regarding the field of trauma counseling.

The important themes of the literature review were the identification of vicarious trauma and compassion fatigue and the variations in the presentation of these effects by different individuals. This helped to show possible links between the counsellors personal history, life experiences, education and level of expertise. It showed a flow between acquired knowledge and innate knowledge and the culmination of its effects during counselling and therapy. The literature also touched on coping strategies in operation. The uniqueness of these styles is their flexibility. They are not rigid in application and can be designed to fit different fields of counselling.

Furthermore a number of frameworks were addressed in previous research. However the following three theoretical framework of Trauma Transmission Model, Ecological Framework of Trauma and The Multidimensional Framework, were closest to the themes explored in this study. It allowed me to gain further insight into the operational functionality of these variables within specific frameworks.

Another one of the facets, in addressing the effects of trauma, that was explored in detail was the role of supervision. There are different types of supervision that can be accessed at any time and in any place. Supervision can be supportive or judgemental but it depends on the facilitator and the participants.

The common themes that emerged regarded the psychological effects of trauma on the participants were:

- All the participants experienced the first effects of secondary trauma within three months after starting the internship programme.
- Feelings of ineffectiveness. The participants maintained a skeptical attitude regarding their abilities as counsellors. They questioned their training and abilities throughout the internship.
- The participants also experienced intense vulnerability and exposure during the first few months of training.
- They experienced feelings of disconnection from their clients as well as their families and their personal relationships suffered because of the heaviness experienced during these periods.
- The physical effects culminated in chest infection, fatigue and loss of energy. All the participants experienced an intense decline in energy at several points during their training as well as a significant loss of interest in their professional environment.
- All the participants also succumbed to emotional and psychological distress such as emotional numbing, emotional disconnection, moodiness, intense irritation, frustration, aggression, helplessness, withdrawal, psychological vulnerability and cynicism.
- The positive effects of the trauma counseling internship was experienced by all the participants. They all felt this incredible feeling of lightness when they could see the effects of their presence. It confirmed their niche in society.

These themes helped to reveal how each participant coped or was hindered by the effects of secondary trauma. This included:

- The participants experienced a significant shift in their worldviews. The participants were unaware of the intensity of the trauma unit and they did not experience a gradual introduction into the trauma unit. They were immediately assigned to the emergency cases and this forced them to confront their greatest fears on regular basis. They became wary and cynical about life and death.
- None of the participants had sufficient life experience to prepare them for the horror of the trauma unit. They were vicariously confronted by crimes of passion, violence and violent deaths in the hospital. Alice was confronted by her suppressed memories that threatened to resurface. She spent a lot of energy denying her emotions and this created a lot of ambivalence in her professional life.
- The participants had a unique way of coping with secondary trauma stress. Alice and Hope decided to take a break from the hospital environment and reflect on their processes. The break away from this stressful environment forced them to become more aware of their physiological and psychological mechanisms. Brett was forced to take a break, due to physical illness. It was during the two months of forced bed rest, that Brett had to seriously look at his position and adjust his lifestyle. He realized that the trauma unit needed more volunteers.
- Although it took Alice a while to realize the benefits of supervision, she did admit that she eventually learnt to mobilize the support offered to her by the trauma unit and found the experience beneficial. Hope utilized the supervision provided by the unit as she also did not have a personal supervisor at the beginning of her internship. She maintains that the support she received from the other members of the unit and later on from her supervisor helped her to strengthen her counseling skills and also to learn more about self-care procedures. Brett did not have any formal

supervision but the pastoral counsellors provided a support structure for him at the hospital. He understood the benefits of supervision. He then went on to ensure that a supervision structure was in place for new counsellors. He still attends sessions with his psychologist, at least once a month in order to debrief.

The biomedical model is prevalent in hospitals and many health professionals believe that healing is restricted to the physical and observable dimension only. The integration of the trauma unit in this particular hospital has provided a shift in the understanding of treatment and healing. The patient's holistic functioning takes precedence over physical treatment. This prescription produces a lot of pressure amongst the interns. They are forced to take a crash course in medical terminology before approaching the patient. The trauma counsellor needs to be able to effectively communicate reasons for various treatments and procedures to the patient. This can evoke painful memories for the intern counsellor. Alice was constantly reminded of her past because of these cases.

As indicated by Morrison (2007), the novice counsellors have to experience the effects of vicarious trauma. The information provided by this study and other studies aim to identify ways that the psychological effects of trauma can be reduced. I have realized that awareness by the counsellors is the most effective tool and this can be facilitated by the supervisors and support structure provided by the organization. Furthermore I observed some traits of inner strength, positivity and flexibility in the personal style and attitudes of the participants and this seemed to play a pivotal role in their enduring attitude towards trauma counseling.

Gachutha (2006), focused on supervision as a strategy for burnout. Although the author acknowledged that counsellor burnout was inevitable, she also expounded on the relevant nature of supervision and self-care. The awareness of burnout was instrumental in assisting supervisors and counsellors to become proactive in maintaining their well-being and mental health.

Supervision and therapy were described as a recursive process of perturbations and compensation. There was an intermingling of realities involving the supervisor, trainee and client. The role of the supervisor was to bring about some semblance of awareness of the storied reality for the trainee and the client in order to cultivate a richer experience for all involved in the therapeutic process. This form of co-creation of reality and awareness played a significant role in the minimization the psychological effects of trauma (Becvar and Becvar, 2006).

Resilience was also a prominent theme in the participants narratives. It encapsulated the inner strength present within each individual. The process of recovery entailed deep reflection of one's identity. The trauma counselling training was provocative and intense and it forced the novice counsellors to engage in active integration of one's self. The counsellors had to become aware of their own vulnerabilities and they had to be able to transform the negative impact of the work. They were forced to focus on finding meaning in their work and day-to-day activities, challenge negativity, participate in community building activities and join with others around a common purpose or value (Saakvitne et al., 2001).

The most important and relevant themes that emerged, involved the application of a team approach to managing the risk of vicarious trauma and compassion fatigue. It focused on emphasizing the different approaches to preventing and reducing the effects of trauma.

7.3 Vicarious Trauma and Compassion Fatigue

The journey of exploring the psychological effects of trauma on novice trauma counsellors, was instituted by my personal experience. I was inspired by the effects of secondary trauma on my family and me. It whet my appetite for wanting to know more about this phenomenon. The participants also entered this exciting field of trauma counseling with little or no knowledge of the

intensity of the traumatic cases.

Vicarious trauma and compassion fatigue formed the crux of this study. The importance of these effects for novice trauma counsellors were reiterated. The novice as well as the professional counsellor face trauma upon trauma in every session with a client. In order to form a human connection with the client, the counsellor has to join empathetically on different levels. This includes an emotional exposure to the clients experience. The effects of this exposure is the reason for this study. It is not a unique phenomenon but it often seems like a well kept secret.

The effects of vicarious trauma and compassion fatigue are powerful enough to emotionally cripple a novice as well as a professional counsellor and it is not limited to counsellors. Clinical psychologists in training as well as social workers often experience these effects. The onset, duration and intensity of the effects is the only variable that depends on the individual. The occurrence of vicarious trauma, compassion fatigue or secondary trauma is often inevitable.

The psychological effects of secondary trauma that result from repeated exposure to trauma culminate in various degrees of vicarious trauma and compassion fatigue. The best predictor of vicarious traumatization is exposure to trauma. 'Caseloads', or the extent of trauma exposure, have been found to be predictive factors of vicarious traumatization (Morrison, 2007). Hope experienced vicarious traumatization towards the end of her internship, due to a heavy work load and fewer trauma counsellors. Her working hours had been increased as she was also responsible for the emergency telephone.

Alice was one of the counsellors who personally endured repeated exposure to distress and she had to use her own feelings of sorrow as tools for therapy. As such, it was impossible for her to escape this kind of work without personal consequences. Wasco and Campbell (2002) stated that, because vicarious traumatization occurs in the work place, this environment is highlighted as particularly important. Their research found links between the organizational setting and counsellor advocates' ability and propensity to engage in self-care

activities. They found that specific organizational procedures or cultures facilitate or bar opportunities for certain self-care routines; and organizational cultures or policies create situations that necessitate or eliminate the use of particular types of self-care activities or routines.

Trauma counsellors, especially novice counsellors assistance and support to others in pain, either physical or emotional, tend to be empathetic and compassionate. These necessary qualities that help them to do their jobs, place them in the direct path of experiencing secondary trauma or compassion fatigue reactions. Often when the novice trauma counsellor is confronted with a traumatic case, they are not sufficiently equipped to understand the intense emotions that are evoked within them. In the past, this term was labeled burnt-out. However this description does not accurately describe the phenomena. Many helping professionals as a result of listening to stories or witnessing the aftermath of traumatic events could develop many of the same symptoms associated with Post-Trauma Stress Disorder as well as symptoms that are more insidious. Brett was regularly afflicted by compassion fatigue as he was one of two counsellors at the hospital. He tried to handle everything alone and this eventually culminated into physical illness. He became aware of the need for self-care. This instituted self-care rituals as part of the internship.

The themes of vicarious trauma and compassion fatigue featured strongly throughout the narratives. Hope experienced compassion fatigue very early into her internship and she attributed this to lack of private supervision and naivety. She further maintained that her own mortality was constantly challenged every time she had to provide support to a grieving family. She also experienced vicarious trauma towards the end of her internship and this can be linked to the increase in her case loads due to lack of staff in the trauma unit and attend to the emergency telephone. She began to develop signs of fatigue, withdrawal, alienation and cynicism. The supervisor at the hospital and her personal supervisor picked up on Hope's lack of energy and they encouraged her engage in a self-care routine.

Brett was unable to identify the signs and symptoms of vicarious trauma and compassion fatigue early in the internship and he succumbed to the intensity of these effects. When he started to gain more experience and knowledge in the field, he began to understand what had happened to him. This awareness made him become proactive in initiating self-care programmes into the hospital regime. Since he is still actively involved in the trauma course, he admits to being vulnerable to the psychological effects of secondary trauma and therefore goes for regular supervision.

Despite all the literature and research being done on vicarious trauma and compassion fatigue, the information is not readily available and rarely forms part of any academic curriculum. The South African community is confronted by all types of crime on a daily basis. Trauma counsellors provide an essential service to the community. As has been previously iterated, secondary trauma is a consequence of offering empathy, support and caring too much.

7.4 Conclusion

The dialogue that ensued between the participants and myself, hurled me back into the trauma unit. I often felt myself being encapsulated by the intensity of the session and I often returned from my interviews without any cognizance of how I reached my destination. On reflection, I realized that just listening to the stories of the trauma unit was bringing me closer to my experiences and it was not comfortable for me to relive the experiences. I realized at that stage that I was still vulnerable to developing secondary trauma, especially since I had not been engaging in a disciplined self-care routine since I began this research project. It made me sit back and take stock of my behavior.

This study provides a benchmark for future research on implementation of different preventative strategies for addressing the psychological effects of trauma on novice trauma counsellors and volunteers in the hospital. It is imperative that continuous evaluations be made in order to gauge the effects of secondary

trauma on individuals and implement relevant strategies.

I also learnt a very important lesson during my internship as a trauma counsellor. The further you run from your past, the faster it gets to you and in this field you cannot deny your past. Your past makes your present palatable and your future inescapable.

7.5 Limitations of the Study

Since this is an exploratory study, it is important to note that most of the information is based on my subjective experiences. This experience provided the foundation for exploring different narratives in the same culture and environment. One has to be cautious when generalizing the findings to other groups in different organizations. The experiences narrated in this study are unique to each individual. This study aimed to explore the experiences of novice trauma counsellors in this particular culture within a provincial hospital. This study does not claim that the information elicited from the participants are facts that can be generalized to other contexts.

7.6 Recommendations

The Ecological Model for the Prevention of Secondary Traumatic Stress Disorder (Figley, 1995a) is a useful blueprint for implementing suitable measures for preventing the development of compassion fatigue. Although secondary traumatic stress is an inevitable side effect of trauma work, the effects can be reduced if there are some precautionary safety measures in place.

When an individual enters the area of trauma counseling, he or she is already vulnerable to the effects of the intensity of the exposure to trauma. The individual also comes in with a personal map that involves his or her history, family, friends, partners, acquaintances and life experiences. The individual is

a product of this map. On introduction into the trauma unit, a professional map begins to develop. This map is shaped by the individual's beliefs and biases stemming from his personal map. His personal life is then integrated into his professional life. He cannot objectively compartmentalize his personal and professional life. They are bound to inevitably merge to constitute optimal functioning in all areas of his life.

The counsellor has to become attuned to his personal needs in response to the environment. The physical, social and psychological well-being has to be considered on the individual level. The level of awareness that one has about one's own functioning is the barometer used to gage one's performance. There must be mechanisms in place to regulate the flow of positive and negative energy between the professional and personal psyche of the individual. These mechanisms will ensure optimal functioning of the individual in any context.

The environmental dimension involves the societal and organizational background. This includes familiarizing oneself with the structural functioning of the organization. Another important aspect for personal growth is to test the flexibility of the system to different information. This can be done by talking about it to other counsellors and also the support staff. It becomes vitally important for the novice counsellor to introduce himself into the system as a sponge. The organization can facilitate this process by allowing the individual to gain unrestricted experience of the trauma unit, whilst simultaneously providing a safety net for supporting the individual through this transitory period. The individual enters the trauma environment as raw material and emerges as a kaleidoscopic projection of the internal processes.

The advent of the Ecological Model for the Prevention of Secondary Traumatic Stress Disorder into this particular environment can serve as an adjunct to the existing measures in place. The flexibility of this model as well as the permeability of the system allows for optimal benefits for the novice trauma counsellors. This hospital is a wholistically functioning institute that is open to new and different ways of enhancing service delivery to the public. Accord-

ing to the ecological perspective self-care routines of counsellors when dealing with vicarious traumatization can best be understood as interactions between individuals and their environments.

The indicators of psychological distress are so subtle, that it can only be discernible when the emotional and psychological effects begin to manifest as serious physical ailments (McCann and Pearlman, 1990). It is also my recommendation that the training team should mobilize the novice counsellors to provide support for each other in their personal and professional domain. They should be given the space where they can hold the intensity of each other's emotional turmoil. This can be done by ensuring that the students become aware of each other by spending time out of the work environment.

This will ensure that they develop some form of connection that can facilitate their process during the internship. The qualified counsellors should also be obligated to share their experiences with the students and provide a secondary level of support by being accessible to the students.

Of the making of books, there is no end.

Ecclesiastes

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