**Psychology Master's Degree**

**Short Dissertation**

**Title:**

"Vicarious traumatization in therapists working with trauma: do defences make a difference?"

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**DECLARATION - PLAGIARISM**

I, **Urishka Sharee Dubock**, declare that:

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2. This thesis has not been submitted for any degree or examination at any other university.

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## ABSTRACT

Vicarious traumatization presents a significant concern for therapists around the globe. In South Africa, research around therapist wellbeing appears lacking. Despite various international studies on vicarious trauma, there remains a lack of conceptual clarity and comprehensive theory on vicarious trauma in therapists. Several studies have attempted to find factors associated with the development of vicarious trauma, with varying outcomes. Factors such as history of personal trauma, trauma caseload and supervision have been found to be associated with vicarious trauma. However, few studies have focused on the possibility that defence style could play a significant role. Recent research by Adams and Riggs (2008) found trauma symptoms in trainee therapists to be significantly associated with defence style. The current study explored the relationship between vicarious trauma and defence style (image-distorting, affect-regulating and adaptive defence styles). In addition, demographic factors were analyzed to discover whether they may be better determinants of vicarious trauma. The study used 127 participants (independent practitioners) from across South Africa. Participants were requested to complete three questionnaires: a demographic questionnaire, the DSQ 60 and the ProQol 5. Data were analyzed using a quantitative, positivist method. Correlations were used to identify significant relationships among the variables and a series of multiple regressions were conducted to explore predictive factors of the defence styles. Multiple regressions were also used to explore the predictive ability of the demographic variables and professional quality of life. The findings indicated a strong positive relationship between image distorting defence style and vicarious trauma. Of the demographic factors analyzed, therapeutic modality was found to be a significant predictor of vicarious trauma. A significant negative correlation was also found between help seeking for personal trauma and compassion satisfaction. This study provides evidence for the relationship between defence style and vicarious trauma. Further, it is indicative that most demographic factors had no effect on professional quality of life and ultimately, vicarious trauma. The current study suggests that further research needs to be done to further investigate the impact of defence style on vicarious traumatization. Implications, limitations and future directions of these findings are discussed further.

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# CHAPTER ONE

# INTRODUCTION

Contemporary research has highlighted the effect secondary trauma can have on therapists who are exposed to graphic representations of traumatic events (Adams & Riggs, 2008; Bride & Figley, 2007; Craig & Sprang, 2010; Figley, 2002; McCann & Pearlmann, 1990; Pearlman & Saakvitne, 1995; Pearlman & Saakvitne, 1995; Salston & Figley, 2003). It is suggested that this can be damaging to the therapist and the therapeutic process especially in the context of trauma, which is continuously on the rise in South Africa. Studies have empirically linked vicarious traumatization with trauma therapy reporting moderate to high levels of symptoms in therapists (Bride, Jones & MacMaster, 2007; Conrad & Kellar-Guenther, 2006; Hargrave, Scott & McDowall, 2006; Johnson & Hunter, 1997; Way, Van Deusen, Martin, Applegate & Jandle, 2004).

It is evident that researchers have attempted to determine factors that may influence the development of vicarious trauma. In a study by Trippany, Wilcoxon and Satcher (2003), personal and practise variables were studied as influencing vicarious trauma. The study was able to highlight a significant relationship between personal trauma history and the development of vicarious trauma among female therapists. Research by Nelson-Gardell and Harris (2003) also found a significant link with personal history of trauma and the development of vicarious trauma. Over time, researchers have attempted to pair different factors with vicarious trauma, with varying results. Literature has recognized the mediating role of factors such as caseload, trauma history and supervision (Adams & Riggs, 2008; Jordan, 2010; Nelson-Gardell & Harris, 2000; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995). Few studies have, however, focused on the link between *defence style* and vicarious trauma in therapists.

Pearlman and Saakvitne (1995) and Adams and Riggs (2008), however, underscore the role of defence style in the development of vicarious traumatization, which could have implications for further study. Adams and Riggs' (2008) findings indicate that less adaptive defence styles such as image-distorting defence style are associated with more vicarious trauma symptomology in trainee psychologists. Is it possible that maladaptive defence styles render *therapists* vulnerable to vicarious trauma? Adams and Riggs' (2008) findings indicate

that a less adaptive defence style may require more supervision to encourage self-exploration and development of mature defences. Are other factors better determinants of vicarious trauma? If supervision, for example, can assist in developing a more mature defence style, then it is possible that other factors do play a mediating role in the development of vicarious trauma.

### 1.1. Rationale for the study

It is apparent in the literature that research into the mental health of professionals has increased recently (Adams & Riggs, 2008). In line with this, is the growing body of knowledge focusing on how secondary exposure to trauma can adversely affect mental health professionals (Adams & Riggs, 2008). As mentioned, there have been numerous factors that have been associated with the development of vicarious trauma (Adams & Riggs, 2008; Jordan, 2010; Nelson-Gardell & Harris, 2000; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995). However, literature on vicarious trauma in South African therapists appears to be lacking. In addition, there is even less research on the role of defences in the development of vicarious trauma in this context. For decades defence mechanisms have been studied and linked to what unconsciously motivates a person's behaviours (Freud 1940, as cited in Adams & Riggs, 2008). It has been hypothesized that defences make up relatively stable patterns that determine how an individual will cope in stressful situations. Understanding how defences work in managing stress makes it possible to understand the role they may play in the development of vicarious trauma. Adams and Riggs (2008) made it apparent in their research that defence style may play an important role in the development of vicarious trauma. There is a need in South Africa for research pertaining to the wellbeing of therapists. South Africa has a high rate of trauma related incidents, which are often processed in trauma therapy. This alone can increase a therapist's vulnerability to vicarious trauma. Exploring *defence styles* of therapists can also allow for the identification of defence styles at risk for developing vicarious trauma. The current study examined the link between vicarious trauma and defence style in an attempt to identify psychological mechanisms and how they interact with other mediating variables.

## 1.2. Definition of Terminology

### 1.2.1. Defence Mechanism

According to the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM 5), defence mechanisms mediate a person's reaction to emotional conflicts and external situations that are perceived as stressful, with defences being classified as either maladaptive or adaptive (American Psychiatric Association, 2013). Defence mechanisms are considered comparable to *coping mechanisms* because of the automatic psychological process that provides the person with protection against adverse anxiety provoking situations that are either internal or external (Bonsack, Despland & Spagnoli, 1998). Defence mechanisms are defined as predominantly unconscious processes (Vaillant, 1994). According to Nishimura (1998), defence mechanisms are organized along a continuum that assumes that there are certain defences that are considered more adaptive and less associated with pathology.

### 1.2.2. Defence Style

Bond (1983, as cited in Nishimura, 1998, p. 419) suggested that defence mechanisms tend to cluster into styles that can be "ranked on a developmental continuum". A grouping or cluster of certain defence mechanisms can therefore be referred to as a 'Defence Style' with the presumption that some styles are more mature than others. Bond and Wesley (1996, p 1) originally explained their research as a way "to elicit manifestations of a subject's characteristic style of coping with conflict, either conscious or unconscious" which later would be referred to as a person's defence style. Defence style is discussed further in Chapter 3.

### 1.2.3. Vicarious Traumatization

Although researchers over the years have classified vicarious trauma in different ways and used different terminology, the term was first defined by McCann and Pearlman (1990, as cited in Bride, Radey & Figley, 2007, p. 155). They described vicarious traumatization as a "transformation in cognitive schemas and belief systems resulting from empathic engagement with clients' traumatic experiences". Pearlman and Saakvitne (1995, p 151) explain that a

transformation such as that described by McCann and Pearlman (1990) can result in a significant disturbance in a person's "sense of meaning, connection, identity, and world view, as well as in one's affect tolerance, psychological needs, beliefs about the self and other interpersonal relationships, and sensory memory". Literature describes vicarious trauma as resulting in symptoms similar to those of Post-traumatic Stress Disorder (Figley, 1995). Vicarious traumatisation has also been described using various terms such as *compassion fatigue* and *secondary trauma,* and these can be used interchangeably with *vicarious trauma* (Bride *et al*., 2007; Dunkley & Whelan, 2006; Figley, 2002; Howlett & Collins, 2014; Huggard & Nimmo, 2013; Stamm, 2010). Although there are differences in theoretical foundation and terminology (vicarious trauma/secondary trauma/compassion fatigue), all definitions refer to the negative impact of therapy on the clinician (Bride *et al*., 2007). However, in Chapter 2 an attempt is made to clarify each term for the purposes of conceptual clarity.

### 1.2.4. Therapist

This paper will refer to 'the therapist' as a professional in the field of psychology. This term can be used synonymously with *psychologist* or *clinician.*

### 1.2.5. Trauma

Kira (2001) explains that there are various definitions of trauma. However, according to Kira (2001) an event that causes physical and mental stress and is considered outside of the person's usual experience can be referred to as a trauma. This also suggests that what is traumatic for one person may not be for another. The DSM 5 describes a trauma as a situation where a person experiences "actual or threatened death or serious injury or a threat to the physical integrity of self or others" (American Psychiatric Association, 2013, p. 271). The definition of trauma is further discussed in relation to vicarious trauma.

## 1.3. Outline of the dissertation

**Chapter One**

This chapter includes an introduction and overview of the current study.

**Chapter Two**

Chapter Two includes the literature review. It comprises a review of available literature on vicarious traumatization. Included as part of this chapter is literature pertaining to trauma and factors related to vicarious trauma. Definitions are provided for *trauma, burnout, compassion fatigue, secondary trauma* and *vicarious trauma*. Along with these definitions is an explanation of their relevance to the current study and an attempt to conceptually clarify terms. A brief description of trauma in the South African context is also included. The following section highlights treatment and psychotherapy with traumatized victims, and includes implications for the therapist's wellbeing. The final section of the literature review focuses on factors that have been empirically associated with vicarious trauma including, demographic factors, occupational factors and personal factors.

**Chapter Three**

Chapter Three pertains to the theoretical foundation of this dissertation: a theoretical understanding of defence style. The theoretical foundation highlights the notion of defence from a psychodynamic perspective. This chapter includes definitions for defence mechanisms and brief descriptions of individual defences. Furthermore, defences are discussed in terms of their hierarchical nature and how they contribute to particular defence styles. The chapter concludes with a section on therapists' use of defences, highlighting the effect defences have on mental health professionals.

**Chapter Four**

Chapter Four includes the data analysis and interpretation of results. This chapter begins by explaining the research objectives and questions. Following this is an explanation of the quantitative, positivist approach in research design. Sampling and sampling method are discussed next, followed by location of the study and data collection methods and procedures. A brief description of each instrument used is provided, followed by the method of analysing data which includes a description of both descriptive (Frequencies, mean and standard deviation) and inferential statistics (Little's MCAR, Multivariate Regression and Correlation). The chapter ends with a discussion on reliability, validity, ethical considerations and risks/benefits.

**Chapter Five**

Chapter Five provides a discussion of the quantitative results. After a brief introduction, the chapter begins with a discussion on the reliability and integrity of the results. This includes Little's MCAR test which was the initial step in safeguarding the integrity of the data. This is followed by the reliability results of both ProQol and DSQ 60 scales. Descriptive statistics are provided next followed by the correlation results pertaining to research questions 1 and 2. A table of results is also provided for correlations between demographic variables and professional quality of life. Although it was not the purpose of this study, correlations between demographic factors and defence style are also provided to determine whether they should be considered pertinent. The multivariate regression results are discussed next. Lastly, additional multivariate results are provided in relation to demographic variables followed by the conclusion of results.

**Chapter Six**

Chapter Six comprises the discussion of the main results of the study. It is a consolidation of the results in relation to relevant literature. This chapter includes a discussion on defence style and vicarious trauma, including implications. In addition, the various factors associated with vicarious trauma are discussed, with implications.

**Chapter Seven**

The final chapter of this study is the conclusion chapter which includes the limitations of the study and recommendations for further research.

# CHAPTER TWO

# LITERATURE REVIEW: VICARIOUS TRAUMATIZATION

## 2.1. Introduction

While vicarious traumatization is a contemporary concept, the understanding of it is vital for the fortitude of the field of Psychology (Holstien, 2011). It is imperative for the wellbeing of therapists that vicarious trauma be highlighted in research in order to promote their health and decrease its incidence. It appears that recent research has escalated in the area of clinician wellbeing and development of vicarious trauma. Many researchers are interested in the complex factors that are associated with clinicians, in order to discover what makes them successful and efficient therapists. Research has highlighted that cognitive, emotional and relational characteristics of therapists can differentiate therapist efficiency (Jennings & Skovholt, 1999), and could possibly contribute to clinician vulnerability to vicarious trauma. One hears news stories of violent crimes taking place and horrendous traumas suffered by individuals around the world, but what happens to the therapists who are there during the journey to recovery? It appears that the impact this has on therapists is less of a concern for the profession. It is not apparent how therapists are able to sustain a professional stance and cope in a personal capacity after entering into numerous therapeutic relationships with victims of trauma.

Researchers have highlighted numerous factors associated with the development of vicarious traumatization, such as personal history of trauma, supervision engagement and clinical caseload (Adams & Riggs, 2008; Badger, Royse, & Craig, 2008; Brady, Guy, Poelstra, & Browkaw, 1999; Cunningham, 2003; Elwood, Mott, Lohr & Galovski, 2011; Ghahramanlou & Brodbeck, 2000; Jordan, 2010; Kassam-Adams, 1995; Meyers & Cornille, 2002; Schauben & Frazier, 1995; Sprang, Clark, & Whitt-Woosley, 2007). Vicarious trauma can cause a number of negative changes in the clinician that can transform their clinical efficiency and personal grounding (Pearlman & McKay, 2008). Therefore, it is imperative to understand how vicarious trauma originates, in order to strategize preventative measures. The literature review highlights the relevant research pertaining to vicarious trauma and associated factors.

## 2.2. Trauma Defined

As mentioned in the introduction, there are numerous definitions for *trauma*. Literature has postulated that situations or events can become traumatic when the experience in an individual's existing memory scheme is disrupted during the process of integration (Janet, 1889, as cited in Van der Kolk, 1987).

McCann and Pearlman (1990, p. 10) separate the definition of trauma in three parts:

> Trauma can be defined as "(1) sudden, unexpected, or non-normative, (2) exceeds the individual's perceived ability to meet its demands, and (3) disrupts the individual's frame of reference and other central psychological needs and related schemas".

It appears that trauma can affect individuals in different ways – not everyone may be affected by what others perceive as traumatic. Kira (2001) explained that traumatic triggers/stimuli occur in a manner that is not customary for the individual experiencing them, and causes both physical and mental stress. According to Kira (2001, p. 73), "Traumas are the out of the ordinary stressors that have low expectancy, probability, and controllability". In other words, it is not possible to predict when a trauma may negatively affect a person. As a result, it is something that occurs randomly and without the general ability to control the outcomes. General stressors can have a variety of effects on individual functioning and according to the diathesis-stress model, individuals have a certain degree of susceptibility when triggered (Kira, 2001). Giller (1999) explains trauma as an extreme form of stress that can overwhelm an individual's ability to cope effectively.

The DSM 5 classifies trauma and stressor-related disorders as pre-empted by "exposure to a traumatic or stressful event" (American Psychiatric Association, 2013, p. 265), with the clarification that "psychological stress following exposure to a traumatic or stressful event is quite variable". The recent change to the criteria for Post-traumatic Stress Disorder has also had significant implications for the understanding of trauma and *vicarious trauma*. Previously the DSM included a prerequisite for the diagnosis of PTSD that included only direct exposure to a traumatic event. The renewed classification of PTSD in 1994 included the criterion that repeated exposure to adverse details of traumatic events (together with work related incidents) can be associated with a diagnosis of PTSD (American Psychiatric Association,

1994). Since the addition of this criterion, there have been developments within the assessment realm of vicarious trauma. Psychometric developers appear to have incorporated symptomology similar to the criteria for PTSD in order to provide some measure for vicarious trauma. It appears that the new criterion for PTSD opened up the prospect of vicarious trauma being conceptualized and considered within this broader diagnostic classification.

### 2.3. Trauma in context: South Africa

The consequences of high levels of violence and traumatic burden in South Africa have been documented by a number of studies (Atwoli, Stein, Williams, Mclaughlin, Petukhova, M., Kessler & Koenen, (2013); Kaminer, Grimsrud, Myer, Stein & Williams, 2008; Williams, Williams, Stein, Seedat, Jackson & Moomal, 2007; Sui & Padmanabhanunni, 2016). According to Williams *et al*., (2007, p 845) "Trauma is deeply rooted in the South African society". It is evident in the literature that South Africa is characterized by high crime rates (Williams *et al*., 2007). The results of the South African Stress and Health (SASH) study publicized that the highest lifetime prevalence of a mental disorder in South Africa is Anxiety Disorders[1] (Herman, Stein, Seedat, Heeringa, Moomal, & Williams, 2009). Although Anxiety Disorders are prevalent worldwide, the SASH study revealed that 36 % of their sample had experienced severe cases of PTSD (Herman *et al*., 2009). Williams *et al*. (2007) note that such high crime rates are related to psychological consequences. Shaw (2002, as cited in Kaminer *et al.,* 2008) explained that South Africa has one of the highest rates of violent crimes), and it has been noted in research that the consequences of violence are one of the leading causes of PTSD.

Sui & Padmanabhanunni's (2016) phenomenological study on Vicarious Trauma in South Africa provides an in-depth analysis of the experiences of South African Psychologists who have worked with trauma survivors. The results of this study reported that the participants "experienced disruptions in cognitive schemas characterized by cyclical views of the world and others" (Sui & Padmanabhanunni, 2016, p. 129). Sui & Padmanabhanunni (2016) reported that the symptoms experienced by participants were 'sub-clinical', and derived from the criteria used to diagnose PTSD (p. 129). Other experiences noted by Sui & Padmanabhanunni (2016) include recurrent intrusive memories, persistent negative emotions,

[1] Prior to the publication of the Diagnostic and Statistical Manual 5th Edition - DSM 5, the DSM IV-TR classified PTSD under the spectrum of Anxiety Disorders.

alterations in arousal and reactivity, and somatic symptoms. Further, Sui & Padmanabhanunni (2016) report 'vicarious post-traumatic growth' as a positive transformation that occurs from working with trauma survivors. Overall the article provides ample evidence to the existence of vicarious trauma in the South African context and also highlights how Psychologists experience the phenomena.

With regards to prevalence amongst mental health professionals, van Mol, Kompanje, Benoit, Bakker & Nijkamp (2015), provide a systemic review of the prevalence of burnout and compassion fatigue amongst healthcare professionals who work in Intensive Care Units (ICU). van Mol *et al.,* (2015) identified thirty studies that discuss the emotional distress related to working with victims of trauma. This study in particular highlights the environment as a potential stress inducing factor (van Mol, 2015). With the high rates of trauma related cases, mental health professionals are also exposed to an increased frequency of trauma incidents. Exposure to such incidents can have adverse effects on an individual's mental health (Williams *et al*., 2007). One of the consequences of this for a mental health professional is a higher vulnerability towards vicarious trauma.

### 2.4. Vicarious Traumatization, Secondary Traumatic Stress, Compassion Fatigue and Burnout: Conceptual Clarity

Since 1990 when McCann and Pearlman coined the term *vicarious traumatization*, many researchers have struggled with distinguishing between it and other concepts such as burnout, secondary trauma or compassion fatigue. While all four of these terms have their place in psychology, vicarious traumatization has been specifically linked to difficulties experienced by mental health professionals who are exposed to clients presenting with trauma-based difficulties (Figley, 2002; McCann & Pearlman, 1990). However, what differentiates the above mentioned concepts from one another? One of the original theorists on vicarious traumatization, Charles Figley (1999), used the term *compassion fatigue.* It was suggested by Figley (1999) that therapists who deal with traumatized clients are more at risk of developing symptoms of trauma due to empathetic engagement with the client and their trauma. According to Newell and MacNeil (2010), vicarious trauma, secondary trauma and compassion fatigue have commonalities as they are all related to work involving traumatic content. Burnout on the other hand, is considered a phenomenon that can be linked to any social service or work environment, and although it can be, it is not primarily linked to

secondary exposure to trauma and can manifest in a number of professions (Newell & MacNeil, 2010). In the literature, the term *secondary trauma* appears to be most associated with compassion fatigue, as it was Figley (1995) who made the association in order to broaden the understanding of the concept and to make it more understandable to the lay person.

Research and conceptualization on vicarious trauma indicates two schools of thought; some authors make clear distinctions between the different terms while others regard them as interchangeable. This has caused considerable ambiguity and confusion around the difference between concepts; the following sections are an attempt to define and clarify each viewpoint. For the purposes of clarity, each concept is reviewed individually and a discussion on interchangeability follows.

### 2.4.1. First School of Thought: Clear Distinction

#### 2.4.1.1. Burnout

"As a metaphor for draining of energy, burnout refers to the smothering of a fire or the extinguishing of a candle" (Schaufeli, Leiter, & Maslach, 2009, p. 205).

Pines and Aronson (1998, as cited in Newell & MacNeil, 2010, p. 58) define the phenomenon of burnout as "a state of physical, emotional, psychological, and spiritual exhaustion from chronic exposure to (or practice with) populations that are vulnerable or suffering"). According to Newell and MacNeil (2010), burnout occurs over time and is related to the individual, as well as to contributing external factors. Leiter and Maslach (2001, p. 145) describe burnout as an accumulation of "overwhelming exhaustion; feelings of frustration, anger, and cynicism; and a sense of ineffectiveness and failure". Common amongst most definitions of burnout is the gradual onset over time, usually beginning with feelings of hopelessness with regard to subjective work efficacy (Leiter & Maslach, 2001; Newell & MacNeil, 2010).

Maslach (1998, as cited in Newell & MacNeil, 2010) points out that emotional exhaustion, which is a significant feature of burnout, is subsequent to the demands of clients, superiors or

companies, which leaves the individual with depleted emotional resources available to them. The emotional exhaustion creates a feeling of reduced personal achievement and lack of confidence in subjective abilities (Newell & MacNeil, 2010). Burnout appears to describe a type of strain between a person and their relationship with work (Clarke, 2007). The *strain* described has both interpersonal and intrapersonal effects on wellbeing. Clarke (2007) explains that certain interpersonal effects, like depersonalization (cynicism), produce 'negative or detached responses' to parts of the individual's work (Clarke, 2007, p. 7). In turn, individuals begin to feel incompetent at their job and too exhausted to continue the work they previously enjoyed. However, it seems that burnout for a therapist, given their innate sense of responsibility towards their clients, can prevent them from acknowledging the signs of burnout and often leads to the overriding of the therapist's own difficulties (Wolfe, 1981). According to Wolfe (1981), the end result is both physical and emotional fatigue.

A defining feature of burnout is that it is *not* an outcome of trauma specific work (Newell & MacNeil, 2010). However, research has shown that burnout predominantly occurs in 'human service work in general' (Newell & MacNeil, 2010, p. 59), placing clinicians at a higher risk for burnout. Therapists are required to deal with various emotional responses in therapy sessions and according to Maslach, Schaufeli and Leiter (2001, as cited in Newell & MacNeil, 2010, p. 59), "requirements to either repress or display emotions routinely, as well as the chronic use of empathy, are strongly associated with the experience of professional burnout".) In addition to emotional exhaustion, burnout sufferers also begin to feel negatively towards their clients (Schaufeli *et al*., 2009) leading to the assumption that they could become dangerous treatment providers in a clinical setting (Wolfe, 1981). In summary, burnout, from a clinical and professional outlook, can mean detrimental negative effects for both the therapist and client (Wolfe, 1981).

#### 2.4.1.2. Compassion Fatigue and Secondary Trauma

Compassion fatigue is a term that originates from research by Charles Figley. Figley (2002) describes compassion fatigue as a secondary traumatic reaction, which is one reason why in many studies there remains a lack of clear distinction between these two particular concepts. Given this lack of clarity, it seems imperative to discuss these two concepts in one section. According to Figley & Kleber (1995), the term compassion fatigue has been used in place of

secondary traumatic stress because it is easier for the lay person to understand and use. Therefore, it is clear that the terms secondary traumatic stress and compassion fatigue have been used interchangeably. However, there are some distinctions that have been highlighted in the literature. Figley (1995) states concisely that compassion fatigue is the reduced ability to bear the suffering of others as a result of a secondary traumatic reaction from listening to client narratives.

Figley (2002, p. 1435) defined compassion fatigue as:

> "a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders and persistent arousal (e.g., anxiety) associated with the patient. It is a function of bearing witness to the suffering of others".

In other words, compassion fatigue can occur as a natural reaction that originates from caring for another person who has been traumatized. Unlike burnout, which was previously outlined, compassion fatigue occurs as a reaction to a trauma, that is, from listening to or witnessing another individual's trauma. Figley & Kleber (1995) were clear about the *natural* consequence that occurs from caring for another person who has been traumatized, leading to a direct physical effect on an individual (Figley & Kleber, 1995; Figley, 1999). In line with this, Figley (1995) further classified compassion fatigue as including symptoms of PTSD. It was noted in his research that the individual can be traumatized secondarily following a single incident/exposure to a traumatic narrative which can give rise to symptoms almost indistinguishable from PTSD (Figley, 1995). However, along with the symptoms of PTSD, compassion fatigue is also seen as related to the emotional and spiritual exhaustion that is felt by the individual – an exhaustion that occurs as a consequence of a loss or reduction of compassion (Holstein, 2010). According to Figley (2002), individuals begin to identify with the helplessness and suffering of traumatized individuals.

In addition, Devilly, Wright and Varker (2009, p. 375) point out that there are three distinct features of compassion fatigue. These features include typical PTSD symptoms such as intrusion, avoidance and hyperarousal which have been labelled as 'compassion stress' or secondary traumatic stress. Burnout has been incorporated as another feature of compassion fatigue as well as compassion satisfaction as the third feature (Devilly *et al.*, 2009). It was thought that these three features were predictive of vulnerability to developing compassion

fatigue. However, there is no definite research that identifies the interrelatedness of these features (Devilly *et al.*, 2009). In essence, it appears that compassion fatigue comprises both secondary traumatic stress and burnout components. Figley (2009, as cited in Holstein, 2010 p.14) did, however, make a distinction in the definition of compassion fatigue and secondary trauma, explaining compassion fatigue as a "state of exhaustion and dysfunction (biologically, psychologically and socially) as a result of prolonged exposure to compassion stress [a.k.a. *secondary traumatic stress*]", therefore implicating secondary trauma as the *stressor* which prompts the development of compassion fatigue.

Secondary traumatic stress was defined by Figley (1995, p. 7) 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".

A distinction can thus be made between compassion fatigue and secondary traumatic stress. It appears that the literature differentiates the two (compassion fatigue and secondary traumatic stress) by reference of a *secondary* trauma, or a trauma experienced by someone else, acting as a trigger for the development of compassion fatigue (Figley, 2007, as cited in Holstein, 2010). It is also distinguishable from burnout as it involves secondary exposure to a stressful or traumatic incident. Further, the definition of secondary trauma appears more as a physical reaction occurring as a response to another individual's traumatic event to the point that they themselves begin to experience similar symptoms to the victim (Baird & Kracen, 2006; Figley, 1995). Moreover, literature points to secondary traumatic stress as a "set of psychological symptoms" that are closely related to a diagnosis of PTSD (Baird & Kracen, 2006, p. 181). The response and onset of symptoms associated with secondary traumatic stress have been explained as sudden and can occur after one session with a traumatized client (Figley, 1995). Compassion fatigue, as explained above, is thereafter an emotional phenomenon that is rooted in the overarching need to care for a client or victim of a trauma, to the point that personal wellbeing is neglected (Holstein, 2010).

The important point to make note of is that compassion fatigue and secondary trauma are closely related concepts and usually do not exist without the other (Figley, 1995). With trauma therapy, a therapist may experience symptoms such as intrusion or avoidance (secondary traumatic stress), which can in turn lead to a loss of compassion and emotional

exhaustion (compassion fatigue). It is a complex phenomenon, that appears very similar to the concept of vicarious trauma. It is for this reason that literature discusses the proverbial overlap between these terms. The similarities discussed in research studies are highlighted further in this literature review.

#### 2.4.1.3. Vicarious Trauma

Distinguishing vicarious trauma from the other concepts discussed is difficult. Although there remains a "lack of conceptual clarity" (Craig & Sprang, 2010, p. 320) surrounding these terms, these authors refer to vicarious trauma as describing "cognitive-emotional-behavioural changes" that are experienced by health professionals due to the secondary effects of trauma. Such changes have been linked to exhaustion, angry outbursts, detachment from painful dealings, fear, and sleeplessness (Berzoff & Kita, 2010). Vicarious traumatization has also been described in the literature as being similar to PTSD (Adams & Riggs, 2008; Berzoff & Kita, 2010; Wilson & Lindy, 1994).

McCann and Pearlman (1990) originally described vicarious traumatization as pervasive changes that happen within a therapist who has been working with a victim of some traumatic incident. McCann and Pearlman (1990) included *change* in the therapist's spirituality and worldview, interpersonal relationships, behaviour and sense of self as symptomology of vicarious trauma. Interestingly, Herman (1997) referred to vicarious traumatization as a form of traumatic countertransference, where the therapist would experience the patient's emotions, albeit with less intensity. It appears that the understanding of countertransference creates a good background for understanding vicarious trauma (McCann & Pearlman, 1990). McCann and Pearlman (1990) note that traumatic images, thoughts, as well as feelings associated with trauma work are incorporated into the writings of both vicarious trauma and countertransference. It has been highlighted, however, that vicarious trauma is a broader concept because it considers features of the therapist *and* the situation (Dunkley & Whelan, 2006; McCann & Pearlman, 1990). In comparison to burnout and vicarious trauma, for example, countertransference only emphasizes the therapist's personal characteristics when reacting to the trauma narrative (McCann & Pearlman, 1990). Although burnout is not primarily associated with mental health professionals, they are at risk for burnout just as much as any other professionals. However, *burnout*, in this instance, would be associated

with individual features of a particular stressor. Vicarious trauma on the other hand, places emphasises on both inherent features of the therapist *and* the situation (McCann & Pearlman, 1990).

In addition, those who see vicarious trauma as a distinguishable category also tend to use a different theoretical foundation, which is embedded in the constructivist self-development theory (Clarke, 2010). The basic understanding of this theory is that a trauma narrative can "disrupt the counsellor's imagery system of memory, as well as schema about the self and others" (McCann & Pearlman, 1993, as cited in Dunkley & Whelan, 2006, p. 109). Dunkley & Whelan (2006) note that this theory accounts for response differences depending on personal trauma experiences that could be similar to those of the client. According to the theory, an individual develops unique cognitive structures which provide the bases for constructing their own reality and interpreting situations (McCann & Pearlman, 1990). Disruption of these cognitive schemas can have several adverse effects on the therapist's wellbeing and fundamental needs (McCann & Pearlman, 1990). Sabin-Farelle & Turpin (2003) emphasize that severe psychological effects experienced by therapists can be long lasting and cause changes in one's professional- and personal-identity (Saakvitne & Pearlman, 1996; Sabin-Farelle & Turpin, 2003). Moreover, a therapist's unresolved trauma can result in emotional distancing and the inability to sustain sincere and empathic responses (McCann & Pearlman, 1990).

Furthermore, Howlett and Collins (2014) note that there are conceptual problems with the definition of *compassion fatigue* which contributes to misunderstanding of the other concepts (i.e. secondary trauma and vicarious trauma). What is evident in the literature is that the term compassion fatigue, whilst seeming similar to vicarious trauma, encompasses (1) a negative response to a client as a result of *compassion* rather than resulting from the trauma narrative; (2) mental or physical fatigue (Howlett & Collins, 2014). Vicarious trauma differs from other concepts as it is seen as a direct result of working with victims of trauma, rather than encompassing other factors of emotional stress. Vicarious trauma may differ with regard to theoretical foundation; however, with regard to symptomology, there is a clear overlap between all *four* concepts which has caused great confusion in the literature.

### 2.4.2. Second School of Thought: Interchangeable Concepts

It seems that much of the literature has yet to clarify the conceptual confusion around vicarious trauma and other concepts. Although all four concepts do seem to have some differences in the literature, there are many authors who discuss these terms interchangeably (Bride *et al*., 2007; Dunkley & Whelan, 2006; Figley, 2002; Howlett & Collins, 2014; Huggard & Nimmo, 2013; Stamm, 2010) adding to the overall confusion of whether these concepts are in fact the same or conceptually different. Looking at the definitions for vicarious trauma, it is clear that it is similar to how both compassion fatigue and secondary traumatic stress are described, especially with regard to physical symptomology, making it difficult to distinguish between the concepts. Vicarious trauma, appears to be a concept that incorporates elements of burnout, secondary trauma and compassion fatigue, in an effort to conceptualize them into one working definition of work related trauma – that is both indirect and specific to the therapist/helper. These concepts (excluding burnout) are ultimately all "used to describe the potential impact on health professionals working with traumatized patients and clients." (Huggard & Nimmo 2013, p. 37). These concepts highlight the impact of work related stress or indirect exposure to stress that affects the therapist negatively (Stamm, 2005). It has been noted by Stamm (2010) that these negative outcomes can *lead* to vicarious trauma. According to Stamm (2010, p. 9), the issue of conceptual clarity is one that has been discussed in the literature for a long time and "continues to be a taxonomical conundrum".

It has already been established in this literature review that the terms compassion fatigue and secondary trauma have been used interchangeably (Figley, 1995; Figley, 1999). With the exception of understanding secondary trauma as a trigger for compassion fatigue, they have been regarded as the same concept. As for vicarious trauma, the shared symptomology between these terms could place vicarious trauma in the same category. For instance, each concept refers to PTSD symptomology as a clinical feature (Adams & Riggs, 2008; Berzoff & Kita, 2010; Figley, 1995; McCann & Pearlman, 1990; Wilson & Lindy, 1994). It seems that there is a huge overlap in physical symptoms which cannot be ignored. In line with this is the association with trauma therapy. Each concept clearly links symptomology with some form of secondary exposure to trauma through trauma therapy with a client/patient (Figley, 1995; McCann & Pearlman, 1990). It appears that in a broader context, these terms cannot be clearly defined because of such similarities. Looking at the original classification of vicarious

trauma by McCann & Pearlman (1990), the definitional difference appeared to be the association with intrinsic changes within the therapist, which in turn affects their emotions, feelings about the self, and spiritual changes. However, other authors discuss both compassion fatigue and secondary trauma as being associated with emotional and spiritual sectors of the therapist's life (Figley, 1999; Holstein, 2010). Therefore, no clear distinction can be made between these concepts. Figley (1999) attempted to distinguish between vicarious trauma and secondary traumatic stress as the accumulation of exposure to the pain and suffering of others being specific to vicarious trauma. Secondary traumatic stress on the other hand, can occur after a single session and onset can be sudden. Therefore, for the purposes of clarity, it is possible to view vicarious trauma, secondary traumatic stress and compassion fatigue as comprising similar symptomology with differing exposure.

Parallel to this, is the issue of assessment of vicarious trauma. With conceptual clarity lacking, assessment of these concepts is not an easy endeavour for any researcher interested in measuring vicarious trauma. Stamm (2005, p. 4) developed the Professional Quality of Life Scale (ProQol) as a tool to assess "compassion fatigue or secondary/vicarious trauma". This statement alone has conceptual issues. However, Stamm (2005) attempts to clarify this by contending that compassion fatigue and secondary traumatic stress are related to vicarious trauma. Stamm (2010) developed the ProQol as an assessment measure to test for the negative effects of secondary exposure to trauma. In essence, the scale appears to have been developed without a clear distinction between these concepts, but rather considering the broader context of secondary exposure to trauma. The subscale of 'compassion fatigue' incorporates elements of secondary trauma, and as highlighted by Stamm (2010), secondary trauma is related to vicarious trauma through similar characteristics. Currently, the ProQol is the most commonly used instrument to measure the negative effects of work related trauma, whether it be compassion fatigue, secondary traumatic stress or vicarious trauma (Stamm, 2010). The scale itself has also shown good construct validity in over 200 published papers (Stamm, 2010).

Sabin-Farrell and Turpin (2003, p 453) provide a summary of the important features of all the concepts in an attempt at redefining the phenomena under one umbrella:

> (1) cognitive, emotional, behavioural, and physical responses, which might be considered as a normal response to hearing traumatic material;

(2) symptomatic responses, which might be considered as extreme versions of the responses described in 1;
(3) cognitive changes in beliefs and attitudes; and
(4) additional effects on interpersonal and occupational functioning.

In conclusion, there does not appear to be enough evidence to accept that these terms (excluding burnout) are completely different from one another. There are far too many authors that highlight the similarities between the concepts in an effort to explain that they are interchangeable. Despite the slight differences noted in the above sections, all three concepts are in fact very similar and relate to the same fundamental issues: (1) trauma, (2) secondary exposure, and (3) negative effect on the clinician. The fact that all four concepts share most of the same symptomology provides evidence that more research is necessary prior to classifying these concepts separately. Therefore, in this dissertation, the term vicarious trauma is used interchangeably with the other concepts discussed. However, the lack of conceptual clarity and inability to separate these concepts at this time are also acknowledged.

### 2.6. Impact of Secondary Exposure to Trauma: Trauma Treatment & Implications

Psychotherapy with traumatized victims can be emotionally taxing and draining on the therapist. Therapists are sounding boards for their clients' non-fictional narratives that involve rapes, assaults, natural disasters, death, motor vehicle accidents and so forth. It also happens that certain modalities used to treat traumatic disorders involve telling and re-telling of the story, to which the therapist would then actively listen (Eagle, 1998). It appears that this alone could cause one to be vulnerable towards developing vicarious trauma due to the emotionally taxing process involved in the re-telling process. The question, however, is what differentiates one therapist from another who may not develop vicarious traumatization. Researchers have attempted to answer that very question. Empirical studies allude to different factors that play a role in the development of vicarious trauma. However, in order to dissect the context, it seems imperative to highlight the common trauma treatment modalities in South Africa and factors related to trauma treatment.

### 2.6.1. Therapeutic modality

#### 2.6.1.1. WITS Trauma Model

Although various therapeutic modalities can be utilized for trauma therapy, a common mode of therapy for traumatic cases in South Africa is the WITS Trauma Model (Eagle, 1998). This model encourages the client to narrate the sequence of the traumatic event to the therapist. The narration of the traumatic event will then be repeated throughout the trauma therapy. Eagle (1998) emphasizes the benefits of the Wits Trauma Model in terms of its integrative approach and application to the South African context. It is also important to note that this model is designed only for short term, uncomplicated trauma cases (Eagle, 1998). However, in saying this, it appears to be a relevant model in the South African context, especially considering the high turnover of trauma cases in low resourced areas, that require short term interventions. This section summarizes the model for the reader and discusses the potential risks for the therapist.

The WITS Trauma model comprises five parts;

1. Telling/retelling the story.
2. Normalizing the symptoms.
3. Addressing survivor guilt or self-blame.
4. Encouraging mastery.
5. Facilitating creation of meaning.

Therapy would typically begin with the client's chronicle of events. Eagle (1998) explains the initial phase as a factual process, with thoughts and feelings only being processed after the story has been delineated for the therapist. The next component of the WITS model is to normalize the symptoms the client may be experiencing. According to Eagle (1998), PTSD symptoms may surface causing a person to feel that they are not in the right frame of mind. The third step involves reframing the feelings of guilt or self-blame. People involved in traumatic situations tend to view their actions or behaviours in a negative way, requiring reframing (Eagle, 1998). The fourth step entails the encouragement of mastery. Eagle (1998) explains this step as a way to re-establish their former level of functioning by equipping them with the necessary skills to manage the anxiety and trauma. The final step in the process involves the therapist facilitating the 'creation of meaning'. This is accomplished by facilitating the process of the client figuring out why such a trauma happened to them. The

therapist here would need to be mindful of their own ideas so that they do not impose their own meanings onto the situation. It is a vital part of the healing process that the client constructs their own meaning around what has happened to them.

Although the model is based on empirical research, there has been some negative literature on the topic. Hajiyiannis & Robertson (1999) discuss the limitations of the model, suggesting that vicarious traumatization could be a possible risk factor for the therapist when engaging in trauma therapy. Van Wyk & Edwards (2005) also criticised the model for conceivably re-traumatising those who have experienced a trauma. Throughout the process involved in the WITS trauma model there appears to be a lack of emphasis on establishing a safe and secure relationship between client and therapist, which is a vital part of successful therapy. As one can imagine, the process of trauma therapy can be emotionally taxing for the client as well as the therapist. It seems that the client may also be vulnerable to re-traumatization without the establishment of a secure attachment relationship. Eagle (1998) emphasizes the use of this model for brief trauma interventions and not for complex trauma cases. It is possible that this could limit its use depending on the therapy required.

#### 2.6.1.2. Psychological Debriefing (Trauma Related)

Dyregrov (1997) emphasized the use of psychological debriefing following critical incidents in a number of cultures and countries. Debriefing can be helpful for both victims and helpers to prevent the reverberations of a traumatic incident (Dyregrov, 1997). According to Van Wyk and Edwards (2005), early psychological intervention is what has come to be known as 'debriefing' (Van Wyk & Edwards, 2005, p. 135). Literature explains that debriefing originated from the need to prevent symptoms of PTSD in victims of trauma (Van Wyk & Edwards, 2005). In South Africa, many counsellors and therapists are required to conduct debriefing sessions following traumatic incidents. Debriefing can be seen as a common mode of trauma treatment depending on the situation. According to Dyregrov (1997, p 589-590), "A psychological debriefing is referred to as a planned structured group activity, organized to review in details the facts, thoughts, impressions and reactions following a critical incident as well as providing information on typical reactions to critical events. It aims to prevent unnecessary aftereffects, accelerate normal recovery, stimulate group cohesion, normalize reactions, stimulate emotional ventilation, and promote a cognitive grip on the situation.". Debriefing usually occurs within the first days following a traumatic incident (Kenardy,

2000). The process of debriefing incorporates procedures that 'encourage and normalise emotional expression' (Kenardy, 2000, p. 1032).

Debriefing often occurs at the site of the trauma, and as mentioned previously, therapists are required to conduct a session, for example, in a place where a bank robbery may have occurred or a house break-in; not comfortable or safe environments to work in. Despite this, therapists and counsellors are usually at the scene when needed. It is possible that therapists are more at risk for vicarious trauma while debriefing after traumatic incidents. McCann and Pearlman (1990) note that vicarious trauma can result from simply being unable to process traumatic content. There is not sufficient evidence in the literature on the effects trauma debriefing has on the 'debriefer'/therapist. However, Wessely and Deahl (2003, p 14) advise against trauma debriefing for the 'debriefers' who may be at risk of being traumatised secondarily.

### 2.6.2. Implications

The empathic strain accompanying trauma therapy may have adverse effects on the therapist. In general, any form of counselling or therapy comprises an intense and emotional relationship with the client (Helm, 2010). It is well known in the field of psychotherapy that the therapeutic bond one has with one's client serves as the backbone for good therapy (Hunter, 2012). It is within that bond that therapists' vulnerabilities may lie. Therapists are made aware of the importance of empathy in therapy. However, what is far from awareness is how emotionally taxing it can be to continuously 'put yourself in the shoes of your client' and feel what they may have felt – especially when it comes to trauma therapy. Through the process of containing the client and facilitating healing, the therapist is vulnerable to empathic strain by dealing with agonizing emotions in the room. McCann and Pearlman (1990, p 134) state that "the potential effects of working with trauma survivors are distinct from those of working with other difficult populations because the therapist is exposed to the emotionally shocking images of horror and suffering that are characteristic of serious traumas". It is important, however, to note that *other* factors could also play a role in increasing one's vulnerability towards developing vicarious trauma; these are discussed in the following section.

## 2.7. Factors empirically associated with Vicarious Trauma

There has been copious research on the various factors that may be linked to the development of vicarious trauma, with varying results. According to Elwood *et al.,* (2011), there are many factors which might influence the development of vicarious traumatization including prevalence/severity, closeness to client, personal history of trauma and uniqueness of the traumatic event. Jordan (2010) highlights several factors implicated as affecting the severity of vicarious trauma symptoms. These include personal history of trauma, the perception of adequate trauma training, peer supervision, availability of social support, self-care and leisure, resiliency and stress buffers. Demographic factors have also been empirically associated with increased risk towards developing vicarious trauma including gender (Kassam-Adams, 1995; Meyers & Cornille, 2002; Sprang, Clark, & Whitt-Woosley, 2007) and age (Ghahramanlou & Brodbeck, 2000). Long term psychotherapy targeting sexual abuse (Cunningham, 2003) and occupational stressors (Badger, Royse, & Craig, 2008) have also been associated with vicarious trauma. Several studies appear to have found a strong link between the development of vicarious trauma and a history of personal trauma (Elwood *et al*., 2011; Jordan, 2010; Nelson-Gardell & Harris, 2003). The following sections highlight and discuss some of the factors that have been empirically associated with vicarious trauma.

### 2.7.1. Demographic Factors

As noted by Lerias and Byrne (2003), not all individuals who are secondarily exposed to trauma content will develop vicarious trauma. However, there have been numerous studies that have empirically linked certain factors to the development of vicarious trauma. Literature has highlighted the link between gender, (Kassam-Adams, 1995; Lerias & Byrne, 2003; Meyers & Cornille, 2002; Sprang, Clark, & Whitt-Woosley, 2007) and age (Ghahramanlou & Brodbeck, 2000), and vicarious trauma. In line with the previous classification of PTSD as an anxiety disorder, more females have been associated with anxiety disorders as compared to males (APA, 2000, as cited in Lerias & Byrne, 2003). According to other studies, the female gender is one of the paramount predictors of vicarious traumatization (Kassam-Adams, 1995; Lerias & Byrne, 2003; Meyers & Cornille, 2002; Sprang, Clark, & Whitt-Woosley, 2007). With regard to age, it appears that there is great variation in the way a stressor or trauma is perceived depending on developmental stage of the individual (Lerias & Byrne, 2003). However, the majority of empirical findings explain that younger individuals may have less

life experience, causing them to experience increased distress after exposure to traumatic content (Ensel & Lin, 1998, as cited in Lerias & Byrne, 2003). Younger individuals may also experience more symptoms and intrusive images than older, more experienced individuals (Lerias & Byrne, 2003). The literature appears to acknowledge that older and more experienced individuals may be less vulnerable to developing vicarious trauma. According to Way, Van Deusen and Cottrell (2007), however, there is a need for research that uses larger samples to assess the demographics that have been noted as an important area for further investigation.

### 2.7.2. Occupational Factors: Caseload, Experience Level and Supervision

*Caseload*

It appears that a higher caseload, especially coupled with a higher number of trauma cases, is associated with vicarious trauma (Brady, Guy, Poelstra, & Brokaw, 1999; Chrestman, 1995; Kassam-Adams, 1995; Schauben & Frazier, 1995). Furlonger and Taylor (2013) found a positive correlation between size of caseload and vicarious trauma. Their results show that a higher caseload is strongly associated with both vicarious trauma and negative coping styles (Furlonger & Taylor, 2013). According to Schauben and Frazier (1995), counsellors who had a higher caseload of sexual violence survivors reported higher frequencies of PTSD symptoms, self-reported vicarious trauma symptomology, more disrupted beliefs and negative affect; this is in line with the results of McCann & Pearlman's (1990) original hypothesis on the subject. According to Trippany, Kress and Wilcoxon (2004), therapists whose primary work is with trauma content, will have higher measures of vicarious trauma. This concurs with the assertion that higher caseloads of trauma in general will increase the chances of vicarious trauma.

According to Trippany *et al*., (2004, p 35):

> This implication is consistent with the research of Hellman, Morrison and Abramowitz (1987) who reported that counsellors indicated less work-related stress with a moderate number of clients on a weekly caseload than with a higher number of regularly scheduled clients.

*Experience Level*

Adams and Riggs (2008) point out that novice therapists may be more vulnerable to developing vicarious trauma. According to their study, trainee therapists with less applied experience showed impaired self-reference and a higher maladaptive/image-distorting defence style which predicted higher levels of dissonance in trainee therapists (Adams & Riggs, 2008). Pearlman and Saakvitne (1995) maintain that trauma training is highly important in the prevention or reduction of vicarious trauma incidents as it appears to help therapists handle difficult cases. Pearlman and Mac Ian (1995) explain that more experienced therapists have less disrupted schemas even when paired with a personal trauma history. Tripanny et al. (2004) highlight several other studies that provide evidence that trauma specific training can prevent vicarious trauma e.g. Alpert & Paulson, 1990; Chrestman, 1995; Follette, Polusny & Milbeck, 1994.

*Supervision*

Catherall (1995) found a strong link between the *lack* of formal peer supervision and vicarious trauma. According to Catherall (1995), novice therapists may require trauma-focused supervision in order to enhance their mental health and traumatology proficiency. It appears that peer supervision may serve as a buffer to developing secondary trauma symptoms. Tripanny et al. (2004) explain that peer supervision is also important as it allows for the normalization of the symptomology that the therapist may be experiencing, which also decreases the impact of vicarious trauma. Sommer (2008) highlights the usefulness of supervision in facilitating meaning-making and self-reflecting. According to Furlonger and Taylor (2013), supervision is a platform for therapists to reflect and process their emotions/reactions; this is viewed as a preventative in relation to vicarious trauma. Furlonger and Taylor (2013) were not able to find a positive association between vicarious trauma and supervision. However, their sample of online/telephonic counsellors (N=38) were all supervised and appeared to show positive coping styles.

Furlonger and Taylor (2013, p 90) state that:

> Overall, the findings from the present study added to the small body of literature related to the wellbeing of counsellors working in telephone and online environments, as the data suggested that with support from ongoing supervision the group of telephone and online counsellors maintained average levels of vicarious trauma and more positive styles of coping.

According to Pearlman (1995), vicarious trauma can be controlled or prevented if therapists keep a balance between work and leisure (Pearlman, 1995, as cited in Trippany *et al*., 2004). Tripanny *et al*., (2004) explain that supervision creates good networking for therapists, creating social support. Social support, according to Tripanny *et al*. (2004), increases the ability to *trust* which can be affected by vicarious trauma or secondary exposure to trauma content. Furlonger and Taylor (2013) highlight the lack of emphasis on the role of supervision in the development of vicarious trauma, and acknowledge the importance of more research on the subject.

### 2.7.4. Personal Factors: Personal History of Trauma, Empathy, Emotional Contagion and Defence Style

*Personal History of Trauma*

Literature on the clinician's personal history of trauma empirically links it to the development of vicarious trauma symptoms (Adams & Riggs, 2008; Elwood *et al*., 2011; Figley, 1995; Jordan, 2010; Nelson-Gardell & Harris, 2003; Pearlman & Saakvitne, 1995; Pope & Feldman-Summers, 1992). It is well documented in research that trauma can have myriad adverse effects on a person's wellbeing. Recent research is now highlighting the link between the personal history of a therapist and the development of vicarious trauma. According to Brewin et al. (2000), a previous exposure to a traumatic situation can possibly determine one's ability to cope (Brewin *et al*., 2000, as cited in Lerias & Byrne, 2003). Adams & Riggs (2008) found that approximately a third of their sample reported a personal history of trauma, which was linked to the development of vicarious trauma. Further, their analysis indicated that *defence style* appeared to be a moderating factor between vicarious trauma and personal history of trauma (Adams & Riggs, 2008).

Follette, Polusny and Milbeck (1999) discuss vicarious trauma in relation to mental health and law enforcement professionals, and highlight personal trauma histories as a risk factor for vicarious trauma. They found that 29.8 % of mental health professionals had a history of personal trauma (Follette *et al*., 1999). According to Pope and Feldman-Summers (1992), 33.1% of mental health professionals reported a history of childhood trauma and 36.6% reported a personal history of trauma in adulthood. Pearlman and Mac Ian's (1995) research

found that 60% of their sample had a history of personal trauma and those who had a personal trauma history also reported more symptomology of vicarious trauma than those without a history of trauma. Looking at these percentages it is evident that personal trauma is a frequent occurrence amongst mental health professionals. These figures may well be higher in more recent years and even higher amongst South African therapists given the high rate of crime and trauma incidents in the country. However, it appears that recent documentation is lacking in the literature. Pearlman and Saakvitne (1995) suggested that a personal history of trauma may attract therapists to working with survivors of trauma. However, according to Briere (1992, as cited in Follette *et al.*, 1999), mental health professionals' personal trauma can adversely affect therapist competency and efficiency at providing services to traumatized clients. Similarly, Figley (1999) explained that mental health professionals with a personal history of trauma have an increased risk for developing trauma symptoms as a result of direct work with trauma content. Follette et al. (1999) also point out that mental health professionals are primarily at risk for developing vicarious trauma as a consequence of simply working with traumatic material regardless of other factors. According to Sexton (1999, as cited in Howlett & Collins, 2014), the severity of symptoms as well as onset of vicarious trauma will differ depending on personal trauma history.

There is an abundance of empirical evidence that personal history of trauma increases the risk of developing vicarious trauma. At the same time, it is also important to note that some research asserts that there is variance with regard to the relationship between vicarious trauma and personal trauma history (Salston & Figley, 2003). Figley (1999) highlighted this issue and discussed the associated problems. According to Figley (1999), therapists tended to generalize their personal trauma and emphasize coping strategies that may have been beneficial for their own personal traumas. It seems that, while a history of personal trauma can increase their chances of vicarious trauma, it is also evident that therapists can become harmful treatment providers if they are unaware of such factors.

*Empathy and Emotional Contagion*

According to Sabin-Farrel and Turpin (2003), *empathy* is another possible factor involved in the occurrence of vicarious trauma. Rogers (1980, as cited in Sabin-Farrel & Turpin, 2003) explained that empathy plays a role in therapeutic change and is a vital part of any therapeutic relationship. As mentioned by Pearlman and Saakvitne (1995), vicarious trauma involves empathic engagement with trauma related narratives and material which consequently makes

the therapist vulnerable to vicarious trauma. Helpern (2003) explained that empathy involves an ability to emotionally resonate with a person in order to understand them. Emotional contagion on the other hand, is a rather unconscious type of process that involves experiencing and reflecting on another's distress (Sabin-Farrel & Turpin, 2003). It has, however, been documented that emotional contagion is associated with the process of empathy, linking the two concepts. Emotional contagion has been described as a way by which certain feelings or emotions are contagious and can be spread from one person to another (Sabin-Farrel & Turpin, 2003). It is best described as incorporating psychophysiological, behavioural and social phenomena (Hatfield, Cacioppo & Rapson, 1994). Hatfield *et al*. (1994) explained that emotions are communicated, tracked and recognized in therapy causing automatic emotional responses. According to Pearlman and Saakvitne (1995), this ability to almost synchronize with another's emotions can cause a vulnerability towards vicarious trauma. It appears that both empathy and emotional contagion can contribute to a therapist's vulnerability towards developing vicarious trauma, especially if the therapist is less aware of their vulnerabilities and is unable to monitor their own emotions (Sabin-Farrel & Turpin, 2003).

*Defence Style*

In addition, as mentioned, Adams and Riggs (2008) hypothesize that *defence style* may also be implicated in how the therapist experiences the patient's traumatic presentation. Defence style is discussed further in the next chapter – theoretical framework.

## 2.7. Conclusion

There are a number of important factors and variables worthy of further research when it comes to vicarious trauma. Such factors include trauma case load per week, hours of work per week, previous personal trauma, years of experience, years in practice, access to supervision, racial grouping, gender, and therapeutic modality. Another factor that has been studied more recently and that may influence the development of vicarious trauma is defence style. Although there is earlier research that postulated a relationship between defences and vicarious trauma (Adams & Riggs, 2008; Pearlman & Saakvitne, 1995), research in this area still remains in its infancy. While there are many factors listed above, they constitute either

external or fixed factors. Few studies have looked at ‘internal factors’ or psychological factors such as coping style, personality, sense of wellbeing or defence makeup as moderating factors. A study of defences is thus an attempt to consider these kinds of factors. The next chapter considers the relevant research pertaining to defence mechanisms/style in relation to vicarious trauma.

# CHAPTER THREE

# THEORETICAL FRAMEWORK: DEFENCE STYLE

## 3.1. Introduction

It is hypothesized in literature that defence mechanisms assist a therapist in managing the stress that emerges in therapy (Cramer, 2000). The DSM 5 explains that external stressors and emotional conflicts experienced by an individual are mediated by defence mechanisms which can be both adaptive and maladaptive (American Psychiatric Association, 2013*).* *Defence styles* refer to the typical pattern of defences defence used by an individual (Zeigler-Hill & Pratt, 2007). Literature has suggested that therapists who exhibit defence styles that are maladaptive are more prone to symptoms of vicarious trauma (Adams & Riggs, 2008; Pearlman & Saakvitne, 1995). On the other hand, Adams & Riggs (2008, p. 27) discuss that therapists who exhibit coping styles which are "characterized by active, problem focused strategies reported less PTSD symptoms, less vicarious traumatization, less negative affect, fewer disruptions in self-trust schemas, and less burnout". This appears linked to Bond's (2004) assertion that adaptive defences are related to the formation of a good therapeutic alliance, which essentially provides the basis for effective therapy.

Defence mechanisms are considered to be fundamentally linked to the manifestation of different kinds of pathology and therefore can be a major force in determining how a person may adapt to a situation (American Psychiatric Association, 2000). George Vaillant (1992, 1994) who has made key contributions to the study of defence mechanisms, stated that the type of defence style influences different responses to stressors. Vaillant, Bond and Vaillant (1986) maintain that defences can be hierarchically ordered into categories ranging from immature to mature defence styles. By organising defences into a hierarchy, it is possible to make note of the defence style a person may deploy. According to Thygesen, Drapeau, Trijsburg, Lecours and De Roten (2008), there are three defence styles that can be assessed using the Defence Style Questionnaire (DSQ-60). These are the Image distorting, Affect regulating and Adaptive styles (Thygesen *et al.,* 2008). According to Adams and Riggs (2008), a maladaptive defence style, such as image distorting, could increase the chance of developing Vicarious Traumatization.

The current study would be beneficial in determining the predictive ability of the three defence styles and their effect on vulnerability to vicarious trauma. Studies have found that immature defences can be linked to poor psychological functioning (Adams & Riggs, 2008; Bond 2004; Silverstein, 1996). If this is so, could defence style be linked to the development of Vicarious Traumatization? Recent research has hypothesized a link between defence style and vicarious trauma (Adams & Riggs, 2008; Pearlman & Mac Ian, 1995). The current study focuses on the role of defence style as a factor that could increase a therapist's vulnerability towards vicarious trauma; this is explored further.

## 3.2. Theoretical Positions on Defence Mechanisms

### 3.2.1. Defence Mechanisms Defined

Original research on defence mechanisms hypothesized that defences protect or defend the self against anxiety (Freud 1940, as cited in Adams & Riggs, 2008). The DSM-IV-TR concisely defined defence mechanisms as "automatic psychological processes that protect the individual against anxiety and from the awareness of internal or external dangers or stressors. Individuals are often unaware of these processes as they operate" (American Psychological Association, 2000, p. 807). Freud described defences as mental processes involved in keeping thoughts and affects, perceived as painful or difficult, out of awareness (Freud, 1915, as cited in Cramer, 2000). The majority of modern research has concentrated on the defences of *patients* in therapy (Adams & Riggs, 2008). However, Cramer (2000) hypothesized that *therapists* may use defence mechanisms in order to cope with the high levels of stress and negative emotions that can surface in a psychotherapy session. Given that therapists' emotions and unconscious drives always, to some degree, form part of the therapeutic relationship, this is a likely assumption. It appears that we have overlooked the possibility that, just like others, *therapists* also use defences in order to cope.

According to Vaillant (1974, as cited in Vaillant, 1994, p. 44):

> Defence mechanisms refer to innate involuntary regulatory processes that allow individuals to reduce cognitive dissonance and to minimize sudden changes in internal and external environments by altering how these events are perceived. Defence mechanisms can alter our perception of any or all of the following: subject (self), object (other), idea, or feeling".

Vaillant (1992) also explained how defence style can differentiate people with regard to their response to stressful situations. Defence mechanisms are considered important in the management of conflicts – both external and internal – and are thought to be central to a person's personality organization (Bonsack, Despland & Spagnoli, 1998; Schauenburg, Willenborg, Sammet & Ehrenthal, 2007).

Vaillant (1994, p. 44) highlights the important properties of defence mechanisms:

> (a) Defences are a major means of managing conflict and affect; (b) defences are relatively unconscious; (c) defences are discrete from one another; (d) although often the hallmarks of major psychiatric syndromes, defences are reversible; and (e) defences are adaptive as well as pathological.

According to Vaillant (1994), defences can be separated into those that appear healthy and those that are less healthy. Although the early work on defence mechanisms was initiated by Freud (e.g. 1894/1962), Vaillant later arranged the same defence mechanisms into a *hierarchy* of defences, including pathological, mature, immature and neurotic; these are discussed further in the study.

### 3.2.1. Brief Definitions: Common Individual Defences

It is important to know how individual defences work in order to understand the hierarchical categorization. The following section will provide a brief description of the main individual defences.

*Denial*

According to Freud (1938), in a world perceived as distressing, an individual's ego would fend off external stressors through disavowal of such perceptions or demands of reality (Freud, 1938, as cited in Vaillant, 1992). Due to the fine line between denial and repression, there has been considerable confusion in the literature. According to Freud (1927), in contrast to repression, which is used to control *affects*, denial is used to control *perceptions* of distressing/disturbing realities (Freud, 1927, as cited in Vaillant, 1992).

*Displacement*

According to Baumeister, Dale and Sommer (1998), shifting the target of an individual's impulses towards something else or someone else is what is referred to as displacement. In other words, displacement refers to the transferring of emotional reactions from either an object or a person to another. This defence allows individuals to express their feelings through objects or people that they perceive as less threatening. Literature suggests that displacement of aggression is most frequently studied as it is a more common use of displacement as a defence (Baumeister *et al*., 1998).

*Reaction Formation*

Reaction formation is explained as a means of "converting socially unacceptable impulses into its opposite" (Baumeister *et al*., 1998, p. 1085). In other words, an individual may behave in a manner they assume others would deem acceptable, or portray a trait they do not have (Baumeister *et al*., 1998).

*Projection*

According to Baumeister, *et al*. (1998, p. 1090), projection "in its simplest form, refers to seeing one's own traits in other people". Projection involves perceiving that others have certain traits that they themselves do not have, which is usually an inaccurate perception of the self (Baumeister *et al.,* 1998). Although projection can be viewed as cognitive bias because of the influence of self-concept (Baumeister *et al.,* 1998), Freud pointed out that projection can be considered a defence mechanism if the individual is perceiving a threatening trait which results in the avoidance of self-recognition of the same traits (Freud, 1915/1961, as cited in Baumeister *et al*., 1998).

*Splitting*

The concept of splitting is described in relation to the workings of the ego as a reaction to a conflict between reality and instinct (Vaillant, 1992). Freud emphasized that an individual's instinct is prohibited by reality which causes conflict and could result in an impairment in the ego (Freud, 1940, as cited in Vaillant, 1992). It is hypothesized that splitting can be resultant of pathological jealously in which "[t]wo psychical attitudes...one...which takes account of reality, and another which under the influence of the instincts detached the ego from reality" (Freud, 1938, p. 202, as cited in Vaillant, 1992, p. 12).

*Fantasy*

According to Freud, "phantasies" include all content that may have previously been defended against or repressed (Vaillant, 1992, p. 13).

*Humour*

The humour defence is hypothesized as being more adaptive and mature than most of the other defences (Vaillant, 1992). According to Vaillant (1992) Freud developed the understanding of humour as a mature defence as compared to wit. Freud discussed humour as a means "of obtaining pleasure in spite of the distressing affects that interfere with it" (Freud, 1905, p. 228, as cited in Vaillant, 1992, p. 20-21).

*Isolation*

According to Baumeister *et al.* (1998, p. 1099), isolation is a defence that attempts to create a "barrier between some threatening cognition and other thoughts and feelings". The barrier that is created does not remove the threat from consciousness but rather buffers the impact of the threatening thought (Baumeister *et al*., 1998).

*Undoing*

The act of *undoing* is associated with the reversal of 'hostile wishes' (Vaillant, 1992, p. 16) in an attempt to alter or change past events. According to Baumeister *et al*. (1998), some individuals attempt to imagine alternate outcomes of events, usually to compensate for a misfortune. Individuals who tend to ruminate on events are most likely to imagine alternative endings (Baumeister *et al.*, 1998).

*Sublimation*

When an instinct is expressed in an alternate form that is not related to the actual or original instinct, it is referred to as sublimation (Baumeister *et al*., 1998). This defence acts as a channel for unacceptable desires which are expressed in a socially acceptable manner in order to prevent any damage to self-esteem (Baumeister *et al.*, 1998).

*Suppression*

The defence of suppression occurs when the ego experiences distress (Freud, 1894, as cited in Vaillant, 1992). The consequence of this distress is the decision to forget about what caused such distress (Vaillant, 1992). However, the information *is* attainable and individuals are able

to recollect the experience unlike repression which is associated with unconscious material (Vaillant, 1992).

*Dissociation*

According to McWilliams (2010, p. 114), dissociation is a 'normal' reaction to a trauma. It can be described as a detachment from reality or a 'splitting of the mind' as a consequence of inability to cope with traumas or agonizing pain (Vaillant, 1992, p. 14).

*Repression*

McWilliams (2010, p. 118) describes repression as "motivated forgetting or ignoring". Repression, in essence, is the defence against harmful/threatening information that can upset the individual. Such information is pushed further from consciousness and remains unconscious (McWilliams, 2010).

*Rationalization*

Rationalization is a defence that is used when an individual fails to get something they may have wanted (McWilliams, 2010). In order to cope with this the individual may conclude that what they wanted was not as desirable as they once thought (McWillaims, 2010).

*Hypochondriasis*

According to Vaillant (1992), hypochondriasis refers to the defence against painful *affects*. It is explained as negative affects about others that would be transformed into negative feelings about the self.

*Passive-aggression*

According to Bloom (2008, p. 116), passive-aggression is a defence that "shows minimal assertiveness and seeks primarily to deny the existence of aggression". In other words, aggression towards others is expressed in an indirect manner, as opposed to overtly expressed aggression.

*Acting out*

Fenichel (1945) explains that 'acting out' describes the extreme behaviour by which unconscious feelings and thoughts are expressed (Fenichel, 1945, as cited in McWilliams, 2010). Such feelings/thoughts would be difficult to express, and thus the individual would

turn such passive thoughts into action, which is perceived as more powerful and less vulnerable for the individual (McWilliams, 2010).

### 3.3. Empirical Research on Defences

Empirical research has supported the existence and functioning of defence mechanisms in a number of ways. According to Baumeister *et al*., (1998), research in the field of social psychology has significant evidence for the use of defences in social settings when self-esteem is threatened (Baumeister *et al.*, 1988, as cited in Cramer, 2000). Hart & Chmiel (1992) conducted a longitudinal study on the influence of defence mechanisms on moral judgement. The researchers periodically interviewed males from the age of 13 until age 44 (Hart & Chmiel, 1992). By using Haan's (1977) "Q-Sort" the researchers were able to assess both immature and mature defences. The results of their research indicated that males with mature defence profiles appeared to reason at higher levels of moral judgement (Hart & Chmiel, 1992, p. 722). Cramer (2015) used a validated coding method along with the Thematic Apperception Test (TAT) and Defence Mechanism Manual in order to understand defences in both normal and pathological development. According to Cramer (2015) the TAT stories were coded for defence use and "show how defence use changes after a period of psychotherapy, and how defences change with age. Evidence for reliability and validity is provided, both from correlational and experimental studies" (Cramer, 2015, p. 40) Interestingly, more recent research has also highlighted the existence of defences through neuroimaging studies of the brain (Cortina, 2010; Olsen, Perry, Janzen, Petragia, and Presniak, 2011). Olsen *et al*. (2011) also highlight cognitive avoidance as empirically supported evidence of defence mechanisms in reference to retrieval errors.

### 3.4. Psychodynamic Understanding of Defences

In order to understand defences within the framework of this research, defences need to be explored from a psychodynamic perspective. This understanding is vital to the present study as it pertains to the defence makeup and character of the therapist. It is hypothesized that, depending on the defences they use, their vulnerability towards developing vicarious trauma would increase or decrease respectively. As Olson *et al*. (2011) have observed, defences have been a focal feature of psychodynamic thought since Freud published his early papers in

1894. Although literature has since evolved, within the psychodynamic framework, defences are thought of as healthy and creative adaptations which are used throughout a person's life (McWilliams, 2011). McWilliams (2011) emphasizes that defences also serve to maintain one's self-esteem. However, defences can become maladaptive or pathological when adopted rigidly across varying situations (e.g. highly threatening or emotional).

Psychodynamic psychology has discussed the role that defences play in different ways in everyday life. According to McWilliams (2011), *Ego* psychologists, for example, highlight the positive role that defences play in managing anxiety. Those who have an affinity towards *Object Relations*, underscore how defences are involved in separation and attachment and they also emphasize the role of defences in coping with grief (McWilliams, 2011). Another example provided by McWilliams (2011, p. 97) is that of *self-psychologists* who highlight "the role of defences in the effort to maintain a strong, consistent, positively valued sense of self." All approaches agree that individuals display a system of preferred defences which are linked to coping style, temperament and early childhood experiences (McWilliams, 2011).

It seems that there is consensus in psychodynamic literature that defences are initially immature and primitive in nature and operate in a global, undifferentiated way (McWilliams, 2011). McWilliams (2011, p. 98) explains that primitive or primary defences share two qualities: a "lack of attainment of the reality principle"; and a "lack of appreciation of the separateness and constancy of those outside the self". It is hypothesized that the more primitive defences develop prior to object constancy and experiences are categorized into all-good or all-bad. Primitive defences closely mirror how a child would perceive the world in a natural sense (McWilliams, 2011). Primitive defences as discussed by McWilliams (2011) include withdrawal, denial, projection, introjection, projective identification and splitting. Further, there are secondary or higher-order defences discussed in psychodynamic theory (McWilliams, 2011). Repression is discussed as one of the most basic of the secondary defences (McWilliams, 2011). McWilliams (2011) specifies other higher-order defences as regression, isolation, intellectualization, rationalization, moralization, compartmentalization, undoing, displacement, reaction formation, reversal, identification, acting out, sexualisation and sublimation.

Research on pathological or maladaptive defence mechanisms has highlighted the various adverse effects they can have. It has been discussed that pathological defences have a certain

rigidity and can be described as imbalanced defences. McWilliams (2011) explains that defences, whether pathological or not, work unconsciously to avoid or manage stressful, life threatening and anxiety provoking situations. Bond (2004) and Thygesen *et al*. (2008) further demonstrated that not only can defences affect a person's personality and coping style but also have an effect on the therapeutic alliance. Here, rigid and immature defences have been associated with a poor alliance.

### 3.5. Hierarchical Organization of Defences

Theories on defence mechanisms have evolved over the decades, with the current understanding of them as progressing hierarchically or defined in different levels (Vaillant, 1994; Bond, 1995). In order to address concerns over clinical validity and rater reliability of defence mechanisms, research was conducted on whether defences could rather be categorized into hierarchies of psychopathology (Vaillant *et al.,* 1986). Vaillant *et al's*., (1986) research confirmed that defences progress hierarchically. Vaillant (1994) expanded on Freud's understanding of defences as simply a mechanism to manage anxiety; and described defences as ranging from unhealthy responses to anxiety to healthy responses.

Vaillant (1994) described four levels of defences including Psychotic, Immature, Neurotic and Mature. The categorizing of defences in a hierarchical manner mirrors the stages of psychosexual development and allows for a better understanding of the progression of defences on a *continuum* (Berzoff, Flanagan & Hertz, 2008). It also makes it possible to describe different levels of ego functioning and organization in a slightly more reliable manner (Berzoff *et al.,* 2008) According to Vaillant (1994, p. 45), the defences categorized as immature defences 'underlie much personality disorder'. These include projection, fantasy, hypochondriasis, passive-aggression, acting out and dissociation. Vaillant (1994) explains that immature defences alter or distort an individual's relationship between self, object, idea and affect. These defences are most related to personality disorder and psychopathology (Vaillant, 1994). Therefore, individuals who use mature defences have better mental health and interpersonal relationships (Vaillant *et al*., 1986), which have implications for the overall wellbeing of therapists.

### 3.6. Clustering of Defences: Defence Style

Literature on defences asserts that *defence style* can contribute to how a person responds to stressful environments and this can be supported by empirical evidence (Vaillant, 1992). As do Vaillant *et al*. (1986), Bond (1995) also described defences as progressive in nature. This progression is considered as shifting from a high level of anxiety around control of impulses to a more adaptive style that focuses on the inner self and creative self-expression. The latter is seen as more adaptive when preoccupation with others is shifted to the self (Bond, 1995). Bond (1983, as cited in Nishimura, 1998, p. 419) suggested that defence mechanisms tend to cluster into styles which can be "ranked on a developmental continuum"). Originally, Bond (1995) hypothesized that defence styles allow for the identification of an individual's stage of development and provide more information on ego functioning. Other theorists have also recognized the progression of defences and their tendency to cluster into groups or defence *styles* (Bond, 1995; Haan, 1969; Semrad *et al*., 1973 as cited in Bond, 1995; Vaillant, 1994). Literature on defence style highlights the usefulness of clustering defences into styles rather than associating specific defences with illness or diagnosis, which can cause confusion (Bond, 1995).

According to Bond (1995, p. 205):

> Defences should refer to a style of dealing with conflict or stress, whereas diagnosis should refer to a constellation of symptoms and signs. Separating the examination of defences from the issue of diagnosis would allow the use of the concept of defence more precisely during investigation of fluctuations in a person's style when dealing with a particular stress at a particular time and under particular circumstances. The use of a style would also reveal something about the level of the individual's psychosocial development.

Bond and Wesley (1996, p. 1) explained that their research was a way "to elicit manifestations of a subject's characteristic style of coping with conflict, either conscious or unconscious", which they referred to as a person's defence style. Using the hierarchy of defences as a baseline for understanding the progression of defences, Bond (1995) categorized defences into clusters and considered these to be *defence styles* with the presumption that some styles are more mature than others. The Defence Style Questionnaire (DSQ) was one of the original tools developed to measure defence styles and Bond (1995)

reported its accuracy in discriminating between both adaptive and maladaptive defences. In his research determining the clusters of defence style, it was found that the same defences clustered together along a continuum (Bond & Wesley, 1996). It was suggested by Bond & Wesley (1996, p. 12) that the DSQ taps into "aspects of psychological functioning which have significant and unique implications for psychopathology".

Since the development of the original DSQ, there have been numerous revisions of the scale, as well as of the classification of defence styles. The latest revision of the DSQ by Trijsburg, Bond, Drapeau, Thygesen and De Roten (2005) includes three defence styles, namely image distorting, affect-regulating and adaptive. According to Thygesen *et al*. (2008), an image distorting style (presumed to be the most immature of defence styles) is made up of splitting of the self/other, projection, projective identification and help rejecting/complaining defences. Research indicated that the main feature of maladaptive defence styles is related to a person's conscious perception and their propensity to distort painful reality, which is empirically linked to poor psychological functioning (Punamaki, Kanninen, Qouta, & El-Sarraj, 2002; Silverstein, 1996, as cited in Adams & Riggs, 2008; Silverstein, 1996). According to Bond (2004), a maladaptive defence style (i.e. image-distorting) is significantly associated with mental illness. It appears that such maladaptive defences tend to distort reality in an attempt to restrict painful realities from entering the conscious (Bond, 2004). Other factors associated with maladaptive defences include depression, personality disorders, anxiety disorders and post-traumatic stress disorder. The Affect-regulating defence style comprises intellectualization, isolation and dissociation (Thygesen *et al*., 2008). The Adaptive defence style includes self-observation, self-assertion, anticipation, sublimation and homour (Thygesen et al., 2008, p. 177). According to Vaillant (1971), the more mature defences (like those mentioned in the Adaptive defence style) tend to operate more consciously than the immature defences (Vaillant, 1971, as cited in Adams & Riggs, 2008). According to Punamki *et al.,* (2002), the use of more mature defences, such as the adaptive defence style, serves as a buffer from the negative effects of trauma, and improves mental health.

### 3.7. Therapists and Defences

As with most elements of the human mind and behaviour, therapists too have individual traits and factors that can cause change or variance in their treatment or the way they approach

therapy. Some may be more resilient than others. Some may find it difficult to cope in stressful situations. Knowledge of the defence style of a therapist would make it possible to expand on the literature on therapist wellbeing. Despland, Bernard, Favre, Drapeau, Roten and Stiefel (2009) explain that 10% of the variance on psychological treatment is due to the therapist. Research on therapist wellbeing has highlighted various factors such as therapist's coping, stressful work environments and trauma related work as increasing the variance in treatment (Beutler *et al.,* 2004; Despland *et al.,* 2009; Elkin, Falconnier, Martinovich, & Mahoney, 2006). This variance in treatment has been linked to what is known as the *therapist effect* (Elkin *et al*., 2006). According to Elkin *et al*. (2006), therapist effect is the individual differences of a therapist that can change the treatment outcome in therapy. Therefore, it is hypothesized that there are factors *inherent* to individual therapists that can affect treatment and the overall wellbeing of the therapist. As mentioned in the literature review, defence style has been associated with therapist wellbeing and the development of vicarious trauma, which can be seen as an inherent feature of a therapist/individual (Adams & Riggs, 2008).

Research on therapists' *defence style,* however, appears limited. Nevertheless, there has been a recent advancement in this area of study. Schauben and Frazier (1995) and Weaks (2000) highlight the characteristics of therapists that have healthy coping styles. Some authors discuss defences in relation to coping (Cramer, 2000; Despland *et al*., 2009). Cramer (2000) on the other hand, discusses a clear distinction between coping and defences. According to Cramer (2000), the difference between coping and using defence mechanisms lies in the intentional or unintentional use of either (i.e. whether conscious or unconscious). Fleishman (1984, p. 229, as cited by Kramer, 2010) defines coping as "overt and covert behaviours that are taken to reduce or eliminate psychological distress or stressful conditions". However, Despland *et al.* (2009, p. 74) hypothesized that due to high levels of stress and negative affect that therapists would face in therapy sessions, they would "use defence mechanisms to cope". In saying this, it is possible to hypothesize that defences can be used as a way to cope with or manage stress and trauma. Therapists who display healthy coping styles such as active, problem focused strategies, have reported less PTSD related symptoms. Along with these findings, such therapists would display lower frequencies of vicarious trauma, burnout, and less negative affect and disruptions in self-trust as compared to individuals who utilize less adaptive or avoidant coping styles (Schauben & Frazier, 1995; Weaks, 2000).

A psychodynamic perspective on defences highlights the protective aspect of mental activity as a mediating factor between external reality and individual needs (Vaillant, 1992). According to Vaillant (1992), such mental activity responds to stressors – either internal or external – and would thus link a therapist's defences to their coping strategies in stressful situations. Despland *et al.* (2009) explored the defence mechanisms of therapists in difficult settings. According to the findings of the same study by Despland *et al.*, (2009), the use of rationalization (considered a weaker/more immature defence) can be related to the therapist's difficulty establishing an empathic bond with the patient and a lack of formal training around therapeutic skills. The results indicate that *communication skills training* assists therapists to change their defence functioning to more mature defences (Despland *et al*., 2009). The evidence that therapists are able to change their defence functioning can have implications for treatment of vicarious trauma if defence style is in fact associated with the development of vicarious trauma. Despland *et al*. (2009) also noted that, because defences can change after communication training they must be context specific.

According to Despland *et al*., (2009, p.78):

> A plausible explanation would be that improvable professional ability should be considered as an intermediary variable between inflexible traits and behaviour patterns resulting exclusively from contextual parameters.

Adams & Riggs (2008) explained the fundamental role defences play with regard to protection and maintaining psychological veracity – especially in a threatening situation. It appears that research has highlighted that defences have an immense effect on a person's psychology and should be treated as a mediating variable. Research has shown that defences play a role in adjustment to traumatic situations and there appears to be a definite link between traumatic stress and psychological distress (Punamaki *et al*., 2002, as cited in Adams & Riggs, 2008). Therapists appear to be as susceptible as the normal population to using defences that are more on the immature side of the spectrum of defences. Research has highlighted that workshops and training such as communication skills training are required in order to assist therapists with their adjustment to patients' levels of distress (Despland *et al*., 2009, p. 78).

### 3.4 Conclusion

It is hypothesized that defences play a vital role in managing day-to-day stressors. The understanding of defences has also progressed over the decades. Theorists have discussed defences from their individual use to the understanding of them as developing hierarchically. More recent research has hypothesized that individuals display certain defence styles or groupings of defence mechanisms. With this information available, it is possible to explore therapists' defence patterns and ascertain whether they are more inclined to develop vicarious trauma. However, it is clear in the literature that there is a primary focus on trauma, defences and the *victim*. What is lacking, especially in South Africa, is research pertaining to the impact of working with trauma for therapists; and whether defence mechanisms are related to the development of vicarious traumatization. Furthermore, defence styles of therapists have not been researched in the South African context. This research would be beneficial, especially considering the high prevalence of traumatic incidents. Another consideration is the unconscious role defences play in therapists' vulnerability towards vicarious trauma. The above literature describes the literature on defences and their relation to therapists.

# CHAPTER FOUR

# RESEARCH METHODOLOGY

## 4.1. Introduction

The research methodology applied in this study is provided in this chapter. It includes a detailed description of all the elements of the research study and the procedural steps that were followed, including research design, sampling, location of the study, data collection instruments, data collection methods, ethical considerations, data analysis and issues of reliability and validity (Terre Blanche, Durrheim, & Painter, 2006).

## 4.2. Research objectives

The aim of this research study was to generate a better understanding of vicarious trauma in therapists in South Africa and to explore the association between defence style and vicarious trauma. In addition, the study aimed to add to the existing knowledge about vicarious trauma within the South African context with regard to various factors that have already been empirically acknowledged internationally as linked to the development of vicarious traumatization. The following were the main objectives of this study;

**1.** To explore and generate a better understanding of vicarious traumatization in South African therapists.

**2.** To explore the association between defence style and vicarious traumatization.

**3.** To determine how defence style and vicarious traumatization interact with other factors such as race, gender, amount of exposure, type of trauma.

## 4.3. Research questions

The specific questions investigated in this research study on vicarious traumatization and defence style were as follows:

1. *Primary Research Question*: Is there a relationship/association between vicarious traumatization and defence style?

2. Is the image-distorting defence style a good predictor of vicarious traumatization?

3. Are there significant relationships between the variables associated with a psychologist (personal trauma, time-lapse, help-seeking, trauma experience, supervision, caseload, years in practice, age) and vicarious traumatization?

4. Does vicarious trauma differ based on the demographic variables (gender, ethnicity, qualification, province and therapeutic modality)?

### 4.3. Research Hypotheses

*$H_1$:* A primitive defence style (Image-distorting style) is associated with vulnerability towards vicarious traumatization.

*$H_2$:* An Image-distorting defence style is a stronger predictor of vicarious trauma than the Adaptive or Affect-regulating defence styles.

*$H_3$:* There is a relationship between the variables associated with a psychologist and vicarious traumatization.

*$H_4$:* Vicarious trauma differs based on the demographic variables.

### 4.4. Research Design

A quantitative research approach was utilized, adopting a correlational design. Correlational research designs are utilized as a precursor to explanatory research in which cause-effect conclusions can be drawn. In general, quantitative methods for research are based on the principles of deductive reasoning, pragmatism and objectivity. Durrheim and Tredoux (2004, p. 5) summarize the advantages of quantitative methods as "*efficient*, that they provide useful *models* of phenomena, and that they provide us with *a powerful language*". Ultimately, the goal of quantitative research in psychology is the discovery of causal laws of human behaviour and providing scientific explanations. In essence, the aim is to determine the relationship between (an) independent variable/s and a dependent variable/s in a sample

which can allow for the establishment of, for example, a causal relationship between variables.

Quantitative research allows for the explanation of phenomena by way of statistical methods to analyze numerical data using mathematically based methods (Aliaga & Gunderson, 2000, as cited in Muijs, 2010). It is important to note that the foundation of the quantitative approach is rooted within the realist or positivist paradigm, which makes use of objective methods to uncover phenomena (Muijs, 2010). Positivism purports to work according to the laws of cause and effect using reliable measurement instruments (Muijs, 2010). It is through science that we are able to explain social life through causal laws and either reject or accept theories that are tested using reliable tools (Mujis, 2010). Neuman (2014) explains that two conditions need to be met for positivists' explanations, namely, (1) having no logical contradictions, and (2) having consistency with observed facts.

A quantitative approach with a moderately large sample size (n=130) is considered suitable in order to allow for generalizability of results within a broader South African context (Neuman, 2005; Terre Blanche *et al*., 2006). This study used a correlational design in order to describe and measure relationships between variables. This study also made it possible to determine what factors are associated with Vicarious Trauma in therapists in order to better understand, prevent and manage vicarious traumatization.

### 4.5. Location of the Study

The study was conducted in Durban, South Africa, during the period of November 2015 to February 2016. Potential participants were contacted electronically in all provinces across South Africa, via a registered online survey tool.

### 4.6. Sampling and Sampling Method

A target minimum of 130 therapists participated in the study. According to Balnaves and Caputi (2001), an appropriate sample size to conduct multivariate research should be at least ten times larger than the variables being studied. In line with this criterion, the sample size was considered large enough to make inferences about the sample as well as the population in

relation to the number of therapists in South Africa. For the current study, it was a requirement that the sample included *registered psychologists and trauma therapists.* Some of the participants may not have the formal training received at master's degree level but are qualified as trauma therapists or counselors. Participants were therefore also requested to indicate their qualification and years of experience with trauma therapy specifically. This was required in order to test the association between level of experience and vicarious trauma.

Due to the nature of the research, a nonprobability sampling method (i.e. snowball sampling) was used. Snowball sampling is a method of gradually accumulating participants in a study by referral or associations (Terre Blanche *et al.,* 2006). Researchers usually rely on nonprobability samples as they are easier to obtain and "the selection of elements is not determined by the statistical principle of randomness" (Terre Blanche *et al.,* 2006, p. 139). The use of snowball sampling increased the chances of acquiring the desired participants and sample size (Terre Blanche *et al*., 2006). Due to the anticipated difficulty with acquiring participants for the study, snowball sampling appeared appropriate in order to obtain a large enough sample of therapists. By using this sampling method, the researcher was also able to work on a referral basis with other participants and thus expand the sample size quite swiftly. The initial phase of gathering the sample utilized the online registers of therapists across South Africa. A total of approximately 347 therapists were invited to participate and were asked to forward the invite to participate to their colleagues to initiate the snowball sampling method. A total of 127 participants provided useable data for the current study. This excluded 18 participants who did not complete the questionnaires sufficiently.

### 4.7. Data Collection

The following section explains the process of data collection. Positivist researchers make use of quantitative methods that "predefine the objects being studied" (Terre Blanche *et al.,* 2006, p. 51). In order to 'predefine' observational methods, positivist research follows a dual process of conceptualization and operationalization, i.e. defining the construct and transforming it into a discernible indicator (Terre Blanche *et al*., 2006, p. 51).

Consistent with the quantitative, positivist method, data were collected using structured scales, making it possible to analyze data from a sample. Data collection utilizing

questionnaires/surveys allows one to gather information about participants, and to analyze it using objective and numerical methods in order to generalize across a population (Durrheim & Tredoux, 2004). Questionnaires were deemed applicable to this study as they can be used to collect information on phenomena that may not be directly observable, such as defence styles (Balnaves & Caputi, 2001; Terre Blanche *et al*., 2006). The use of questionnaires was a convenient way of collecting data that could be kept completely anonymous, increasing the chance of open and honest answers from participants. According to Terre Blanche *et al.* (2006), questionnaires make it possible to collect information on participants' demographics and other information (i.e. measured scales) in a convenient and anonymous manner.

Self-administered questionnaires were made available to participants electronically via registered online software. Questionnaires were accessible online in the form of a survey. Access was granted with an online survey link, only to participants who had received an invitation to participate in the study. Participants were asked to forward the invitation to participate to colleagues in the field. Every respondent was given the option *not* to participate with no repercussions if they refused to participate. Once informed consent was obtained (Appendix 1), participants were directed to the three questionnaires. Questionnaires (see instruments) that included directive (scaled) questions were used in order to gather demographic data from participants. Secondly, Likert-type rating scale questionnaires were used to gather information on Defence Style and Vicarious Traumatization. The questionnaires were administered in English, taking into account the professional background and education level of participants.

### 4.8. Data Collection Procedure

The initial phase of the data collection procedure included obtaining ethical clearance from the Humanities and Social Sciences Research Ethics Committee (HSSREC) of the University of KwaZulu-Natal. Ethical clearance was obtained through the HSSREC in November 2014 before the commencement of this study.

Participants were emailed an introduction to the study and invited to participate by following the online link provided, which allowed them access to the questionnaires. Before commencing the survey, permission to participate was sought via informed consent forms

which included details of the purpose of the study. Participants were required to either agree to participate or not. If they selected 'do not wish to participate', the participant would not be redirected to the questionnaires. To ensure anonymity, participants were not required to supply names or identifying information. Participants were made aware of the objectives of the study and assured of confidentiality. They were also informed that they would be able to discontinue at any time during the process, that the questionnaires would take 15-20 minutes to complete, and that completed questionnaires would be kept in a secure location for at least five years. All answered questionnaires have been password protected.

## 4.9. Instruments

### 4.10.1. Demographic Questionnaire

The Demographic Questionnaire (Appendix 2) consisted of questions that related to the sociodemographic details of the participants. The demographic questionnaire allowed for further study into whether these factors are linked to the development of vicarious traumatization in therapists. These demographics included age, race, gender, province of residence, years in practice, trauma caseload, supervision attendance, therapeutic modality, client caseload per week, trauma history, and time lapse between trauma and present date.

### 4.10.2. Defence Style Questionnaire (DSQ 60)

The DSQ 60 is a shortened version of the original DSQ-88, developed by Trijsburg, Bond and Drapeau (2003) as a measure of defence style. "Items from the DSQ-88 (Trijsburg, *et al*., 1989), DSQ-40 (Andrews *et al.,* 1993), and DSQ-42 (Trijsburg *et al*., 2000) were examined and the authors refined and formulated new items for any DSM-IV defences which were missing" (Thygesen, Drapeau, Trijsburg, Lecours & de Roten, 2008, p. 173).

The questionnaire comprises 60 self-report items. It includes 30 defence mechanisms, with two items relating to each. The items are organized utilizing the Likert scale format with a 9-point rating scale (Appendix 3). Participants were requested to rate the statements on how applicable they are to themselves, on a scale of 1 (not applicable to me) to 9 (completely

applicable to me). A score for each defence can be acquired by calculating the mean of the two representing items (Thygesen *et al*., 2008). Once a score is obtained for each defence, a 'Style' score can then be obtained by "taking the mean belonging to each factor scale" (Thygesen *et al*., 2008, p. 175).

According to Thygesen *et al*., (2008, p. 177)

> Image distorting style is comprised of help rejecting complaining, splitting-self/other, projection, and projective identification. Factor two contains the defences of intellectualization, dissociation, isolation, and was named the affect regulating style. The third factor contains defences generally thought to be healthy (self-observation, self-assertion, anticipation, sublimation, and humor), and thus was called the adaptive style.

Examples of items from the DSQ 60 include: "*I get satisfaction from helping others and if this were taken away from me I would get depressed*"; "*I often feel superior to people I'm with*"; "*There is someone I know who can do anything and who is absolutely fair and just*"; and "*When something exciting is happening, I tend to fuss over unimportant details*".

In previous studies, internal consistency coefficients have been found for the scales as follows: Cronbach coefficient alpha for image-distorting style (α = .64), adaptive style (α = .61) and affect-regulating style (α = .72). Image-distorting style and adaptive styles were classified as having low/adequate internal consistency and affect-regulating style was considered fair (Thygesen *et al.*, 2008). In the current study the overall internal consistency for the DSQ 60 was good (α = .87). Cronbach's alphas for each scale were as follows: Image-distorting style (α = .81), affect-regulating style (α = .79) and adaptive style (α = .80).

### 4.10.3. Professional Quality of Life Scale (ProQol-5)

The third and final part of the survey included the Professional Quality of Life Scale (ProQol-5). The Professional Quality of life scale is a 30 item Likert type scale established as a revision of the 'Compassion Fatigue Self-Test' developed by Charles Figley (Bride, Radey & Figley, 2007). According to Stamm (2010), the original self-test had psychometric

complications which needed to be corrected. Bride *et al*. (2007) consider the instrument appropriate to use for any form of trauma experienced by a clinician. As discussed in the literature review, there is some conceptual confusion surrounding the terms *vicarious trauma, compassion fatigue, secondary trauma* and *burnout*. However, there also appears to be a lack of reliable instruments to measure *vicarious trauma* directly. According to Stamm (2010), the ProQol 5 can be used to measure any form of negative outcome from secondary exposure to trauma. Stamm (2010) noted that research on the ProQol has been rigorous over the years and across varying cultures internationally. In an attempt at justifying the use of the ProQol 5 as a measure for *vicarious trauma*, Stamm (2010) makes a valid conclusion.

According to Stamm (2010, p.9):

> There are issues associated with the various terms used to describe negative effects. There are three accepted terms: compassion fatigue, secondary traumatic stress, and vicarious trauma. There do seem to be nuances between the terms but there is no delineation between them sufficient to say that they are truly different…The three terms are used often, even in writing that combines Figley (compassion fatigue), Stamm (secondary traumatic stress) and Pearlman (vicarious traumatization).

Overall, the ProQol 5 appears to be the best measure of any form of secondary exposure to trauma and most commonly used in research studies (Stamm, 2010). It was crucial to the current study that a reliable and well-constructed instrument was used to gather data on vicarious trauma. According to Stamm (2010), the subscale termed *compassion fatigue* (which is the focus of this research) incorporates symptomology of vicarious trauma. Therefore, for the purposes of this research, it is important to note that the subscale of compassion fatigue is used interchangeably with the term vicarious trauma as discussed by the developer (Stamm, 2010).

The ProQol-5 is composed of three discrete scales and measures burnout, secondary trauma/vicarious trauma and compassion satisfaction. The questionnaire is organized on a 5-point Likert scale to measure the quality of life of therapists. For the purposes of this study, the researcher was interested in the *vicarious trauma scale* scores of participants. However, it is important to note that compassion satisfaction is a moderator and mediator of secondary/vicarious trauma. Stamm (2010) suggests that all subscales are used in order to explore outcomes and possible interaction of scales. Participants were requested to rate the

statements from 1 (Never) to 5 (Very often). The data collected from this scale was analyzed using the manual provided (Stamm, 2010). According to Stamm (2010), "The first step is to reverse some items. The second step is to sum the items by subscale and the third step is to convert the raw score to a t-score" (Stamm, 2010, p. 15). All tables for conversion and interpretation are provided in the ProQol-5 manual (Stamm, 2010). The scores for each variable (vicarious trauma, burnout or compassion satisfaction) are on a ***continuous scale*** from 1 to 99 measuring the participant's level of vicarious trauma, burnout or compassion satisfaction. Examples of items of the ProQol-5 include: "*I am happy"; "I like my work as a therapist"; "I feel worn out because of my work as a therapist";* and "*I can't recall important parts of my work with trauma victims*".

Stamm (2010) reports the Cronbach's alpha reliabilities for each scale of the ProQol-5 as follows: Compassion Satisfaction ($\alpha$ = .87), Burnout ($\alpha$ = .72) and Secondary/Vicarious Trauma ($\alpha$ = .80).

### 4.10. Data Analysis methods

Each specified questionnaire was analyzed using the appropriate scoring methods set by the developers, and descriptive statistics was applied in order to characterize the sample. The data was analyzed using *Statistical Package for Social Sciences* software (SPSS) version 23.0. For all analyses, an alpha level of .05 was used to determine statistical significance

### 4.11.1 Descriptive Statistics

Descriptive statistics were used in order to summarize the data in a meaningful way and describe patterns that emerged from the data (Neuman, 2014). Data was categorized by the number of variables and frequency tables were used in order to graphically represent the information. Measures of central tendency were described and explained in order to summarize the data. To gain a more holistic view of the data, measures of variation/dispersion were described and analyzed, including the percentiles, standard deviation, minimum and maximum.

### 4.11.2. Inferential Statistics

Inferential statistics allowed for generalizations to be made about the population using quantitative statistical methods. Once the questionnaires had been scored for each participant, the following tests were conducted;

- In order to address concerns over incomplete data and to ensure the integrity of the data, the accuracy of the data coding and entry into SPSS, data was analyzed using Little's Missing Completely at Random Test (Little's MCAR test).

- To establish whether there was a significant relationship between vicarious trauma and defence style, Pearson's Product-Moment Correlation Coefficient was used. This made it possible to determine a relationship between the variables and the strength of the correlation between the variables (Neuman, 2011).

- Multiple Regression analysis was used to address research question two. It was hypothesized that the image-distorting defence style would be a better predictor of vicarious trauma than the adaptive or affect-regulating style. Multiple regression analysis was used to identify which defence style would optimally predict vicarious trauma.

- An interesting component of this study was to include the interaction of other factors on the development of Vicarious Trauma. These included: ethnicity, gender, age, personal trauma, experience, case load per week, trauma sessions per week, work environment, and supervision.
    - Pearson's Product-Moment Correlation Coefficient was used to address research question 3, to determine the strength of the *linear* correlation between each variable associated with a therapist (personal trauma, time-lapse, help-seeking, trauma experience, supervision, caseload, years in practice, age) and vicarious trauma (Neuman, 2014). By performing these statistical analyses, the researcher was able to determine which factors might be associated with vicarious trauma (Neuman, 2014). Due to the dichotomous nature of a few of the variables (gender, work environment, personal trauma and help-seeking)

point-biserial correlations were conducted for the above mentioned variables, and are included in table 8.

- In order to determine whether the dependent variable (vicarious traumatization) varied as a function of the demographic variables of ethnicity, province, therapeutic modality and qualification, several one-way analysis of variances (ANOVA) were conducted to address research question 4.
- An independent-sample t-test was conducted to compare the differences between males and females (gender) in terms of vicarious trauma.

- Due to the continuous nature of variables, multivariate regression was used to analyze the demographic data and professional quality of life. Due to the independent and dependent variables being related constructs, it made conceptual sense to analyze them using multivariate regression in order to determine the effects between the variables.
    - Vicarious trauma was analyzed separately using univariate analysis methods (test of between subjects – ANOVA). All post hoc pairwise comparisons were analyzed using a Bonferroni adjustment.

- As an additional analysis, the *demographic variables* were correlated with defence style to determine whether these relationships should be of consideration in the current study or for future research.

## 4.11. Validity and Reliability

### 4.11.1. Validity

Validity refers to the extent to which an instrument 'measures what it is supposed to measure' (Terre Blanche *et al*., 2006). Stamm (2010) reports good construct validity for the Professional Quality of Life Scale. Thygesen *et al*. (2008) provided preliminary support for the validity of the DSQ-60. The current study used questionnaires that have been used in other research that have supported the validity of the instruments. The demographic questionnaire allowed participants to choose the appropriate answer and thus, did not impede validity.

### 4.11.2. Reliability

Although assessment of defences has been discussed as being subjective and thus unreliable (Vaillant *et al*., 1986), Kline (1972, cited in Vaillant *et al*., 1986, p. 786) stated that "reliability could be achieved [when studying defences] only at the expense of clinical validity". In other words, the study of defences can yield consistent results. Although there are limitations with regard to the study of defences, further study is imperative in order to gain insight on whether they can unconsciously influence the health of therapists in South Africa who are overwhelmed with trauma cases. The current study ensured reliability by providing a clear description of the research process and analysis (Terre Blanche *et al*., 2006).

The questionnaires in this study have been tested by the developers. According to Terre Blanche *et al*. (2006), an instrument (in this case the questionnaires) is considered reliable if it produces similar results in different situations. Internal consistency is a measure of reliability as it reflects the "homogeneity of the items comprising a scale" (DeVellis, 1991 as cited in Bride, Robinson, Yegidis and Figley, 2004, p. 29). It is suggested that a coefficient alpha .80 or more is considered sufficient internal consistency (i.e. reliability) of a scale (Bride *et al*., 2004).

The Coefficient alphas derived from the DSQ 60 were .72 on the Affect Regulating Style, .64 on the Image Distorting Style and .61 on the Adaptive Style (Thygesen *et al*., 2008). The alpha score for the latter two are deemed low when discussing possible significance and the Affect Regulating Style is seen as having fair reliability. The coefficients of the Image Distorting and Adaptive Styles could limit the reliability of the scale. However, an assessment of the DSQ's reliability was included in the current study. The alpha coefficient results for the Professional Quality of Life Scale are: Compassion Satisfaction alpha = .87, Burnout alpha = .72, and Vicarious Traumatization alpha = .80 (Stamm, 2010). The alpha coefficient results suggest sufficient reliability.

## 4.12. Ethical Considerations

Ethical clearance was obtained from the University of KwaZulu-Natal's Humanities and Social Sciences Research and Ethics Committee (Appendix 1). The study chose to use independent practitioners and therefore no approval was required to access the sample. Each participant was, however, given the option to participate in order to create a collaborative partnership between the researcher and the participants. A collaborative partnership is regarded as an integral part of research (Terre Blanch *et al.*, 2006). In other words, research needs to be conducted in a way that will incorporate the needs and values of the sample being studied, without exploitation. Participants need to be included in each step of the research, explicit details of the research must be provided about the mutual benefits of the study.

As noted by Terre Blanche *et al*. (2006), a crucial ethical consideration is that of 'informed consent'. The researcher complied with this by providing each participant with a complete explanation on the nature of the study and requested respondents to provide informed consent prior to their participation. In addition, Terre Blanche *et al*. (2006) explicitly state that there are four basic ethical principles which guide research and good ethical practice. These include autonomy and respect, nonmaleficence, beneficence and justice. All basic ethical principles were considered throughout the research study. Further, the researcher provided each participant with guaranteed anonymity. Given the nature of the sample in the current study, it was important to provide therapists with guaranteed anonymity because of the nature of the questions being asked.

### 4.12.1. Gender Oversight

The initial data gathering phase did not include a specifier for gender on the demographic questionnaire. Once the oversight was recognized, the researcher added the specifier to the online questionnaire. However, due to the initial oversight, only 41.73% of the sample were able to specify their gender. This is discussed further in the limitations to the study.

### 4.13. Risk and Benefit Ratio

When conducting any research there is a certain risk-benefit ratio (Terre Blanche *et al*., 2006). It is important to limit the risks by providing a maximum potential of benefits for the participants and overall value of the research to society (Terre Blanche *et al.,* 2006). In the current study, the researcher attempted to minimize any potential risks and the benefits were maximized by:

- Validating the relationship between vicarious trauma, defence style, and other factors. This constitutes, an effort to contribute to appropriate self-care/monitoring guides for therapists.
- Making the results available to participants.

The risks were minimized using the following:

- Participants (therapists) received complete anonymity in order to prevent any possibility of their credentials being known.
- Participants were informed about the study and their right to withdraw at any stage of the survey process with no negative consequences.
- In order to prevent long and tedious data collection processes for the participants, questionnaires were provided in an online format which took only 15 – 20 minutes to complete.

### 4.14. Conclusion

In summary, chapter four has included a detailed description of the methodology used in this research study. The research objectives and questions were reported at the opening of the chapter with the main objective of exploring vicarious trauma and defences in therapists. Following this was an explanation of the research design utilized and a description of both the quantitative approach and correlational design of the current study. Sampling and sampling method were discussed, followed by location of the study and data collection methods and procedures. A brief description of each instrument used was provided, followed by the method of analysing data which includes a description of both descriptive (Frequencies, mean and standard deviation) and inferential statistics (Little's MCAR,

Multivariate Regression and Correlation). The chapter concludes with a discussion on reliability, validity, ethical considerations and risks/benefits.

# CHAPTER 5

# INTERPRETATION OF RESULTS

## 5.1. Introduction

The present chapter explores the main findings of the present study. The results that emerged from the statistical analysis are presented in the form of tables and discussed accordingly. As mentioned in previous chapters, the main objective in this study was to explore whether Defence Style is linked to the development of vicarious traumatization. In addition, an interesting component of this study was to explore other factors typically associated with a higher vulnerability towards the development of vicarious trauma. A minimum of 130 participants were required for the study. A total of 145 psychologists responded to the questionnaires, of which 127 produced usable data.

This chapter also discusses the diagnostic actions taken to ensure the integrity and appropriateness of the data. Missing data patterns and the steps taken to credit missing data are examined. Findings are discussed in terms of their relationships and effects on the study's variables. In addition, descriptive statistics are utilized to present various characteristics of the participants.

## 5.2. Diagnostics/Missing Values: Little's MCAR Test

The initial step conducted to safeguard the integrity of the data was to examine the accuracy of the data coding and entry into the statistical program (SPSS). Little's Missing Completely at Random (MCAR) test was then used to determine whether missing cases (on each of the two scales) were completely at random or not (See Tables 1 & 2 for results on deletion). Results were significant for both the DSQ 60 and ProQol 5, meaning that the values were not missing at random and a pattern of missing answers was detected. Thus, certain questions from each questionnaire had to be deleted prior to analysis.

Table 1: Little's MCAR Test: Case Processing Summary: ProQol 5

| ***Compassion Satisfaction*** | | **N** | **%** |
|---|---|---|---|
| **Cases** | **Valid** | 124 | 97.6 |
| | **Excluded**[a] | 3 | 2.4 |
| | **Total** | 127 | 100.0 |
| ***Burnout*** | | | |
| **Cases** | **Valid** | 121 | 95.3 |
| | **Excluded**[a] | 6 | 4.7 |
| | **Total** | 127 | 100.0 |
| ***Vicarious Traumatization*** | | | |
| **Cases** | **Valid** | 125 | 98.4 |
| | **Excluded**[a] | 2 | 1.6 |
| | **Total** | 127 | 100.0 |

a. Listwise deletion based on all variables in the procedure.

Table 2: Little's MCAR Test: Case Processing Summary: DSQ 60

| ***Image Distorting Style*** | | **N** | **%** |
|---|---|---|---|
| **Cases** | **Valid** | 120 | 94.5 |
| | **Excluded**[a] | 7 | 5.5 |
| | **Total** | 127 | 100.0 |
| ***Affect Regulating Style*** | | | |
| **Cases** | **Valid** | 119 | 93.7 |
| | **Excluded**[a] | 8 | 6.3 |
| | **Total** | 127 | 100.0 |
| ***Adaptive Style*** | | | |
| **Cases** | **Valid** | 117 | 92.1 |
| | **Excluded**[a] | 10 | 7.9 |
| | **Total** | 127 | 100.0 |

a. Listwise deletion based on all variables in the procedure.

The Little's MCAR test for the DSQ 60 data was statistically significant, $\chi^2$ (996) = 1077.20, p < .037, indicating that the data was *not* missing at random and there was an identifiable pattern to the missing data in the DSQ 60. The Little's MCAR test for the ProQol data was also statistically significant, $\chi^2$ (289) = 336,800, p < ,028. Therefore, results on both tests revealed that the missing data was not missing at random. It appeared that more than one participant might have skipped the same question more than once; thus certain questions were deleted from the data prior to analysis. Data analysis was conducted without replacing missing data.

### 5.2.1. Reliability

As discussed earlier, reliability was assessed using Cronbach's Alpha Coefficient. The results on both measures were tabulated as follows:

Table 3: Cronbach's Alpha results for the ProQol Scales

| **ProQol Scales** | **Cronbach's Alpha** | **N of Items** |
|---|---|---|
| **Compassion Satisfaction** | .86 | 10 |
| **Burnout** | .52 | 10 |
| **Vicarious Traumatization** | .82 | 10 |

Table 4: Cronbach's Alpha results for the DSQ Scales

| **DSQ 60 Scales** | **Cronbach's Alpha** | **N of Items** |
|---|---|---|
| **Image-Distorting** | .81 | 22 |
| **Affect-Regulating** | .80 | 20 |
| **Adaptive** | .80 | 18 |

## 5.3. Descriptive Statistics – Demographic characteristics

A total of 127 participants provided useable data for the current study. This excluded 18 participants who did not complete the questionnaires sufficiently, yielding an inclusion rate of 87.59%. The characteristics of the participants are displayed in Table 2. This section

presents the general demographic characteristics of the participants, as well as personal factors associated with vicarious trauma.

Table 5.1: Descriptive Statistics: Demographic Characteristics

| **Characteristics** | | **N** | **%** | **Mean** | ***SD*** |
|---|---|---|---|---|---|
| **Racial Grouping** | **Cumulative** | 125 | 98.4 | 1.42 | .806 |
| | **White** | 94 | 74.0 | | |
| | **Black** | 12 | 9.4 | | |
| | **Indian** | 16 | 12.6 | | |
| | **Coloured** | 3 | 2.4 | | |
| **Gender** | **Cumulative**[2] | 53 | 41.73 | 1.77 | .423 |
| | **Male** | 12 | 9.4 | | |
| | **Female** | 41 | 32.3 | | |
| **Age** | | 127 | 100 | 43.30 | 12.545 |
| **Qualification** | **Cumulative** | 127 | 100 | | |
| | **Undergraduate** | 4 | 3.1 | | |
| | **Honours** | 6 | 4.7 | | |
| | **Masters** | 89 | 70.1 | | |
| | **PhD** | 28 | 22.0 | | |
| **Province** | **Cumulative** | 124 | 97.6 | | |
| | **KZN** | 72 | 56.7 | | |
| | **Gauteng** | 29 | 22.8 | | |
| | **Western Cape** | 16 | 12.6 | | |
| | **Mpumalanga** | 1 | .8 | | |
| | **North West** | 2 | 1.6 | | |
| | **Free State** | 1 | .8 | | |
| | **Eastern Cape** | 1 | .8 | | |
| | **Other** | 2 | 1.6 | | |

[2] Due to the initial oversight of the gender specifier during data collection, only 53 participants specified their gender. Refer to chapter 7 for a discussion on the limitations of the study.

Table 5.2: Descriptive Statistics: Variables associated with a Therapist

| Characteristics | | N | % | Mean | *SD* |
|---|---|---|---|---|---|
| **Years in Practice** | | 127 | | 13.02 | 9.763 |
| **Place of Work** | **Cumulative** | 126 | 99.2 | | |
| | **Institution** | 30 | 23.6 | | |
| | **Private** | 79 | 62.2 | | |
| | **Clinic** | 9 | 7.1 | | |
| | **Other** | 8 | 6.3 | | |
| **Years of Experience: Trauma** | | 127 | | 10.98 | 8.112 |
| **Trauma Caseload Per Week** | | 123 | | 7.36 | 6.145 |
| **Hours Per Week Seeing Clients** | | 124 | | 23.42 | 10.257 |
| **Personal Trauma** | | 126 | | 1.21 | .412 |
| **Time Lapse (Trauma and Present)** | | 98 | | 6.66 | 7.486 |
| **Help Seeking** | **Cumulative** | 97 | 76.4 | | |
| | **Yes** | 56 | 44.1 | | |
| | **No** | 41 | 32.3 | | |
| **Supervision Hours** | | 99 | | 1.17 | .861 |
| **Therapy Modality** | | 127 | 100.0 | | |
| | **CBT** | 45 | 35.4 | | |
| | **Psychodynamic** | 32 | 25.2 | | |
| | **Eclectic** | 33 | 26.0 | | |
| | **Person Centered** | 2 | 1.6 | | |
| | **Trauma Models** | 3 | 2.4 | | |
| | **Transpersonal** | 2 | 1.6 | | |
| | **Solution Focused** | 2 | 1.6 | | |
| | **Systems** | 4 | 3.1 | | |
| | **Interpersonal** | 1 | .8 | | |
| | **EMDR** | 2 | 1.6 | | |
| | **Existentialism** | 1 | .8 | | |

The initial collection of data excluded gender as a demographic specifier thus yielding a smaller sample to analyze gender differences. Of the sample of 127 participants, 53 specified

their gender (41.73%). Of the specified gender sample 9.4% of participants were male and the majority of the sample were female (32.3%). Given the relatively small sample of the gender specifier, a gender analysis was not possible. This is further discussed in the limitations section of the study.

The sample was disproportionately white South African (in relation to the South African population as a whole) and accounted for 74% of the sample. The mean age of participants was approximately 43 years (*SD* = 12.55), ranging from 23 years to 73 years of age. The highest qualification of participants ranged from undergraduate to Doctoral degrees, with the majority (70.1%) having a Master's degree. The mean number of years in practice was 13.02 (*SD* = 9.76).

The majority of respondents were from the Kwazulu-Natal province in South Africa and accounted for 56.7% of the sample, followed by 22.8% of the respondents from the Gauteng province, and 12.6% from the Western Cape. A majority of the sample specified private practitioner as the place of work (62.2%) and 23.6% of participants worked in various institutions.

With regard to years of experience with trauma cases, the average number of years of experience was 11 (*M* = 10.98, *SD* = 8.11). The average number of trauma cases participants engaged in therapy with each week was 7 (*M* = 7.36, *SD* = 6.14), with the average number of hours spent seeing clients each week being 23 (*M* = 23.42, *SD* = 10.26). Of the respondents who had experienced personal trauma, 44.1% had sought help for the trauma experienced and 32.3% had not.

Supervision had been sought by 99 respondents, with the average time in supervision being 1 hour per week (*M* = 1.17, *SD* = .86). The majority (35.4%) of participants specified Cognitive Behaviour Therapy as their primary therapy modality, followed by 26% of participants making use of Eclectic modalities. Psychodynamic therapy was the primary therapeutic modality for 25.2% of participants.

## 5.4. Descriptive Statistics of the Questionnaires: ProQol and DSQ

The following tables include the descriptive statistics pertaining to each questionnaire including the number of participants per scale, means and standard deviations.

Table 6: Descriptive Statistics: ProQol

| **Scales** | **Mean** | ***SD*** | **N** |
|---|---|---|---|
| **Compassion satisfaction** | 54.98 | 5.80 | 121 |
| **Burnout** | 49.54 | 4.94 | 117 |
| **Vicarious trauma** | 59.55 | 7.21 | 121 |

The mean scores on the ProQol indicate that the majority of the sample tended to score higher on the vicarious trauma scale, with a mean score of 59.55. The sample however, tended to derive professional satisfaction (compassion satisfaction) from their work as therapists; with a mean score of 54.98. The sample were least affected by burnout, with a mean score of 49.54, and instead have more positive attitudes about their work.

Table 7: Descriptive Statistics: DSQ

| **Scales** | **Mean** | ***SD*** | **N** |
|---|---|---|---|
| **Image-distorting** | 28.64 | 8.73 | 116 |
| **Affect-regulating** | 31.22 | 8.62 | 116 |
| **Adaptive** | 50.90 | 8.88 | 113 |

## 5.5. Addressing Research Question 1: *Is there a relationship/association between vicarious traumatization and defence style?*

### 5.5.1. Pearson's Product Moment Correlations

Pearson's correlations were run to determine: (1) whether there was a significant *linear* relationship between vicarious traumatization and image-distorting defence style; (2) whether there were significant *linear* relationships between the demographic data collected and vicarious trauma. Table 8 summarizes the correlations between all continuous/ordinal variables. This section focuses on the results for Question 1. Preliminary analyses were performed to ensure that there was no violation of the assumptions of normality, linearity and

homoscedasticity. Data was relatively normally distributed. The data represented a reasonably straight diagonal line, suggesting no major deviations from normality. All effect sizes were determined using Cohen's (1988) estimate of effect sizes.

Table 8: Pearson Correlation results: Demographic Variables, professional Quality of life and Defence style

| **Variables** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** | **15** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Years in practice | 1 | | | | | | | | | | | | | | |
| ^Work environment | -.287** | 1 | | | | | | | | | | | | | |
| Trauma experience | .803** | .254** | 1 | | | | | | | | | | | | |
| Trauma caseload p/w | -.067 | .063 | .016 | 1 | | | | | | | | | | | |
| General caseload p/w | -.221* | -.024 | -.090 | .338** | 1 | | | | | | | | | | |
| ^Personal trauma | .116 | -.023 | -.006 | -.115 | -.214 | 1 | | | | | | | | | |
| Time lapse | .295** | .110 | .321** | .033 | .052 | .c | 1 | | | | | | | | |
| ^Help seeking | -.007 | -.169 | -.027 | .101 | -.087 | .120 | -.102 | 1 | | | | | | | |
| Supervision | .135 | -.327** | .105 | .019 | -.005 | -.058 | .401** | .127 | | | | | | | |
| Satisfaction | .009 | .040 | .096 | -.089 | .143 | -.144 | .188 | -.214* | -.040 | 1 | | | | | |
| Burnout | -.043 | .059 | -.041 | .104 | .077 | .073 | -.120 | .176 | .143 | -.699** | 1 | | | | |
| Vicarious Trauma | -.032 | -.043 | .044 | .051 | .068 | -.043 | .170 | .143 | .103 | -.211* | .390** | 1 | | | |
| Image-Distorting | -.230* | -.244** | -.210* | -.093 | -.022 | -.043 | .069 | .090 | .115 | -.161 | .334** | .642** | 1 | | |
| Affect-regulating | -.009 | -.013 | .003 | -.089 | -.225* | -.035 | .020 | .232* | .043 | -.356** | .439** | .408** | .567** | 1 | |
| Adaptive | -.062 | -.039 | .019 | -.029 | -.026 | -.220** | .066 | -.030 | .104 | .254** | -.182 | .224* | .240* | .208* | 1 |

**. Correlation is significant at the .05 level (t 2-tailed) *. Correlation is significant at the .01 level (2-tailed) .c cannot be computed because at least one of the variables is a constant

^ Point-biserial Correlations

In terms of defence style and vicarious trauma, there were three positive correlations found. A large positive correlation was found between vicarious trauma and image-distorting defence style, $r$ (117) = .64, $p$ < .001. A moderate positive correlation between affect-regulating defence style and vicarious trauma, $r$ (115) = .41, $p$ < .001. A small positive correlation was found between adaptive defence style and vicarious trauma, $r$ (113) = .22, $p$ = .018.

## 5.6. Addressing Research Question 2: *Is the Image-distorting defence style a better predictor of vicarious traumatization?*

### 5.6.1. Multiple Regression

Preliminary assumption testing was conducted to check for linearity, normality, univariate and multivariate outliers, homogeneity of variance-covariance matrices, and multicollinearity, with no severe violations noted. Multiple regression analyses were conducted to examine whether defence style was predictive of vicarious trauma and whether the image-distorting defense style was a better predictor than the adaptive or affect-regulating defence styles. Analysis on research question two ($H_2$) is continued below.

The multiple regression analysis was statistically significant, $F$ (3, 98) = 24.09, $R^2$ = .42, $p$ < .001, indicating one or more defense styles were predictive of vicarious trauma. Specifically, image-distorting was statistically significant ($\beta$ = .64, $p$ < .001), but affect regulating ($\beta$ = -.00, $p$ = .981) and adaptive were not ($\beta$ = .06, $p$ = .488).

## 5.7. Addressing Research Question 3: *Are there significant relationships between variables associated with a psychologist (personal trauma, time-lapse, help-seeking, trauma experience, supervision, caseload, years in practice) and vicarious traumatization?*

### 5.7.1. Pearson Pearson's Product Moment Correlations

The secondary aim of performing Pearson correlations was to explore whether there were linear relationships between vicarious trauma and the other variables. The relationship between these variables (years in practice, work environment, trauma experience, trauma caseload, general caseload, personal trauma, time lapse between personal trauma and present day, help seeking for personal trauma and supervision) and professional quality of life (compassion satisfaction, burnout and vicarious traumatization) were investigated using the Pearson product moment correlation coefficient.

In terms of the above mentioned variables there were no significant relationships between the variables and vicarious trauma. There were significant relationships found between one variable and compassion satisfaction. A significant positive relationship between help-seeking for trauma and compassion satisfaction was found, $r$ (91) = -.21, $p$ = .04, with increased help-seeking associated with less compassion satisfaction.

## 5.8. Addressing Research Question 4*: Does vicarious traumatization differ based on the demographic variables (gender, ethnicity, qualification, province, therapeutic modality)?*

### 5.8.1. Analysis of Variance (ANOVA)

One-way ANOVA's were conducted in order to explore the impact of the demographic variables on vicarious trauma. Levene's test for homogeneity of variance was examined to ensure that the assumption of homogeneity was not violated. Only one of the demographic variables were found to be statistically different in relation to vicarious trauma. There was no statistically significant difference between ethnicity and vicarious trauma: $F$ (3,115) = 2.12, $p$ = .101. There was no significant difference was found between qualification and vicarious trauma: $F$ (3,117) = .264, $p$ = .852. There was no significant difference between province and vicarious trauma: $F$ (7, 110) = 1.573, $p$ = .151. There was a statically significant difference between therapeutic modality and vicarious trauma: $F$ (7, 113) = 3.156, $p$ = .004. Due to

statistical power the omnibus test was significant, however post hoc analyses revealed no statistical difference between the various therapeutic modalities and vicarious trauma.

### 5.8.2. T-Test

A T-test was conducted to compare the vicarious trauma scores for males and females (gender). Levene's test for equality of variances was examined to determine which t-value is the correct one to be used. Since the Sig. value for Levene's test was larger than .05, equal variances was assumed and examined. There was no significant difference in the scores for males ($M$ = 57.64, $SD$ = 7.32) and females ($M$ = 56.18, $SD$ = 6.79) conditions; t (49) = .622, p = .537. The magnitude of the differences in the means (mean difference = 1.46, 95% C/: -3.26 to 6.18) was large (eta squared = 2.35).

## 5.9. Additional multivariate analyses on demographic variables

Additional multivariate analyses were conducted on the demographic variables in order to measure the predictive ability of each variable in relation to vicarious trauma. The results are as follows:

### 5.9.1. Age

The multivariate regression on age was not statistically significant, $F$ (3,109) = 1.19, $p$ = 318, Wilks $\Lambda$ = .968, $\eta_p^2$ = .032. As a result, age group comparisons across professional quality of life were not performed.

### 5.9.2. Gender

Multivariate test results indicated no significant result across the three dependent variables, $F$ (3, 43) = 1.12, $p$ = .319, Wilks $\Lambda$ = .922, $\eta_p^2$ = .078. As a result, no gender comparisons across professional quality of life were performed.

### 5.9.3. Ethnicity

The multivariate regression performed on ethnicity showed no significant result, $F$ (9,255.69) = 1.78, $p$ = .073, Wilks $\Lambda$ = .863, $\eta_p^2$ = .048, therefore no comparisons were made across professional quality of life.

### 5.9.4. Work Environment

A multivariate test was conducted between work environment (private practice and institutions) and professional quality of life. The multivariate test showed no significance, $F$ (3.108) = .531, $p$ = .662, Wilks $\Lambda$ = .985, $\eta_p^2$ = .015. No further univariate test was conducted between subjects.

### 5.9.5. Personal Trauma

The multivariate regression on personal trauma was not significant, $F$ (3,108) = 1.35, $p$ = .263, Wilks $\Lambda$ = .964, $\eta_p^2$ = .036. As a result, no further univariate comparisons were done across professional quality of life.

### 5.9.6. Time lapse – personal trauma

A statistically significant multivariate result was obtained for the time lapse of personal trauma and professional quality of life, $F$ (3.84) = 2.96, $p$ = .037; Wilks $\Lambda$ = .904; $\eta_p^2$ = .096. Further univariate analyses showed that statistical significance was not reached across all three dependent variables.

### 5.9.7. Help-seeking for personal trauma

The multivariate regression on help-seeking for personal trauma did not reach statistical significance, $F$ (3. 84) = 1.85, $p$ = .145, Wilks $\Lambda$ = .938, $\eta_p^2$ = .062, therefore no comparisons were made across the three dependent variables.

### 5.9.8. Years of experience

The multiple regression analysis on years of experience showed no significance, $F$ (3, 109) = 1.20, $p$ = .315, Wilks Λ = .968, $\eta_p^2$ = .032. As a result, no 'years of experience' comparisons were made across professional quality of life.

### 5.9.9. Trauma caseload per week

The multivariate analysis on trauma caseload yielded no significant result, $F$ (3.105) = .733, $p$ = .535, Wilks Λ = .979, $\eta_p^2$ = .021. Therefore, no trauma caseload comparisons were made across professional quality of life.

### 5.9.10. Work Caseload per week

A statistically significant result was obtained for the multivariate test between overall caseload per week and the combined dependent variables: $F$ (3.106) = .3,76, $p$ = .013; Wilks Λ = .904; $\eta_p^2$ = .096. However, when the variables were considered separately, none of the variables (compassion satisfaction, burnout and vicarious trauma) reached statistical significance ($p$ = .198 to .380)

### 5.9.11. Supervision

The multivariate regression analysis on the number of weekly hours in supervision engagement showed no statistical significance, $F$ (3. 82) = .695, $p$ = .558, Wilks Λ = .975, $\eta_p^2$ = .025. As a result, no univariate comparisons were made across the dependent variables.

### 5.9.12. Therapeutic modality

A statistically significant MANOVA result was obtained for therapeutic modality and Professional Quality of Life: $F$ (21, 296.31) = 1.69, $p$ = .032; Wilks Λ = .723; $\eta_p^2$ = .102. When the variables were considered separately (*univariate analyses)*, the only factor to reach statistical significance was secondary traumatic stress (vicarious trauma) which had a statistically significant effect on therapeutic modality: $F$ (7, 105) = 3.039, $p$ = .006; $\eta_p^2$ = .168. Post hoc analysis revealed no significant differences between each of the groups on vicarious trauma.

## 5.10. Additional Analysis: Correlations: Demographic Factors and Defence Style

Although it was not the main aim of this study to investigate the defence style in relation to the demographic factors, analyses were run in order to determine whether these should be considered as pertinent. The difference with these analyses is that *defence style* was used to analyze the possible association with the demographic variables in place of vicarious trauma. The results of these analyses are presented in brief below.

A significant negative correlation between years in practice and image-distorting defence style was obtained, $r$ (114) = -.23, $p$ = .013, with higher years in practice associated with lower image-distorting defence style. In terms of years of experience with trauma therapy there was a significant negative correlation with image-distorting defence style, $r$ (114) = -.21, $p$ = .024, with increased years of experience associated with lower image-distorting defence style. A significant negative correlation was found between province and image-distorting defence style, $r$ (113) = -.24, $p$ = .009. A significant negative correlation was found between caseload per week and affect-regulating defence style, $r$ (111) = -.23, $p$ = .016, with higher hours per week associated with lower affect-regulating defence style. A significant positive correlation was observed for help seeking (personal trauma) and affect-regulating defence style, $r$ (87) = .23, $p$ = .028, with higher help-seeking associated with higher affect regulating defence style. There was a significant negative correlation between personal trauma history and adaptive defence style, $r$ (110) = .22, $p$ = .020, with higher levels of personal trauma associated with lower adaptive defence styles.

## 5.11. Conclusion

This chapter presented the results of the research conducted. The results were in relation to the study's main hypothesis. Image-distorting style was found to have a relationship with vicarious trauma in therapists. Multiple regression analysis results indicated that the image-distorting defence style *was* predictive of vicarious trauma. With regards to the factors associated with vicarious trauma, there were no significant relationships. When looking at the significant differences between the demographic factors and vicarious trauma, therapeutic modality was found to be significantly different. Post hoc analysis however, indicated no significance between therapy modalities and vicarious trauma. No other variables showed

significant results in relation to vicarious trauma. Interestingly, the results of the analysis between defence style and the demographic factors indicated numerous significant results. A significant negative correlation between years in practice and the image-distorting defence style was obtained. A significant negative association was found between the years of experience in trauma therapy and the image-distorting defence. A significant negative correlation between hours per week seeing clients and affect-regulating defence style was also obtained. A significant positive correlation was observed for help seeking (personal trauma) and affect-regulating defence style. In addition, there was a significant negative correlation between personal traumatic experiences and adaptive defence style. The following chapter will discuss the main findings of this research study and highlight the relevant literature in relation to these results.

# CHAPTER 6

# DISCUSSION

This chapter includes a discussion and integration of the results of the study. The results of the variables are presented in comparison to the relevant literature on vicarious trauma, defence style and related factors. The significance and implications are considered and discussed further.

## 6.1. Introduction

The current study was conducted to examine the relationship between vicarious trauma and defence style. Various risk factors were predicted as influencing vulnerability to vicarious trauma. This study is one of very few in the field and especially in South Africa. Various studies have researched factors associated with vicarious trauma, but few have focused on defence style in relation to therapists in the South African context. This study explored whether a relationship between defence style and vicarious trauma can be confirmed. The main prediction was substantiated. The decision to conduct a study on vicarious trauma was made due to the very high rates of trauma-related cases in South Africa and the potential effect this could have on therapists' wellbeing. In addition, it appears important to add to knowledge about therapist self-care in order to help prevent vicarious trauma or burnout.

In addition, it was pertinent to the study's objectives to explore whether there were associations between vicarious trauma and other factors. In terms of the demographics explored, it was predicted that the demographic variables (which were chosen in relation to relevant literature on factors associated with vicarious trauma) would be related to vicarious trauma in therapists. Surprisingly, the findings of the analysis between these variables in relation to vicarious trauma were mostly insignificant. This is discussed further below. Although the current results require replication with a larger sample, they can be considered as representative of South African psychologists, as the sample size was sufficient enough to allow for inferences to be made.

## 6.2. Defence Style and Vicarious Trauma

As mentioned in the introduction, the main aim of this study was to explore whether there was an association between *defence style* and the development of *vicarious trauma*. One objective here was to identify whether such psychological mechanisms play a part in therapists' development of vicarious trauma. The current study *was* able to substantiate the main hypothesis. The results showed that therapists who scored higher on the vicarious trauma scales were more likely to adopt an image-distorting defence style. The results confirmed that the image-distorting defence style had a strong positive relationship with vicarious trauma. In addition, image-distorting defence style was considered predictive of vicarious trauma. Of all three defence styles, image-distorting defence style was considered a better predictor of vicarious trauma than the remaining defence styles.

It appeared that the majority of the sample had a tendency towards using more mature/adaptive defence styles which corroborates the findings of similar studies (Adams & Riggs, 2008; Shauben & Frazier, 1995). Ninety-one percent of the sample reported the adaptive defence style. The second defence, considered on the healthier spectrum, is the affect-regulating defence style, and 7.3% of the sample reported using this style. Only .8% of the sample reported that they utilised the image-distorting defence style which is considered maladaptive/immature. However, although .8% of the sample can be classified as having an image-distorting defence style, the analysis used continuous data suggesting a tendency towards image-distorting defence style as being predictive of vicarious trauma. Therapists' inclination towards the adaptive defence style suggests that most therapists use mature defences, which can be considered a desirable result due to the implications of the aforementioned defence style.

A secondary objective of the study was to explore relationships between the variables associated with a therapist and vicarious trauma. In addition, the study sough to look at the differences between the demographic variables and vicarious trauma. It was hypothesized that these variables may in fact influence the development of vicarious trauma. The results of these analyses however were mainly non-significant. There were no significant relationships found between the factors associated with a therapists and vicarious trauma. When the demographic factors were analysed for differences, therapeutic modality was significantly different in terms of vicarious traumatization. Further post hoc testing, however, was unable

to provide any significant results when analysing each modality independently in relation to vicarious trauma. The additional analyses done in relation to defence style (as opposed to vicarious trauma) and the demographic variables did provide surprising results. These, however, were not included as an aim of the current study and are discussed in Chapter 7 as a recommendation for future research. The implications for both defence style and vicarious trauma are discussed below.

### 6.2.1. Implications

***Defence Style.*** The literature on defence mechanisms explains that defences can aid therapists with the management of the stress they may experience during therapy (Cramer, 2000). Further, it is postulated that certain clusters of defences (e.g. sublimation and humour) can be more beneficial than others (e.g. splitting and projection) in the prevention of phenomena such as vicarious trauma. The predominance of the adaptive defence style in the current study indicates that the majority of therapists in South Africa use healthy defences as a means of coping, suggesting that they may have improved self-awareness (Adams & Riggs, 2008). In addition, the findings of the current study are similar to the finding of Adams & Riggs (2008) that therapists have a tendency to use the healthy defence mechanisms and the adaptive defence style in order to cope or deal with high levels of stress. Such defence mechanisms are considered mature defences which, as explained in Chapter 2, are implicated in the reduction of or prevention of vicarious trauma symptomology (Adams & Riggs, 2008). Therefore, the findings that the current sample have an inclination to use adaptive defences implies that the majority of therapists have less of a chance of developing vicarious trauma symptomology.

An additional implication similarly suggested by Adams & Riggs (2008), is that the high frequency of the adaptive defence style indicates that post-graduate university courses in psychology evidently select student psychologists who have the qualities or traits that are necessary for the profession. It appears that the adaptive defence style is the most preferred defence style, due to the more mature and healthy manner these individuals cope under stress. However, psychology training courses could establish programmes in order to promote healthy coping and encourage students to be aware of their defence styles in order to prevent future symptomology. Being aware of tendencies towards using particular defences can

increase the prevention of vicarious trauma and promote the use of healthy or mature defences.

As discussed in Chapter 3, factors such as poor communication skills have been associated with immature defences (Despland *et al*., 2009). Training programmes that aim to improve a therapist's communication skills could be established to assist in preventing or treating vicarious trauma (Despland *et al*., 2009). Despland *et al*., (2009) also explain that communication skills training can change an individual's defence style from immature to mature. According to Despland *et al.,* (2008) the affect regulating defence style could also be predictive of improvement towards healthier defence use. Therefore, it is postulated that monitoring an individual's improvement from less mature defence to more mature defence use is possible through self-report questionnaires such as the DSQ. Further, Vaillant (2000) highlights the value of being aware of an individual's defence pattern as it can be predictive of positive or negative health consequences.

In addition, the findings that an *image-distorting style* could be predictive of vicarious trauma can potentially provide a platform for further research on therapist wellbeing and coping. It may benefit therapists' wellbeing if training programmes similar to the one discussed above were implemented in graduate programs or institutions that hire psychologists. Furthermore, most hospitals employ psychologists who deal with high numbers of trauma related cases. Such institutions may benefit from these programs in order to promote the wellbeing of their mental health care practitioners. As the findings indicate therapists' tendency towards using particular defences within the image-distorting style, such as splitting and projection, increases the chances of vicarious trauma. The findings are valuable because they allow for the realization of which defences are implicated in either the poor functioning or wellbeing for therapists. The findings in the current study suggest that the tendency to such defences within the image-distorting style can be hazardous to therapists' wellbeing, and increase their chances of developing vicarious trauma. Additionally, undetected or unmanaged vicarious trauma can also affect their efficiency as therapists. Vaillant (2000) asserts that mature defence styles, like the adaptive defence style, aid in the development of healthy interpersonal relationships. Therefore, it is possible to assume that an adaptive defence style would be a preferred defence style for a therapist due to the importance of the therapeutic alliance which relies heavily on one's ability to form healthy interpersonal relationships. However, Vaillant (2000) asserts that an adaptive defence style does not necessarily

transform reality, but rather an individual's perception of reality, which is considered subjective. Thus, Vaillant (2000) explained that an adaptive defence style may not predict physical health decline, which is considered more objective.

This study does not suggest that an image-distorting defence style predicts poor effectiveness as a therapist, but rather that it could affect therapist' wellbeing. The alternative is the possibility that they could become harmful treatment providers if unaware of their defence use. Conte & Plutchik (1995) further explain that knowledge of defence style could allow for advanced understanding of developmental stages and ego functioning because defences can be grouped, as opposed to only considering individual defences in human functioning and progression. As it stands, understanding "intrapsychic and interpersonal processes" is not an easy endeavour. Thus knowledge on defence style can assist in validating and explaining behaviour or reactions to situations as related to groups of defences (Conte & Plutchik, 1995, p. 202). Further, defence style as opposed to individual defences allows for exploration of the combination of defences (defence style) in relation to an individual's ability to deal with stressors in different situations (Conte & Plutchik, 1995). Literature has highlighted the link between defence use and vicarious trauma (Adams & Riggs, 2008; McCann & Pearlman, 1990). It is vital to point out that vicarious trauma is known to affect a therapist's ability to be a good treatment provider. However, vicarious trauma can be prevented and treated. The implications of vicarious trauma are discussed below.

The limited research on defence style of therapists in South Africa and internationally limits the comparison with other studies and also minimizes the literature available on defence style. This does, however, demonstrate the possible contribution and relevance the current study can have in South Africa, to both scientific knowledge and therapists' wellbeing. Further research on defence styles of therapists is necessary to investigate the potential impact on wellbeing and treatment. This research does reveal the possibilities with regard to the measurement of defences and the probable implications of defence styles in therapists. Bond (2004, p. 270) asserts that the quality of defences a person may possess, "makes a difference in adult development". Thus, the use of adaptive defences can limit any future harmful outcomes.

***Vicarious Trauma.*** The implications of the current findings for vicarious trauma are that defence style could be predictive of vicarious trauma. One reason for this statement is that,

contrary to the bulk of the literature, the majority of the aforementioned variables and demographic factors were *not* found to be associated with vicarious trauma. Therefore, emphasis should be placed on the significance of *defence style* in relation to vicarious trauma. Nonetheless, the researcher cannot disregard other factors as possibly playing a role in the development of vicarious trauma, especially owing to the abundance of empirical evidence as discussed in Chapter 2. It is possible that the current sample was not large enough to produce significant results. In addition, it is also possible that the sample did not represent therapists from differing work environments in South Africa, some of whom may receive more trauma specific cases. The sample consisted mainly of therapists in private practice (62%) where the workload may be lower, with fewer trauma specific cases. It is possible that therapists who work in higher stress environments such as government hospitals or rural based clinics in South Africa, may provide evidence to the contrary. Hospitals and clinics are most likely to receive trauma specific cases which are followed up in their psychology departments. In addition, the majority of South Africans are unable to afford private practice fees and would rely more on institutional or clinic based interventions. Further analysis conducted to explore the difference between institutions and private practice (as these were the larger groups in terms of frequencies in work environment) in relation to vicarious trauma. However, the results were non-significant. This indicated that there was no difference between those who engaged in supervision in relation to vicarious trauma and those who did not.

It is proposed that a larger more representative sample may render different results and is a recommendation for future studies. Nonetheless, there are several implications for the treatment of vicarious trauma, as the literature indicates that vicarious trauma has negative effects on mental health care workers. Further, the results of the current study do provide some evidence that vicarious trauma is associated with defence style. This can have significant implications for further studies on vicarious trauma.

### 6.3. Factors Associated with Vicarious Trauma

As discussed in Chapter 2, literature has highlighted various factors as posing a risk for, or increasing the vulnerability of therapists to, vicarious traumatization. More specifically, the variables of gender, age, supervision attendance, years of experience, trauma experience, trauma caseload, general caseload, personal trauma history and help seeking for personal

trauma, have been empirically associated with the development of vicarious trauma. However, the results of the current study were not able to provide sufficient evidence that *all* these factors are in fact associated with vicarious trauma in South African therapists. The results and implications are discussed below.

***Age.*** According to the literature on vicarious trauma, age was hypothesized as being linked to the development of vicarious trauma. Ensel and Lin (1998, as cited in Lerias & Byrne, 2003) suggest that the perception of a stressor will vary according to the age and development of the individual. One study by Ghahramanlou and Brodbeck (2000, p. 229) showed a link between age and the development of vicarious trauma, supporting their hypothesis that a younger age "significantly predicts higher levels of secondary trauma intensity". What also appears associated with vicarious trauma and age is the experience of the individual, which could possibly buffer the association between age and vicarious trauma. The less experienced individual may be more vulnerable to vicarious trauma regardless of age. However, it is evident that experience comes with years of practice as a therapist suggesting that older therapists may be less vulnerable to vicarious trauma (Lerias & Byrne, 2003).

The current study showed no significance between age and vicarious trauma despite the literature indicating that such significance is expected. It is possible that the sample size may have affected the current results. According to Way *et al*., (2007), research using larger samples is necessary to properly assess such demographic factors like age or gender. It is hypothesized that using a larger sample size could render significant results. The average age of therapists in the current study was 43 years with the average years of experience being 11 years. This could imply that most of the participants have more than 10 years of experience. As the literature indicates, the more years of experience therapists have, the less likely they are to develop vicarious trauma. It is perhaps the case that, on average, the mean age was high which may have influenced the outcome of the current study.

***Gender.*** It seems pertinent to address the issues around gender in this study. There has been contradicting literature on vicarious trauma and its relationship to the gender variable. Findings in some studies do indicate that females significantly predict more vicarious trauma symptoms (Kassam-Adams, 1995; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). Other studies indicated no significance with regard to gender and vicarious trauma symptoms (Adams & Riggs, 2008; Way et al., 2004). In line with the latter findings, the current study

found no significance between gender and vicarious traumatization. It is possible that the non-significant result could demonstrate that there are no differences in gender with regard to the development of vicarious trauma symptoms. The frequencies of the current study, although using a small sample size, are also similar to other findings with regard to the ratio of males and females. The current findings indicate that there appears to be higher frequencies of females than that of males (32% females and 9% males) who participate in these studies or are in the field of psychology in general. Unfortunately, this study was unable to do further analyses on the gender variable due to the small sample size (N = 53). The initial questionnaire that was distributed to therapists across South Africa excluded gender as a demographic specifier. When the researcher realised this, efforts were made to rectify it. However, only 53 participants were able to specify their gender after the variable had been added to the demographic questionnaire, limiting its usefulness for further analyses. This is discussed further as a limitation to this study.

***Ethnicity.*** Recent literature on vicarious trauma does not indicate any difference in ethnicity. According to Hesse (2002), symptoms of vicarious trauma may occur regardless of demographics like race/ethnicity. Analyses on ethnicity showed no significant difference in vicarious trauma development. Further multivariate results also indicated no significant association between ethnicity and vicarious trauma. These results are consistent with other research that has found no association between ethnicity and the development of vicarious trauma symptomology (Adams, Matto & Harrington, 2001; Adams & Riggs, 2008; Hesse, 2002; Lerias & Byrne, 2003).

***Personal Trauma***. As discussed in Chapter 2, there is a large body of literature that suggests that a history of personal trauma can increase vulnerability towards vicarious trauma (Adams & Riggs, 2008; Figley, 1999; Ghahramanlou & Brodbeck, 2000; Nelson-Gardell & Harris, 2000; Pearlman & Saakvitne, 1995; Ryan, 1999). In the current study, 92 participants indicated that they had experienced personal traumas and only 23 participants indicated that they had not. The large number of participants who have experienced personal traumas implies that the majority of therapists in South Africa have experienced personal trauma at one point or another in their lives. The finding that 80% of the sample reported a history of personal trauma corroborates with other findings indicating a high prevalence of personal trauma amongst therapists in general (Pope & Feldman-Summers, 1992).

However, the results of the current study did not find any evidence for an association between personal trauma and vicarious trauma. However, literature supports the notion that prior context-specific training in trauma therapy is necessary to buffer the negative effects of working with trauma victims (Adams & Riggs, 2008). It appears that the current sample had approximately 11 years of experience in trauma therapy. It was observed that 70% of the sample had master's degree in psychology which could suggest that trauma-specific training may have been included in the masters programme. Thus, it is possible that the sample were equipped to handle trauma therapy. In addition, 44% indicated that they had sought help for their personal traumas; this could also act as a buffer for the negative impact of trauma work. The benefit of trauma therapy is evidenced in the literature and could serve as a protective factor for therapists who may have experienced personal trauma. Although the *help-seeking for personal trauma* specifier did not reach statistical significance in relation to vicarious trauma, it is possible that participants who sought help would have recovered and maintained their mental health. Furthermore, literature suggests that therapists who are able to maintain a balance between work and play decrease the impact of vicarious trauma symptoms (Trippany *et al.,* 2004).

Interestingly, a statistically significant multivariate result was obtained for the specifier, *time lapse between personal trauma* and overall professional quality of life (burnout, compassion satisfaction and vicarious trauma). Further univariate analyses, however, did not provide a statistically significant result for any of the three dependent variables, including vicarious trauma. An examination of the descriptive statistics reveals that there was an average of 7 years between personal trauma and present date.

***Experience.*** Literature confirms that the experience level of a mental health professional is predictive of less severe vicarious trauma symptomology (Aparicio, Michalopoulos & Unick, 2013). Whether it be years of experience or education/training, literature suggests that increased experience and training is vital for therapists to cope with traumatic content in therapy (Follette *et al*., 1994 as cited in Trippany *et al*., 2004). Despite evidence to the contrary, the findings of the current study did not find significant results between years of experience and vicarious trauma. A majority of the sample in this study had 11 years of experience, with 70% of the sample having master's degrees, and 22% with PhDs. An over representation of the experience variable may have affected the outcome.

The non-significant result could be considered as a desirable result, as it implies that experience has no effect on the development of vicarious trauma symptomology. Although the literature suggests that novice therapists may be less equipped to deal with the emotional and traumatic content of victims, increasing their vulnerability towards vicarious trauma, it is possible that other psychological mechanisms and individual characteristics may be more predictive of vicarious trauma. Further research would be necessary to investigate this further. In addition, a study which focuses on novice therapists in South Africa may be necessary to further explore the differences between novice and more experienced therapists. Contrary to the findings of the current study however, Adams & Riggs' (2008) study on novice/student therapists, reported considerably higher frequencies of vicarious trauma symptoms in student therapists with less practical experience.

***Caseload.*** Vulnerability towards vicarious trauma appears related to caseload according to various studies (Adams & Riggs, 2008; Pearlman & Mac Ian, 1993; Schauben & Frazier, 1995; Trippany *et al*., 2004). According to the literature, therapists whose primary work involves trauma cases are at more risk for vicarious trauma (Trippany *et al*., 2004). However, the current study provided no significant results between *trauma caseload* and vicarious trauma. A statistically significant result was obtained between *overall caseload per week* and the *combined* dependent variables (burnout, compassion satisfaction and vicarious trauma). However, in further analysis between subjects (i.e. when each variable from ProQol was considered separately), none of the variables reached statistical significance, including vicarious trauma. One reason for the non-significance of the univariate result could be due to the imbalance in the sample as there were a variety of answers with regard to caseload per week. It is also worth considering the influence of missing data as this can affect overall analysis.

On the other hand, according to Trippany *et al* (2003), trauma counsellors who saw an average of 14 to 15 clients per week did not suffer from symptoms of vicarious trauma. According to the finding of the current study, South African therapists (the majority of whom were in private practice) were seeing approximately 7 trauma cases per week. Therefore, it appears that controlling the number of trauma cases per week can potentially limit the likelihood of developing vicarious trauma (Trippany *et al*., 2004). These findings appear consistent with others that reported fewer vicarious trauma symptoms and less stress when the overall caseload was limited (Hellman, Morrison & Abramowits, 1987; Trippany *et al*.,

2003; Trippany *et al*., 2004). Given the findings of previous studies, low caseload in the current sample may have influenced the outcome. The majority of participants in this sample worked in private practice and perhaps had a lower overall caseload as opposed to those who work in various institutions or clinics. Further analysis was unable to support a difference with regard to therapists in private practice and those in institutions. Research specifically with therapists in government or other institutions could provide more information on whether caseload has an effect on personal wellbeing and the development of vicarious trauma.

***Supervision*.** It has been empirically supported that supervision, either peer or formal, serves as an important resource for therapists (Catherall, 1995; Schauben & Frazier, 1995; Trippany *et al*., 2004). According to Trippany *et al*. (2004), discussing experiences of trauma can help to normalize any symptoms that may arise due to engagement with trauma therapy. Literature on the topic of supervision appears to highlight the benefit of sharing experiences in order to deal with vicarious trauma (Trippany *et al.,* 2004). The current study was unable to provide similar results with regard to supervision engagement. Further analysis was also conducted to explore whether those who engaged in supervision and those who did not would differ in terms of their vulnerability to vicarious trauma. The findings indicated no significant difference between the groups. It is important to acknowledge the possible interplay of other factors in the development of vicarious trauma. Although this was not an objective of the current study, it could be hypothesized that supervision could influence vicarious trauma depending on other factors in the therapist's life, for example, personal trauma or other life stressors. Future research may include the interaction of these factors as predictors of vicarious trauma, rather than each variable on its own.

It is however, possible to assume there are certain implications with regard to supervision as a protective factor against vicarious trauma. This was further supported by the fact that the majority of the sample were engaging in some form of supervision. Research on the benefit of supervision as a buffer for vicarious trauma may be necessary, perhaps with a larger sample. In addition, according to Pearlman and Saakvitne (1995, p. 360), there are vital components necessary for effective supervision following trauma therapy with clients. These include (1) a good understanding of trauma therapy, (2) understanding the unconscious and conscious aspects of trauma treatment, (3) training around vicarious trauma. In addition to

supervision, literature advocates self-care strategies and the possibility of these being incorporated in supervision discussions (Sommer, 2008).

***Therapeutic modality*.** There are numerous possible therapeutic modalities that a therapist may make use of during a therapy session. As previously discussed, it is possible that certain therapeutic modalities could have an effect on a therapist's wellbeing. Findings in the current study suggest that the majority of therapists in South Africa use Cognitive Behavioural Therapy (CBT) (35% of the study's sample), followed by Eclectic modalities (26%). As indicated in the literature review, specific therapeutic modalities (such as the WITS trauma model) are commonly used to treat trauma specific cases. Surprisingly, only 2% of the sample indicated specific trauma models as their commonly used therapeutic modality, given the high rates of trauma cases in South Africa. However, as discussed in the literature review, most trauma models, like the WITS trauma model or trauma debriefing, are essentially CBT oriented. It is possible that therapists who indicated CBT as their primary therapeutic modality, used CBT techniques or even the WITS Trauma model when dealing with trauma specific cases. Also mentioned in the literature review, was the benefit of using, for example, both psychodynamic and CBT components to promote holistic recovery from a traumatic incident (Eagle, 1998), which could have been the case for those who made use of eclectic modalities. In addition, the second most used modality was the Eclectic type, which implies that these therapists make use of various elements from a range of therapeutic techniques. One benefit of this, is that a high percentage of therapists appear to tailor their therapy to suit the specific needs of their client. It was clear in the literature that using more integrative techniques is beneficial for holistic treatment of trauma, and also preventing PTSD. Is it then possible to suggest that type of therapeutic modality can have an effect on the development of vicarious trauma?

Interestingly, the current study did find a significant result with regard to therapeutic modality and vicarious trauma. The results indicate that therapeutic modalities are significantly different with regards to vicarious trauma. However, further post hoc investigations were thus necessary to determine which modality was specifically predictive of vicarious trauma. However, post hoc testing indicated none of the therapeutic modalities reached statistical significance. It is possible this finding was due to low statistical significance which is largely an indication of the low statistical power, generally, and, more specifically, the low number of participants in some of the modality groups. Unfortunately,

this can sometimes happen, and therefore it is difficult to make a clear determination of which groups are different from which. It is proposed that a larger sample may assist in further investigating the significance between therapeutic modality and vicarious trauma. It is also proposed that certain demographics, like therapeutic modality be categorized in the questionnaire in order to obtain larger groupings, for instance, of specific therapeutic modalities like the WITS trauma model.

### 6.4. Factors Associated with Defence Style

Interestingly, the findings that certain demographic factors (i.e. years in practice, trauma experience, caseload, help seeking for personal trauma and personal trauma history), were associated with the psychological mediator, *defence style.* Although this was not a primary objective in this study, the above mentioned demographic associations were not expected and it is important that these findings are briefly discussed as they add meaning to the results. As previously mentioned in Chapter 3, defences can be related to how a person adapts to different situations (American Psychiatric Association, 2000). In addition, defences are implicated in the management of stress, emotions and psychological functioning. The significant findings in the current study suggest that individual factors (such as years in practice, trauma experience, caseload, trauma history and help-seeking for personal trauma) and psychological mechanisms are associated with the defence styles.

A significant negative correlation between *years in practice* and *image-distorting defence style* was obtained indicating that increased use of unhealthy defences was associated with fewer years in practice. This finding could imply that therapists who have less experience may use immature defences. *Experience with trauma therapy* was also found to be negatively associated with the *image-distorting defence style*. Overall, it appears that the image-distorting defence style is associated with both fewer years in practice and less trauma specific experience. As the literature suggests, defence styles can be progressive or developmental, meaning they can change or develop over time (Bond, 1995). Perhaps the association between experience and the image-distorting defence style could suggest that defences mature over time or as the individual gains experience. As Cramer (2009) explained, there are various cognitive processes that are involved in defence clusters and it is necessary to consider the developmental nature of these defences. In addition, literature

suggests that experience level can also determine an individual's propensity towards vicarious trauma.

The finding of a negative correlation between *general caseload per week* and *affect-regulating defence style* suggests that a higher caseload decreases the frequency of the affect-regulating defence style which is described as comprising more mature defences. Thus, it is possible that participants with a higher caseload are less likely to use the defences associated with the affect-regulating defence style (i.e. intellectualization, isolation or dissociation). In addition, there was a significant negative correlation between *personal trauma history* and *adaptive defence style*. Less personal trauma is associated with more adaptive defence styles. Research on personal history of a therapist indicates that there are possible negative consequences, especially if the trauma is unresolved. The finding that personal trauma history is negatively associated with the adaptive style suggests that these therapists are less likely to distance themselves from their emotions and rather attempt at processing their personal trauma in a healthy manner.

A significant positive correlation was observed for *help seeking (personal trauma)* and *affect-regulating defence style.* This finding suggests that those that use healthier defences seek help for their personal trauma. The affect-regulating defence style, however, is not the healthiest defence style as it comprises defences such as isolation and dissociation. According to Adams and Riggs (2008), such individuals have a tendency towards distancing themselves from their therapeutic work and their emotions, perhaps in higher stress environments. Therefore, it could be postulated that those with an affect-regulating defence style may attempt to seek help for their personal trauma due to the signs and symptoms they may experience. It is possible to assume that this awareness could be related to the defence intellectualization which is clustered within the affect-regulating defences style. The defence of intellectualization allows an individual to talk about their emotions even if they appear 'emotionless' (McWilliams, 2011, p. 124). It would perhaps allow the therapist to think in a rational manner and acknowledge the necessity to seek help for their personal trauma (McWilliams, 2011). Literature shows that managing emotions and stressors is associated with the defences individuals use. These additional findings show how the therapist is able to manage information and their emotions through the use of defence mechanisms, which can influence the development of vicarious trauma symptoms.

# CHAPTER 7

# CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

## 7.1. Conclusion

The main objective of the current study was to explore vicarious trauma of therapists in relation to defence style and other associated factors. The study intended to add to the body of knowledge on therapists' defence styles and wellbeing. In addition, the study proposed to explore whether there were associations between other factors and vicarious trauma, in particular, the relationships between age, gender, caseload, supervision, experience, therapeutic modality, and vicarious trauma. A sample of therapists from across South Africa were requested to participate, with the intention of providing a representative sample. The sample was able to provide information on their demographic factors, defence style and vicarious trauma symptoms via online questionnaires. This research was considered pertinent as it pertains to therapists and their wellbeing. In addition, such research could provide valuable knowledge on factors associated with vicarious trauma. The current study could also contribute to the development and implementation of programs that aim to prevent and treat vicarious trauma.

It is evident that in South Africa there is a lack of empirical research on vicarious trauma. In addition, there is no research pertaining to the defence style of therapists in this context. The effect that defence style can have on wellbeing has been documented internationally; however, it is yet to be investigated in the South African context. As discussed in Chapter 2, South Africa is a country with a high rate of traumatic incidents, which would increase the possibility of vicarious trauma compared to other countries. Findings, however, suggested that the average trauma cases seen in the current sample were lower than what was documented in other studies as increasing vulnerability to vicarious trauma. Furthermore, South Africa is a multicultural and diverse nation, which implies that it requires exploration into the aspects of behaviour and psychological mechanisms within its own context and people. It is therefore imperative to study phenomena such as vicarious trauma and defence style in context, rather than relying solely on international evidence. There appears to be a lack of evidence on the interplay of these variables, especially in South Africa, in order to provide a comprehensive explanation on the range of factors associated with both vicarious

trauma and defence style in therapists. In addition, the vast amount of risk and protective factors associated with vicarious trauma and defence style are plagued with interrelated dynamics that go beyond the focus of this study. Thus, recommendations for further research are presented at the end of this chapter.

It was nonetheless expected that an image-distorting defence style would be predictive of vicarious trauma. This hypothesis was substantiated in the analysis. Although the frequency of the image-distorting defence style was extremely low, the finding was interpreted as favourable, due to the negative implications of the image-distorting defence style on mental health, wellbeing and treatment of patients/clients. These findings were also in line with others who found a very low frequency of maladaptive defences in trainee therapists. The finding that the majority of therapists use more adaptive defences in order to cope, provides evidence that training programs do screen their trainees well before placing them in post graduate programs in order to assist with prevention of phenomena such as vicarious trauma. In addition, it appears that the majority of therapists utilize supervision and self-care guidelines appropriately. Although some of the findings were not expected, i.e. the significant results between the demographic factors (fixed external variables) and the psychological mediator (defences), these findings could be considered as valuable as they pertain to the internal mechanisms of the therapists that are associated with external factors. Such psychological mechanisms are important to consider as they have the potential to increase vulnerability towards vicarious trauma.

It is, however, important to acknowledge that this research is rather limited with regard to the significance of the findings. There are limitations which need to be addressed in order to interpret these findings appropriately. In saying this, further research is definitely needed in the area of vicarious trauma and psychological mechanisms, in order to provide information to therapists on self-monitoring of defence style, vicarious trauma prevention and risk factors associated with trauma work.

## 7.2. Limitations

The findings of the current study are not without limitations and findings should be interpreted in the context of such limitations. The following section highlights the limitations of this study.

***Reliability of the Sample (Therapists).*** One of the limitations of the present study is the use of therapists as the sample. Given the nature of the questionnaires (DSQ and ProQol), it is possible that the participants may have had reservations about answering the questions truthfully. Some questions could have led to the assumption that they were not well trained or efficient enough. Therefore, the use of self-report measures in research can lead to ambiguity around honesty and truthfulness of participants' answers. Furthermore, the participants may have felt that responding truthfully might affect the integrity of their profession. Consequently, the participants might have reported in a socially desirable manner. Efforts were made to reassure participants of anonymity throughout the process in order to increase the likelihood of honest responses. Additionally, ethical approval was obtained from the HSSREC in order to allow participants to agree to participate without providing identifiable information.

***Private Practice.*** A second limitation of this study was the high number of participants in private practice. The reason this is considered as a limitation is that those in private practice perhaps do not have such high rates of trauma cases. As evidenced in the discussion chapter, the frequency of trauma cases was below what has been empirically associated with vicarious trauma. In addition, the majority of trauma related cases are possibly screened in institutions, such as hospitals or clinics. Access to such organizations is a more complicated procedure and is discussed in the section on– recommendations for future research.

***Gender Specifier.*** It is with great regret that the researcher was unable to further explore the gender variable in relation to vicarious trauma and defence style. Although there is contradictory research on whether gender has any association to vicarious trauma or defence style, it would have been an interesting component of this study. The intention was to include a full analysis on the gender variable; however, as previously discussed, the initial questionnaire that was completed by participants did not include a specifier for gender. The researcher did amend the questionnaire when the exclusion was realized, but only 53 participants were able to specify their gender. The researcher further attempted to amend the error by requesting all participants to specify their gender via a separate online questionnaire. However, due to anonymity, the researcher did not have any access to participants' names and had to resend email requests to all therapists who had been contacted to participate. The

results of this were minimal and thus the gender specifier was omitted as part of the overall analysis.

***DSQ Scale reliability.*** The DSQ is an instrument that has been revised numerous times. The instrument used in the current study is the most recent modification, with purportedly better scale reliability than the previous versions. However, it is important to note that the DSQ has a low-to-moderate scale reliability (Adams & Riggs, 2008), which needs to be considered as a limitation.

***Lack of Vicarious Trauma Measures.*** The ProQol as a measure of vicarious trauma was used as it is the measure that is used most frequently for any form of secondary/vicarious trauma. The fact that there is no specific instrument to measure vicarious trauma is considered a limitation.

In spite of these limitations, the findings of the current research are beneficial to the field. This study extends the literature on both vicarious trauma and defence style of therapists in South Africa. In addition, it is suggested that further research on the topic is warranted.

## 7.3. Recommendations for Future Research

Based on the findings of the current study, the following recommendations are made for future research:

- Further research on the Defence Style Questionnaire is necessary with the intention of increasing the reliability of the scales. This would add to the knowledge of defence style and the importance of monitoring personal psychological mechanisms that motivate behaviour and coping. In addition, there is evidence that defence style is associated with vicarious trauma and thus the implications of future research on the topic is apparent.

- Future research on defence style and vicarious trauma in the South African context is required due to the lack of research on this subject. Not enough emphasis is placed on therapist wellbeing and it is suggested that they would benefit from such research,

especially if it intended to prevent or aid in the treatment of phenomena such as vicarious trauma.

- Future research could consider making use of a larger sample size in order to gain a more representative sample, where the results would be more generalizable amongst the population of therapists in South Africa. The sample should include ethnicity and place of work. It is, however, important to consider the extremely low frequency of the image-distorting defence style. Further research employing a larger sample may be necessary to investigate the relationship between these variables.

- Further research on measures of vicarious trauma is necessary. The ambiguity around the various concepts, as discussed in Chapter 2, has made it difficult to measure vicarious trauma specifically. A measure specifically for vicarious trauma is called for.

- It is possible that future research conducted from a qualitative perspective could provide more detailed information on therapists' experiences of vicarious trauma. In addition, some literature proposes that defence style can be examined using qualitative methods, which could add an interesting component to this type of research.

- The additional multivariate results on defence style and the demographic variables, although not the main objective of the current study, indicated significant results for several variables. Thus future research could focus of the relationships between defence style and the demographic variables.

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## Appendix 1: Ethical Clearance Letter


16 November 2015

**Miss Urishka S Dubock 206508620**
**School of Applied Human Sciences**
**Howard Campus**

Dear Miss Dubock

**Protocol reference number: HSS/1368/015M**
**Project Title: Vicarious Traumatization in therapists working with trauma: Do defenses make a difference?**

**Full Approval – Expedited Application**

In response to your application received on 28 September 2015, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL.**

**Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.**

**PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.**

**The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.**

**I take this opportunity of wishing you everything of the best with your study.**

Yours faithfully

.....

**Dr Shenuka Singh (Chair)**
**Humanities & Social Sciences Research Ethics Committee**

**/pm**

Supervisor: Prof Duncan J Cartwright
Academic Leader Research: Dr Jean Steyn
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**Appendix 2: Information Sheet**

**INFORMATION SHEET**

| Research Title: |
| --- |
| "Vicarious Traumatization in therapists working with trauma: do defences make a difference?" |

Dear Participant

The current study seeks to validate and explore 'Defence Styles' used by therapists that could influence the onset of Vicarious Traumatization. The information that will be collected will help collate an understanding of whether Defence Style can influence Vicarious Traumatization in the context of Trauma in South Africa.

- If you agree to participate, you will be sent a link via email which will direct you to one demographic questionnaire and two 'Likert Type' questionnaires that will take approximately 15 – 20 minutes to complete. Alternatively, you will be given a hardcopy of the questionnaires to complete if you would prefer.
- Please be assured that no names or identifying information will be required. A short demographic questionnaire will be utilized for research purposes only.
- There are no 'right' answers. Please be honest and truthful when answering the questionnaires in order to increase rater-reliability.
- You are also free to discontinue as a participant at any time during the process.
- If you have any queries concerning the Questionnaires or the study, please feel free to contact the researcher or supervisor.
- Feedback will be provided to all participants who would like feedback on the results of the study. Please contact the researcher or supervisor to obtain feedback on this study.

  Researcher: Ms. Urishka S. Dubock (Tel: 083 641 1180 Email: uripsyc@gmail.com)

  Supervisor: Prof. Duncan J. Cartwright (Tel: 031 260 2507 Email: cartwrightd@ukzn.ac.za)

  HSSREC: Prem Mohun (Tel: 031 260 4557 Email: Mohunp@ukzn.ac.za)

If you are willing to participate in this study, please indicate (tick) in the space provided on the 'declaration of consent' form below and proceed to the questionnaires.

Thank you for your participation in this study.

**Appendix 3: Declaration of Consent Form**

**DECLARATION OF CONSENT**

**PROJECT TITLE:** "Vicarious Traumatization in therapists working with trauma: do defences make a difference?"


**RESEARCHER**

Urishka S. Dubock
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University of KwaZulu-Natal
Howard College Campus
Proposed Degree: Masters (Clinical Psychology)
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I, Urishka S. Dubock, Student no. 206508620 am a masters (Clinical Psychology) student, at the School of Applied Human Sciences, at the University of KwaZulu-Natal. You are invited to participate in a research project entitled: "Vicarious Traumatization in therapists working with trauma: do defences make a difference?"

Through your participation, I hope to generate a better understanding of Vicarious Traumatization in South African Therapists, to determine the role of unconscious defence style in the development of Vicarious Traumatization and to determine how defence style and Vicarious Traumatization interact with other factors such as race, gender, amount of exposure, type of trauma. I guarantee that your responses will not be identified with you personally. Your participation is voluntary and there is no penalty if you do not participate in

the study. Please check the appropriate box below to show that you have read and understood the contents of this letter. The questionnaire will take approximate 15 to 20 minutes to complete.

**Declaration of consent Template*

DECLARATION OF CONSENT

I **have been informed about the details of the study** on "Vicarious Traumatization in therapists working with trauma: do defences make a difference?"
I confirm that I have read and understand the contents of this letter and the nature of the research project has been clearly defined prior to participating in this research project.
I understand everything that has been explained to me and agree to take part in the study at my own free will. I understand that I am at liberty to withdraw from the project at any time, should I so desire.

I agree to participate ☐
I do not agree to participate ☐

**Appendix 4: Demographic Questionnaire**

**DEMOGRAPHIC QUESTIONNAIRE**

| | | |
|---|---|---|
| 1. | Age | |
| 2. | Racial Grouping | Black ☐<br>White ☐<br>Indian ☐<br>Coloured ☐<br>Other ☐ |
| 3. | Gender | Male<br>Female |
| 4. | Highest Qualification | |
| 5. | Years in practice | |
| 6. | Current province of residence | |
| 7. | Do you work in government, private, clinic or institution? | Government ☐<br>Private ☐<br>Clinic ☐<br>Institution ☐ |
| 8. | How many years of experience do you have working with trauma cases? | |
| 9. | What is your trauma case load per week (hours per week)? | |
| 10. | How many hours per week do you spend seeing clients? | |
| 11. | Have you experienced personal traumatic situations? | Yes ☐<br>No ☐ |
| 12. | Time lapse between present date and trauma experienced? | |
| 13. | Did you seek help for the personal trauma? | Yes ☐<br>No ☐ |
| 14. | Do you engage in supervision sessions? If so how many hours per week? | Yes ☐<br>No ☐<br>Hours p/w _____ |

15. What is the therapeutic modality you use the majority of the time?

**Appendix 5: DSQ 60**

# DSQ-60

DSQ-60

INSTRUCTIONS

The items in this questionnaire refer to people's personal views about themselves. Please use the nine-point scale below to indicate to what extent an item is applicable to you by *circling a number (from 1-9).*

Not Applicable to me 1 2 3 4 5 6 7 8 9 Completely Applicable to me

You will circle a higher number when you agree with an item. For instance, if an item is completely applicable to you, circle 9.

You will circle a lower number when you disagree with an item. For instance, if an item is not at applicable to you, circle 1.

Please do not skip any items.

*There are no right or wrong answers!*

1. I get satisfaction from helping others and if this were taken away from me I would get depressed.

   1 2 3 4 5 6 7 8 9

2. People often call me a sulker.

   1 2 3 4 5 6 7 8 9

3. I'm able to keep a problem out of my mind until I have time to deal with it.

   1 2 3 4 5 6 7 8 9

4. I work out my anxiety through doing something constructive and creative like painting or woodwork.

   1 2 3 4 5 6 7 8 9

5. I often change my opinion about people; at one time I think highly of them, at another time I think they're worthless.

   1 2 3 4 5 6 7 8 9

6. I am able to find good reasons for everything I do.

   1 2 3 4 5 6 7 8 9

7. I'm able to laugh at myself pretty easily.

   1 2 3 4 5 6 7 8 9

8. People tend to mistreat me.

   1 2 3 4 5 6 7 8 9

9. If someone mugged me and stole my money, I'd rather he'd be helped than punished.

   1 2 3 4 5 6 7 8 9

10. If I have a conflict with someone, I try to think of what might have been my part in it.

    1 2 3 4 5 6 7 8 9

11. People say I tend to ignore unpleasant facts as if they didn't exist.

1 2 3 4 5 6 7 8 9

12. I often feel superior to people I'm with.

1 2 3 4 5 6 7 8 9

13. Someone is robbing me emotionally of all I've got.

1 2 3 4 5 6 7 8 9

14. When there's real danger, it's as if I'm not there and I feel no fear.

1 2 3 4 5 6 7 8 9

15. If I'm treated unfairly, I stand up for my rights.

1 2 3 4 5 6 7 8 9

16. I manage danger as if I were Superman.

1 2 3 4 5 6 7 8 9

17. I pride myself on my ability to cut people down to size.

1 2 3 4 5 6 7 8 9

18. I often act impulsively when something is bothering me.

1 2 3 4 5 6 7 8 9

19. Actually I'm pretty worthless.

1 2 3 4 5 6 7 8 9

20. When dealing with people they often end up feeling what I feel.

1 2 3 4 5 6 7 8 9

21. I get more satisfaction from my fantasies than from my real life.

1 2 3 4 5 6 7 8 9

22. I withdraw when I'm angry.

1 2 3 4 5 6 7 8 9

23. When I'm in difficulties I often feel unreal.

1 2 3 4 5 6 7 8 9

24. I've got special talents that allow me to go through life with no problems.

1 2 3 4 5 6 7 8 9

25. I prefer to talk about abstract things rather than about my feelings.

1 2 3 4 5 6 7 8 9

26. There are always good reasons when things don't work out for me.

1 2 3 4 5 6 7 8 9

27. I work more things out in my daydreams than in my real life.

1 2 3 4 5 6 7 8 9

28. When people get angry with me, I tend to think they are exaggerating.

1 2 3 4 5 6 7 8 9

29. Sometimes I think I'm an angel and other times I think I'm a devil.

1 2 3 4 5 6 7 8 9

30. If someone gets angry at me I tend to get annoyed by things I usually ignore.

1 2 3 4 5 6 7 8 9

31. I get openly aggressive when I feel hurt.

1 2 3 4 5 6 7 8 9

32. I hardly remember anything from my early school years.

1 2 3 4 5 6 7 8 9

33. I withdraw when I'm sad.

1 2 3 4 5 6 7 8 9

34. I always feel that someone I know is like a guardian angel.

1 2 3 4 5 6 7 8 9

35. I'm actually worse than people think I am.

1 2 3 4 5 6 7 8 9

36. As far as I'm concerned, people are either good or bad.

1 2 3 4 5 6 7 8 9

37. If my boss bugged me, I might make a mistake in my work or work more slowly so as to get back at him.

1 2 3 4 5 6 7 8 9

38. There is someone I know who can do anything and who is absolutely fair and just.

1 2 3 4 5 6 7 8 9

39. If I've experienced something unpleasant then the next day I've sometimes forgotten what it was about.

1 2 3 4 5 6 7 8 9

40. Helping others makes me feel good.

1 2 3 4 5 6 7 8 9

41. I can keep the lid on my feelings if letting them out would interfere with what I'm doing.

1 2 3 4 5 6 7 8 9

42. I'm usually able to see the funny side of an otherwise painful predicament.

1 2 3 4 5 6 7 8 9

43. I often find myself being very nice to people who by all rights I should be angry at.

1 2 3 4 5 6 7 8 9

44. There's no such thing as 'finding a little good in everyone,' if you're bad, you're all bad.

1 2 3 4 5 6 7 8 9

45. When something I do doesn't turn out well, I try to find out what I may have overlooked.

1 2 3 4 5 6 7 8 9

46. People tend to be dishonest with me.

1 2 3 4 5 6 7 8 9

47. When I have to face a difficult situation I try to imagine what it will be like and plan ways to cope with it.

1 2 3 4 5 6 7 8 9

48. Doctors never really understand what is wrong with me.

1 2 3 4 5 6 7 8 9

49. After I fight for my rights, I tend to apologize for my assertiveness.

1 2 3 4 5 6 7 8 9

50. If someone is annoying me, then I tell them without hurting their feelings.

1 2 3 4 5 6 7 8 9

51. I'm often told that I don't show my feelings.

1 2 3 4 5 6 7 8 9

52. When I feel bad, I try to be with someone.

1 2 3 4 5 6 7 8 9

53. If I can predict that I'm going to be sad ahead of time, I can cope better.

1 2 3 4 5 6 7 8 9

54. No matter how much I complain, I never get a satisfactory response.

1 2 3 4 5 6 7 8 9

55. Instead of saying exactly what I feel, I explain my thoughts extensively.

1 2 3 4 5 6 7 8 9

56. Often I find that I don't feel anything when the situation would seem to warrant strong emotions.

1 2 3 4 5 6 7 8 9

57. When I feel depressed or anxious, I like to engage in some creative or physical activity.

1 2 3 4 5 6 7 8 9

58. If I got into a crisis, I would seek out someone to share my worries with.

1 2 3 4 5 6 7 8 9

59. If I have an aggressive thought, I feel the need to do something to compensate for it.

1 2 3 4 5 6 7 8 9

60. When something exciting is happening, I tend to fuss over unimportant details.

1 2 3 4 5 6 7 8 9

THIS QUESTIONNAIRE CONTAINS 5 PAGES, PLEASE ENSURE THAT YOU HAVE COMPLETED EACH ONE.
PLEASE MAKE SURE THAT YOU HAVE NOT FORGOTTEN ANY QUESTIONS.
THANK YOU FOR YOUR COOPERATION!

**Appendix 6: ProQol 5**

ProQol – 5

When you engage in therapy with people you have direct contact with their lives. As you may have found, your compassion for those you help can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a therapist. Consider each of the following questions about you and your current work situation. Select the number that reflects how frequently you experience these things in the last 30 days.

1 = Never 2 = Rarely 3 = Sometimes 4 = Often 5 = Very Often

Please do not skip any items.

There are no right or wrong answers.

1. I am Happy.

1 2 3 4 5

2. I am preoccupied with more than one person I engage in therapy with.

1 2 3 4 5

3. I get satisfaction from being able to do therapy with people.

1 2 3 4 5

4. I feel connected to others.

1 2 3 4 5

5. I jump or am startled by unexpected sounds.

1 2 3 4 5

6. I feel invigorated after working with clients in therapy.

1 2 3 4 5

7. I find it difficult to separate my personal life from my life as a therapist

1 2 3 4 5

8. I am not as productive at work because I am losing sleep over traumatic experiences of a client/patient.

1 2 3 4 5

9. I think I might have been affected by the traumatic stress of a client/patient.

1 2 3 4 5

10. I feel trapped in my job as a therapist.

1 2 3 4 5

11. Because of being a therapist (providing therapy), I have felt 'on edge' about various things.

1 2 3 4 5

12. I like my work as a therapist.

1 2 3 4 5

13. I feel depressed because of the traumatic experiences of my clients/patients.

1 2 3 4 5

14. I feel as though I am experiencing the trauma of someone I have done therapy with.

1 2 3 4 5

15. I have beliefs that sustain me.

1 2 3 4 5

16. I am pleased with how I am able to keep up with therapeutic techniques and protocols.

1 2 3 4 5

17. I am the person I have always wanted to be.

1 2 3 4 5

18. My work makes me feel satisfied.

1 2 3 4 5

19. I feel worn out because of my work as a therapist.

1 2 3 4 5

20. I have happy thoughts and feelings about my clients/patients and how I can help them.

1 2 3 4 5

21. I feel overwhelmed because my case load seems endless.

1 2 3 4 5

22. I believe I can make a difference through my work.

1 2 3 4 5

23. I can avoid certain activities or situations because they remind me of frightening experiences of the clients/patients I see.

1 2 3 4 5

24. I am proud of what I can do to help.

1 2 3 4 5

25. As a result of therapeutic engagement, I have intrusive, frightening thoughts.

1 2 3 4 5

26. I feel 'bogged down' by the system.

1 2 3 4 5

27. I have thoughts that I am a success as a therapist.

1 2 3 4 5

28. I can't recall important parts of my work with trauma victims.

1 2 3 4 5

29. I am a very caring person.

1 2 3 4 5

30. I am happy that I chose to do this work.

1 2 3 4 5