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Contents

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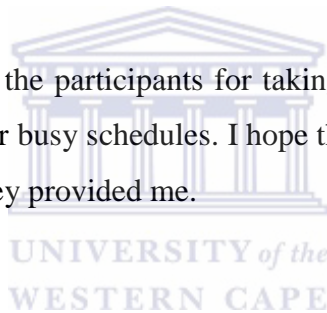
Abstract

In South Africa, psychologists are increasingly encountering survivors of traumatic events in their daily practice due to the high rates of trauma exposure in the general public. Providing psychological care in communities where there is a high prevalence of trauma can take a severe emotional toll on psychologists and result in the occurrence of vicarious trauma. This study is phenomenological in that it explores the idiographic experiences of vicarious trauma among psychologists who work with trauma survivors in the South African context and the coping strategies they use. Individual semi-structured interviews were conducted with six registered clinical/counselling psychologists in Cape Town who have been working in the trauma field for more than three years. Data were analysed by means of an interpretive phenomenological analysis. All participants were found to be affected as a result of working empathically with trauma survivors. The symptoms of vicarious trauma experienced by participants included cognitive symptoms, symptoms characteristic of posttraumatic stress disorder, and psychosomatic symptoms. Despite the negative consequences of working with trauma survivors, vicarious posttraumatic growth was found in many participants. Practical and psychological self-care strategies were used by participants to cope with vicarious trauma. The Constructive Self-developmental Theory was used to interpret the findings. The theory outlines how trauma can challenge an individual's cognitive schema and affect five components of self, namely, cognitive frame of reference, self-capacity, ego resources, psychological needs, and memory and perception. This study provides practical recommendations for training, supervision and clinical practice for psychologists in South Africa so as to enhance the efficiency of psychological service delivery to traumatised populations. Ethics guidelines of the University of the Western Cape were strictly upheld to ensure ethical standards and practices in the conduct of research.

Chapter 1: Introduction

1.1 Background

South Africa is a developing country with a history of past constitutional racial segregation and exploitation in the form of Apartheid. The country achieved non-racial democracy in 1994 to end the long period of political violence and state-sponsored oppression (Norman, Matzopoulos, Groenewald & Bradshaw, 2007). In the post-Apartheid era, there is still a high degree of trauma exposure in the general public (Atwoli et al., 2013). The society is characterised by a high frequency of traumatising events, particularly interpersonal violence. As a result of working in a context where there is a high prevalence of trauma, South African psychologists are increasingly encountering survivors of trauma in their clinical practice (MacRitchie & Leibowitz, 2010).

Traumatic events not only have an impact on the survivors but can adversely affect psychologists who provide psychological care because they are exposed to their clients' trauma material by hearing the trauma narratives. In the last two decades, there has been a growing body of evidence documenting the mental health consequences of providing psychological care to trauma survivors for psychologists (Cohen & Collens, 2012; Gerding, 2012). Providing psychological care can take a severe psychological toll on therapists and lead to them being vicariously traumatised. Vicarious trauma (VT) is the "permanent transformation in the inner experience of the therapist[1] that comes about as a result of empathic engagement with clients' trauma material" (Pearlman & Saakvitne, 1995, p.31).

The main symptoms of VT include a transformation in the therapist's cognitive frame of reference (Jenkins & Baird, 2002). Trauma often presents an enormous challenge to people's beliefs, assumptions and meaning systems (Kaminer & Eagle, 2010). This change in cognitive schemas can affect their tolerance, fundamental psychological needs, deeply held beliefs about self and others, interpersonal relationships, internal imagery, and physical presence in the world (Pearlman & Saakvitne, 1995). One of the common psychological consequences of exposure to trauma is PTSD (Nolen-Hoeksema, 2007). As a consequence from working with traumatised patients over time, it is also possible for psychologists to develop symptoms characteristic of Posttraumatic Stress Disorder (PTSD) as part of the symptom picture of VT (McCann & Pearlman, 1990). The symptoms parallel PTSD yield

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[1] In this study, the term "therapist(s)" refers to clinical or counselling psychologists. It has been used interchangeably with "psychologist(s)" throughout the dissertation.

painful experiences of images and emotions associated with the client's traumatic memories and may be profound and long-lasting (McCann & Pearlman, 1990).

Other symptoms of VT include behavioural and physical symptoms (Gerding, 2002). Consequently, unaddressed VT can lead to a loss of efficiency in the treatment delivery for patients, an inability to discharge professional, social, and personal responsibilities, and diminished job satisfaction (Pearlman & Saakvitne, 1995). Therefore, VT has a detrimental impact on psychologists' personal, professional and social life (McCann & Pearlman, 1990). It is imperative for psychologists to recognise their vulnerability to the exposure to trauma as well as the warning signs, so they can be prepared to care for their own needs to cope with VT for ethical and professional psychological services to be delivered.

1.2 Problem Statement

Significant research efforts have focused on developing treatments for trauma survivors and evaluating their effectiveness. However, little attention has been given to understanding the impact of working with trauma survivors on psychologists. This research aimed to address this gap in the literature. In South Africa, there is a scarcity of published qualitative studies that focus on the experiences of VT among psychologists who work with survivors of trauma. Given the increasing prevalence of traumatic events in South Africa and increasing patient load, psychologists may be vulnerable to the development of VT. Beneficial treatments for trauma survivors largely depend on psychologists who can effectively handle their clients' intense traumatic material. If a psychologist is adversely affected by the work of trauma, the quality of treatment for trauma survivors will be compromised (Figley, 1999). Hence, it is critical that research continues to explore the effects of VT and ways to ameliorate them.

1.3 Aim

To explore the experiences of VT among a group of psychologists from Cape Town, South Africa, who work with trauma survivors and the related coping strategies used by them.

1.4 Research Questions

1. What are the experiences of VT among psychologists who work with trauma survivors?
2. What are the coping strategies the psychologists use to ameliorate the effects of VT?

1.5 Significance of the Study

This research aimed to expand the local research on the phenomenon of VT. Findings of the study will help to facilitate a better understanding of vicarious impact of trauma work as well

as the related coping techniques used by psychologists. Identification of protective factors and effective coping mechanisms of those professionals in this study was a distinct contribution to the South African literature base. This study has practical implications for training, supervision and clinical practice for psychologists in South Africa to enhance the efficiency of psychological service delivery. Exploring the challenges South African psychologists experience as a result of working with trauma survivors may help inform policy and develop effective programmes to address the effects of VT. As such, psychologists would be better equipped to care both for themselves and their clients, and to ensure ethical and professional practice.

Chapter 2: Literature Review

2.1 Prevalence of Interpersonal Violence in South Africa and Risk of PTSD

The South African population is exposed to different types of violent crimes particularly in the forms of physical assault, sexual offences, murder, and intimate partner violence (World Health Organization [WHO], 2013; South African Police Services (SAPS), 2013). Violent crime in South Africa has also been recently highlighted internationally by a new wave of Xenophobic attacks since 2008, leaving many immigrants severely injured (World Report, 2014). SAPS (2013) compared the total numbers of the most prevalent types of crime with the previous year and the results indicated that murder has increased by 4.2%, sexual offences have increased by 2.9%, and cases of robberies have increased by 3.2%. These criminal acts are referred by the police as 'interpersonal' violent crimes that can result in severe trauma, injury, or death to the victim (SAPS, 2013). According to SAPS (2013), the steady increase of violent crimes causes the most fear and trauma amongst the public, and the high prevalence of crime does not seem to deteriorate over time. The latest crime statistics showed that from 2013 to 2014, South Africa experienced two of the worst years in the last decade in terms of crime reduction (Africa Check, 2014). Studies have consistently indicated that exposure to interpersonal trauma is more likely to be associated with PTSD than any other form of trauma (Creamer, Burgess, & McFarlane, 2001; Zlotnick, Johnson, Kohn, Vicente, Rioseco, & Saldivia, 2006). As a consequence of the high rates of interpersonal crime in South Africa, there is an increasing demand for psychological services to be delivered to trauma survivors (Atwoli et al., 2013). Yet, apart from the traumatic events that are interpersonal in nature, other forms of trauma, for example, emotional abuse, neglect, community-based violence, disaster, motor vehicle accidents, and being a witness of trauma are also significant reasons that survivors seek psychological help (Nolen-Hoeksema, 2007).

Traumas are overwhelming experiences that can shatter a survivor's assumptive world (Janoff-Bulman, 1992). That is, after an exposure of trauma, individuals' core beliefs about themselves, other people, and the world that provide grounding and give meaning to their lives are changed profoundly and negatively (Herman, 1992). Before the trauma, most people hold pre-existing assumptions that the world is benevolent, meaningful, and that the self is worthy (Janoff-Bulman, 1992). These inarticulated assumptions and meanings are a vital part of people's internal cognitive model of the world and underpin a sense of basic well-being (Kaminer & Eagle, 2010). Intense feelings of powerlessness during and after a trauma may shatter trauma survivors' basic trust in their own capacity to control events and themselves

which may create enormous distress, vulnerability and uncertainty for them (Janoff-Bulman, 1992).

One consequence of the shattering of the assumptive world is the development of PTSD. The symptoms of PTSD persist when individuals have excessive negative appraisals of the trauma (Ehlers & Clark, 2000). PTSD is characterised by the following categories of reactions: (1) intrusion symptoms; (2) avoidance; (3) negative alterations in cognitions and mood; and (4) alterations in arousal and reactivity (American Psychiatric Association [APA], 2013). PTSD is associated with impairments in functioning across a variety of domains such as social functioning, school functioning and occupational functioning (Holowka & Marx, 2012). Given the pervasive nature of interpersonal violence in South Africa, it is not surprising that high rates of PTSD (19.9%) have been documented among South African patients attending primary healthcare clinics (Seedat, 2013). Atwoli et al. (2013) estimated the lifetime prevalence rates of PTSD in South Africa to be 2.3% and 12-month prevalence rates to be 0.7%. The prevalence of PTSD after trauma exposure was found to be 3.5%.

2.2 Vicarious Trauma in South Africa

In South Africa, the majority of studies have focused on the impact of trauma on the survivor. Yet only few studies have investigated the psychological consequences of working with trauma survivors for psychologists. Existing studies in this area have conceptualised the impact of working with challenging populations as burnout or secondary traumatic stress (STS). The nature of these studies was mostly quantitative focusing on the prevalence and factors that contribute to the negative psychological consequence on health care or service providers as a result of working with challenging population. For example, the prevalence of burn out was found high in therapists working in physical rehabilitation units in South Africa. Most of them suffered from emotional exhaustion in which was found significantly associated with not having children, poor coping skills, overwhelming workload and poor work environment (Du Plessis, Visagie, & Mji, 2014). Another study focused on the psychological impact on trauma workers and the results indicated significant interrelationships between level of exposure, empathy, social support and STS (MacRitchie & Leibowitz, 2010). In a study that explored the emotional stress among clinical and counselling psychologist in South Africa, the results indicated that over half of the participants reported above average anxiety levels and over half were mildly depressed (Jordaan, Spangenberg, Watson, & Fouchè, 2007). Lastly, Ludick, Alexander and Carmichael (2007) explored the level of STS in claims workers operating within the short-term insurance

industry who deal with traumatised clients and distressing materials. 43% of the sample expressed high levels of STS. An association between high STS scores and an exhibition of PTSD symptoms was also established. These studies, even though limited in number, are empirical and give a good indication that professionals who work with survivors of trauma are under the risk of developing psychological and emotional symptoms associated with VT in South Africa.

2.3 Vicarious Trauma as a Consequence for Delivering Psychological Treatment

Trauma treatment is often rigorous and requires the therapist's use of self and relationship to provide emotional containment and facilitation of the resolution of traumatic material (Courtois, 1993). Edwards (2009) mentioned that there is a considerable commonality between different psychological treatments for trauma. Most models would include intervention techniques such as asking clients to tell the story of a traumatic event, and helping them to engage emotionally with their experience of what happened (Edwards, 2009). This means that therapists are directly exposed to the traumatic material by listening to their clients' trauma narratives.

In order to deliver effective interventions to traumatised clients, it is necessary to engage empathically so as to establish an effective therapeutic alliance. However, when working with trauma survivors, being compassionate and empathic can extort emotional costs from psychologists (Figley, 2002). Psychologists are trained to maintain personal and professional boundaries necessary for ethical practice. However, maintaining professional distance does not insulate them from the effects of intense emotional content revealed by trauma victims (Helm, 2008). APA (2013) acknowledges that it is possible to become traumatised by repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties. Psychologists can be adversely affected by the exposure to powerful trauma-based material of their clients and experience symptoms of VT (McCann & Pearlman, 1990). In the literature, VT has been used interchangeably with compassion fatigue (CF), secondary traumatic stress (STS), and professional burnout (PB) (Stamm, 1997; Austin, Goble, Leier, & Byrne, 2009; Helm, 2008; Way, Vandeusen, Martin, Applegate, & Jandle, 2004).

2.4 Impact of the Traumatic Material Presented by Clients on Therapists

The emotional residue or strain of exposure to working with those suffering from the consequences of traumatic events can affect psychologists' mental health, physical wellbeing,

relationships, and effectiveness at work. VT is believed to be a cumulative effect arising from working with several trauma survivors over time (Cunningham, 1999; Trippany, Kress, & Wilcoxon, 2004). Psychologists may experience VT when they repeatedly work with traumatic material presented by clients or find their case load heavy with clients who are chronically in crisis (Mathieu, 2007).

Exposure to traumatic events can shatter a person's assumptive world, leading to intense feelings of vulnerability, helplessness and powerlessness (Kaminer & Eagle, 2010). When listening to the details of trauma experienced by the survivors, psychologists are exposed to the horrific narratives of the traumatic event and this can lead to a profound shift in their cognitive schemas and belief systems (McCann & Pearlman, 1990; Boscarino, Adams, & Figley, 2004). They may experience a transformation in the sense of hope and optimism about the future and value of their work, as well as the way they view the world and others (Mathieu, 2007). VT also has the potential to disrupt one's psychological needs of safety, trust, power, esteem, intimacy, independence, and control (McCann and Pearlman, 1990; Pearlman & Saakvitne, 1995). Common symptoms of VT include decreased sense of personal safety and safety of significant others, difficulties with trust and intimate relationships, and lower self-esteem (Pearlman & MacIan, 1995).

Excessive negative appraisals of the trauma represent one of the key factors that maintain the symptoms of PTSD (Ehlers & Clark, 2000). Exposure to clients' trauma material can lead to the therapist experiencing symptoms that resemblance PTSD (Figley, 1995, Pearlman & Saakvitne 1995). This means that when psychologists work with the traumatised patient, they can re-experience a client's traumatic events, become avoidant of reminders of clients' trauma, or have persistent arousal associated with trauma work (Figley, 2002; McArdle, Hoglund, Joshi, & Klappa, 2014).

Other symptoms of VT include emotional symptoms such as depressed mood and discouragement, and behavioural symptoms such as disruptions in sexuality, or increased substance use (McCann & Pearlman, 1990; Rich, 1997). Some may suffer from physical discomfort in the form of psychosomatic symptoms (Collins & Long, 2003; McKenzie, Gurris & Traue, 2007), such as nausea, headache, general constriction, bodily temperature changes, dizziness, fainting spells, and in severe cases, impaired hearing (Babbel, 2012). There are also professional consequences that are associated with VT as VT can compromise the wellbeing of the psychologists and their ability to provide effective therapy to their

clients. Therapists may lose the ability to experience work satisfaction (McHolm, 2006). They could be dispirited and cynical at work, make clinical errors, violate client boundaries, lose a respectful stance towards clients, and contribute to a toxic work environment (Mathieu, 2007). Some may eventually stop working with their clients (Figley, 1999).

The term VT encapsulates the undesirable outcomes of working directly with traumatised survivors (McCann, Sakheim, & Abrahamson, 1998). Yet, it is also possible for psychologists to experience vicarious posttraumatic growth (VPTG). The concept of VPTG has only been coined into the literature recently. It has been found to be similar to the symptoms of posttraumatic growth (PTG) following directly experienced trauma (Arnold, 2005), in which can be divided into three areas: changes in self-perception, changes in interpersonal relationships and changes in life philosophy (Tedeschi & Calhoun, 1996).

2.5 Coping with Vicarious Trauma

Very often, the symptoms of VT experienced are left unrecognised and untreated (Trippany et al., 2004; Babbel, 2012), due to the lack of formal classification for diagnosis in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V) (APA, 2013). Psychologists who work with trauma survivors tend to disregard their own self-care needs when focusing on the needs of clients (Figley, 2002). However the importance of coping cannot be neglected. Studies have indicated that the vulnerability to VT can be reduced through the use of particular coping strategies (Bloom, 2003; Figley, 1995; Killan, 2008; Newell & MacNeil, 2010; Pearlman, 1999; Smith, Kleijn, Trijsburg, & Hutschemaekers, 2007; Thorton, 1992; Zeidner, Hadar, Matthews, & Roberts, 2013). Self-awareness is the first step in combating the symptoms associated with VT (Saakvitne, Gamble, Pearlman, & Lev, 2000). Psychologists must recognise the warning signs when their work is consuming their thoughts, work life, or personal life. They must acknowledge that they can be vulnerable under the exposure to clients' trauma material and that they are not immune to nightmares, hypervigilence, avoidance, or a preoccupation with the trauma. Along with self-awareness comes the need to engage in adaptive coping (Meichenbaum, 2007). Coping with VT means identifying strategies that can help prevent VT from becoming severe, and help manage VT during times when it becomes problematic (Pearlman & McKay, 2008).

Both practical and psychological coping strategies are documented in the literature. Some of the practical coping techniques include relaxation (Jordan, 2010), exercise (Giberovitch, 2014; Jordan, 2010; Killan, 2008), attending professional training workshop and supervision

(Cerney, 1995; Gerding, 2012; Pearlman & Saakvitne, 1995; Talbot, 1989), and anticipating in continuing education (Killan, 2008). Setting limits to avoid overwork or role strain was also found to be effective (Killan, 2008). Giving oneself permission to take a break from work for a short time and taking care of oneself, may not only help the psychologist but also provide a role model of self-care for the client (Babbel, 2012). Other practical strategies include reaching out to psychological support from family and friends, and stay connected with them (Bloom, 2003; Mathieu, 2007; Pearlman & McKay, 2008). Sharing concerns with others and being provided encouragement may enhance the efficiency of coping (Evans & Villavisanis, 1997).

Some of the psychological coping techniques for VT include having spirituality and religion (Killan, 2008), having a positive attitude towards life such as having a sense of humour, having self confidence, being curious, and being optimistic (Babbel, 2012; Giberovitch, 2014). It is believed that identifying ways to nurture a sense of meaning and hope is important to cope with VT (Pearlman & McKay, 2008) and to transform the pain of VT into something positive and meaningful (Saakvitne et al., 2000). In addition, having a transition and balance between professional and personal life has also been emphasised in the literature as one of the effective coping strategies (Figley, 1995; Hesse, 2002; Pearlman & Saakvitne, 1995; Regehr & Cadell, 1999). When home and work are in balance, psychologists' body and mind are more likely to be in balance (Mathieu, 2007; Babbel, 2012).

Lastly, it is important to note that coping with VT does not simply mean fighting the symptoms, but also involves an active reflection and engagement with feelings which occur during and after the interactions with trauma survivors (Babbel, 2012; Gilmore, 2011). According to Schön (1983), the practice of reflexivity is the process of stepping back from daily intense work to examine, review and explore different ways of understanding the experiences one has had, in order to stimulate new solutions or new approaches. The benefits of reflexivity for the psychologists include feeling more supported, greater confidence in finding own solution, greater client engagement, more open to review own work, more accuracy and efficiency at work, and better therapeutic outcome for the client (Schön, 1983). Psychologists may take time to reflect through reading, writing, prayer, or meditation (Pearlman & McKay, 2008). They may also reflect on how much time for socialising, leisure, or hobbies they are allowing themselves to recharge after working with traumatised clientele (Killan, 2008).

2.6 Theoretical Framework

The Constructive Self-Development Theory (CSDT) helps to identify why psychologists respond to clients' trauma in the way they do (Saakvitne & Pearlman, 1996). It identifies the experience and manifestation of VT as a result of empathic engagement with trauma material.

The underlying assumption of CSDT is that individuals construct their realities based on their cognitive schemas. A schema is an internal cognitive structure or framework through which the individual organises and interprets information from the environment. An individual's existing schemas are developed from their experiences with significant others, and provides a model of the self, others and the world that serves as a guide for behaviour (Piaget & Inhelder, 1969). Traumatic events are often not in congruence with therapists' pre-existing worldview and perceptions of reality. Their assumptive world is therefore shattered in the presence of trauma (Kaminer & Eagle, 2010).

As a result of empathic engagement with trauma survivors over time, the changes in psychologists' belief system and cognitive schemas are pervasive and cumulative. These changes have the potential to affect every aspect of their lives and reinforce their distorted beliefs and schemas. Five components of self are affected as a result of VT, namely, frame of reference, self-capacity, ego resources, psychological needs, and memory and perception (Saakvitne & Pearlman, 1996). Frame of reference refers to the sense of identity, views of self, the world and relationships with others; self-capacity is the ability to manage emotions and feel worthy of loving and being loved; ego resources refer to the capacity for empathy and self-awareness; psychological needs are the needs for safety, esteem, trust, control and intimacy; and lastly, memory and perception can be affected by trauma in that memories can be fragmented or recalled without emotion (Helm, 2008).

<center>**Chapter 3: Methodology**</center>

3.1 Research Design

This study was qualitative in nature and adopted the interpretive paradigm in exploring the experiences of VT among psychologists and the coping strategies that they use. Qualitative research enhanced the understanding of the phenomenon of VT and helped me discover the experiences from the perspectives of participants in their own words. A hermeneutic phenomenological approach was used in the study to inform the assumptions on the nature of reality, knowledge, and values in the interpretive paradigm, in that meanings are constructed by human beings in unique ways, depending on their context and personal frames of reference as they engage with the world they are interpreting (Crotty, 1998).

Hermeneutic phenomenology has the philosophical underpinnings of both phenomenology and hermeneutics (van Manen, 1997). From the phenomenological perspective, meaning making is a dynamic and contextual interaction. The world is subjectively experienced by individuals within their personal and relative social, cultural and historical contexts (Smith, Jarman, & Osborn, 1999). The use of a phenomenological approach thus enabled me to investigate the diversity and variability of participants' experiences. Consistent with Heidegger (1985)'s philosophical understanding of a person's position within time and place, the non-static nature of people's existence in the world was made explicit in this study by seeking out modalities and fluctuations in each participant's ways of thinking, i.e., an idiographic focus. The hermeneutic component of this approach emphasised the shared world of understanding between the participants and I. Hermeneutics adds the interpretive element to explicate meanings and assumptions in the participants' texts that participants themselves may have difficulty in articulating (Crotty, 1998). The use of hermeneutics phenomenology thus enabled the exploration of participants' experiences with my further abstraction and interpretation based on my theoretical and personal knowledge.

3.2 Participants

Purposive sampling was used in the study. Participants were recruited from the therapydirectory.co.za which is an open access website. The website gives the contact details of each psychologist as well as an indication of areas of their specialisation. Based on the information provided on the website, I compiled a list of psychologists who work with trauma survivors and I contacted them via email to invite them to participate in the research. A total of 6 psychologists responded and agreed to participate. The sample consisted of four

<center>11</center>

females and two males. Participants were either clinical or counselling psychologists residing in Cape Town, South Africa. All participants were registered with the Health Professions Council of South Africa (HPCSA) and had at least three years of experience in working with trauma survivors. At the time of the research, the participants worked in private practice or community and public health settings (e.g. Non-Governmental Organisations) with children, adolescents and adults. The types of traumatic event that they encountered among their client population predominantly involved tortures, bereavement, car accidents, separation, transferring/relocation, and interpersonal trauma in the form of physical, emotional and sexual abuse. Most of the traumas their clients experienced were interpersonal in nature.

3.3 Data Collection

Data was collected by means of individual semi-structured interviews and were conducted in English by the researcher, myself. During the interview, participants were encouraged to express their own understandings and meanings of their experiences. I used a self-developed "prompt sheet" comprising questions that aimed to elicit information from the participants associated with VT and its coping strategies. For example, there were questions exploring whether the participant has experienced changes in the perceptions about self, others, or the world, and whether they have experienced symptoms that are characteristic of PTSD. Participants were encouraged to think about the strategies they used to cope with the negative effects of working with trauma survivors. The questions on the prompt sheet were informed by the literature review and the objectives of the study.

Interviews were scheduled with the individuals who agreed to participate in the study at a mutually convenient location, which took place at the participants' home or their work place. Each interview was of approximately one hour duration and each was recorded using an audio recording device. The interview began with a brief discussion of the purpose, procedures, and ethics concerns of the research. Each participant was invited to make any additional comments after the interview to allow them express any thoughts and feelings that were not covered in the interview. Transcription took place immediately after each interview session and the recordings were transcribed verbatim.

3.4 Data Analysis

Interpretive phenomenological analysis (IPA) was used to analyse the data. Participants' experiences of VT and their coping methods were of central concern and were accessed through a double hermeneutic interpretative process, that is, to "make sense of the

participants trying to make sense of their world" (Smith & Osborn, 2003, p. 51). By using IPA, I had the opportunity to develop an idiographic understanding of the experience of the participants, and what it means to them, within their social reality.

Each interview transcript was analysed separately based on IPA's idiographic and iterative approach. Following several readings of the text, descriptive notes that captured key words or phrases used by participants or summations of them were made in the right hand margin of the transcript. Subsequently, possible connections between the descriptive notes were examined to identify emerging themes (e.g., "sadness", "sense of helplessness", "worldview shift"). These initial themes were created to best capture the essential qualities of each interview.

Next, the aforementioned themes were organised into clusters of super-ordinate themes. For example, worldview shifts about self, others, and the world (initial themes), are representative of a broader experience involving shattered assumptions (super-ordinate theme). All super-ordinate themes identified from the interview were then presented on a table with quotations that best captured the essence of the participant's experience. In accordance with IPA's idiographic and iterative approach, each transcript was analysed individually before moving on to the next one. By keeping in mind the super-ordinate themes, I was able to identify new or contradicting themes across different transcripts. Eventually this process led to the identification of six super-ordinate themes, namely, shattered assumptions, symptoms characteristics of PTSD, psychosomatic symptoms, VPTG, practical self-care strategies, and psychological self-care strategies.

3.5 Issues related to trustworthiness (rigour)

To enhance the trustworthiness of the study, Lincoln and Guba (1985)'s four criteria for rigor in qualitative research were used. These criteria include credibility (internal validity), transferability (generalisability), dependability (reliability), and confirmability (objectivity).

To ensure credibility, Smith (1996) suggested that two criteria in IPA can be used, namely, internal coherence and presentation of evidence. Internal coherence refers to whether the argument presented within a study is internally consistent and supported by the data, whereas presentation of evidence refers to presenting sufficient data from participants' discourse within a report to enable readers to evaluate the interpretation. In this study, I used the provision of "thick descriptions" including direct quotes from participants while analysing the data. I also constantly checked my own sense-making against participants' actual

quotations so as to ensure that the themes captured the participants' experiences. Credibility of the study was further enhanced through "member checking". Participants were provided with the transcript of their interview to verify that the information contained in the transcript was representative of their perspective. Additionally, an independent assessor evaluated the transcripts against the audio recordings and the identified themes. Moreover, it has been suggested that in order to enhance credibility in qualitative research, researchers should make their own assumptions and worldviews explicit (Elliott, Fischer, & Rennie, 1999). Accordingly, a reflexivity diary was maintained throughout the research process to record details of the nature and origin of any emergent interpretations from the data. The ongoing documentation of reflection is in line with the essence of hermeneutic phenomenology in that the researcher's interpretation of the world was joined with the understandings of the participants in a hermeneutic cycle.

Transferability refers to showing that the findings have applicability in other contexts (Lincoln & Guba, 1985). It was achieved by conducting interviews until categorical saturation was reached. I had planned to collect data from six participants. The themes that emerged from the data were rich and appeared to be concurrent across all these participants' narratives. Therefore, a decision was made after the analysis of the sixth interview that theoretical saturation had been achieved and no more interviews were needed to be conducted.

Dependability means that the findings are consistent and could be repeated (Lincoln & Guba, 1985). In order to ensure dependability, I made explicit the documentation of data, methods and decisions about the research so as to aid external scrutiny.

Conformability is a degree of neutrality or the extent to which the findings of a study are shaped by the respondents and not researcher's bias, motivation, or interest (Lincoln & Guba, 1985). The study established conformability by having the results confirmed and corroborated by the supervisor of the research and her colleagues in the psychological field.

3.6 Ethics Considerations

The ethical guidelines stipulated by the University of the Western Cape were strictly adhered to by the researcher. Each participant was given an information sheet (Appendix A) with all the relevant information of the study, including the aim and objectives of the study, study procedure, estimated duration of the interview, as well as benefits and potential harm of the

study. The participants were also informed that the use of the information is for academic purposes as well as for dissemination of knowledge by means of publication. Along with the information sheet, each of the participants was given a consent form (Appendix B) that stipulated the confidential and voluntary nature of their participation. Considering that talking about experiences of VT could be potentially distressing, I provided the participants with a list of questions (Appendix C) that they were going to be asked to help them prepare for the interview. By doing so, I gave participants the opportunity to prepare for the interview in order to minimise the risk of negative emotional consequences that they could have experienced as a result of the interview. Participants were informed that the interview would be recorded. To ensure confidentiality, audio recordings were stored in a safe place. Pseudonyms of the participants were used in all reports to protect their identities. Participants' were assured that participation was entirely voluntary and they could withdraw from the study anytime they wished without consequences, although none of the participants wanted to withdraw and none of them indicated any signs of distress during the interviews.

3.7 Researcher's Self-Reflexivity

I am a 25 year old female who is currently undergoing a research internship at the University of the Western Cape where I completed my Master's degree in research psychology. I am a South African Chinese who have lived in South Africa for almost 11 years and 7 years in Cape Town. I have no problem adapting to the South African culture and I feel comfortable living and working in this country.

Throughout the entire research process, I kept a reflexivity diary to document my thoughts and reflections on issues associated with the study. This diary was vital in informing the interview process. For example, my reflection on the interviews challenged my initial assumption that experiences of VT would dominate participants' narratives. I found that participants also spoke about positive growth and transformation as a result of their work with trauma. I thereby reviewed the literature on PTG and identified the concept of VPTG. In subsequent interviews, I asked questions about VPTG and found that it was a new dominant theme. Reflexivity improved the rigour of my data collection and interpretations of the findings. It enabled improved probing, fewer assumptions, avoidance of premature interpretation, and an accentuated sense of curiosity during interviews (McNair, Taft, & Hegarty, 2008).

The reflexivity process also largely helped me understand the impact of my role on the results of the study and enabled me to do something to prevent my own assumptions, beliefs and characters to affect the study's outcomes in a negative way. A researcher's characteristics may have an influence on how participants respond to the study (TerreBlanche, Durrheim, & Painter, 2006). In this study, I realised that being young and a student researcher may have affected the way participants interacted and disclosed information. Because of the participants' profession, they would want to remain a professional face in front of a student, as to show that they are competent of coping with VT. Being a young researcher may have made the trust relationship difficult to establish which may have in turn hindered the extent to how the participants revealed their true vulnerability towards VT. To address this issue, I dressed to look professional and presented myself in a professional manner so as to shorten the age and professional gap. I also spent a considerable time establishing rapport with the participants before asking the interview questions regarding VT. By doing so, I hoped to make participants feel more comfortable to discuss about their personal information to someone who is younger and less experienced in the field.

Further, I found an interesting pattern in the responses of the participants. It appeared that the male participants in the study expressed more positive symptoms of VT and showed more resilience to VT than their female counterparts. This may due to the issues around socialised gender roles and norms as males tend to avoid showing their vulnerability in front of females (Baron-Cohen, 2003). Although this reflection cannot be used to generalise the differences of VT symptoms between genders, being a female researcher could have an influence on male participants' choice of words in the interview and is something that should be considered by researchers in the future studies.

Chapter 4: Results

This chapter presents the results of the study. The results are divided into two parts according to the research objectives. Part one documents the impact of working with trauma survivors for the participants. Part two documents the strategies used by participants to cope with the impact of working with trauma survivors.

Participants' Profile:

Tammy, clinical psychologist who predominantly works with survivors of sexual abuse, bereavement and complication of PTSD from emotional and verbal abuse.

Wendy, counselling psychologist who works with sexual abuse, bereavement, separation, transferring, and loss of possession, physical abuse and emotional abuse. Both Tammy and Wendy also work with survivors who witnessed trauma.

Jennifer, clinical psychologist who specialises in sexual trauma. She works mostly with survivors of childhood sexual abuse.

Eugene, clinical psychologist. He works with children and adults who are survivors of violent trauma and is involved in trauma rehabilitation and torture rehabilitation.

Monica, clinical psychologist who works mainly with trauma of terminal illness, bereavement, motor vehicle accidents, and physical and emotional abuse.

Kevin, counselling psychologist who works with hijackings, break-ins, and domestic violence. He also works with survivors of critical incidents such as natural disasters.

4.1 Part I: Impact of Working with Trauma Survivors

In this study, all participants were affected as a result of their empathic engagement with trauma survivors over time. The psychological reactions resembled symptoms of VT and included shattered assumptions and symptoms characteristic of PTSD. Many participants experienced psychosomatic symptoms associated with VT. Several participants experienced VPTG.

4.1.1   Shattered Assumptions

Janoff-Bulman (1992) stipulated that one of the major consequences of exposure to trauma is a shattering of the individuals pre-existing assumptions (i.e. worldviews) about themselves, other people, and the world. These fundamental assumptions include, the belief that we are invulnerable, good and worthy, that others are fundamentally good, and that the world is governed by just and orderly social laws (Janoff-Bulman, 1992). The primary function of these assumptive worldviews is to provide the individual with meaning, self-esteem, and the illusion of invulnerability, which are essential for healthy human functioning (Janoff-Bulman, 1992). These unarticulated worldviews can, however, shatter as a result of exposure to trauma.

In this study, several participants experienced shifts in their assumptive world as a result of working with survivors of trauma. These shifts corresponded to those identified by Janoff-Bulman and included changes in their assumptions about other people and the world.

Changes in assumptions about the world

A few participants reported that they experienced a transformation in their worldview. They believed that their fundamental assumptions of the world as "good" and "fair" were shattered as a result of engaging empathically with clients who had experienced trauma. This was evident in Jennifer's narrative, where she spoke about how her assumptions of being in a benign world and in control were affected by the experience of working with trauma survivors:

> When I think about trauma clients that I work with, I realise how unfair life is…. Bad things happen to good people. I definitely have a tainted view of the world and I'm aware of that... My worldview, like I said earlier, is more serious than other people and is a bit more... I don't know what the word is, but I think it is tainted.

The effects of VT can lead to the feelings of lack of trust and sense of safety in the world, and this can manifest in "higher levels of fearfulness, vulnerability, and concern" (Pearlman &

MacIan, 1995, p. 558). The susceptibility to fear and concern was evident in the narratives of the two participants in the study: Jennifer and Monica. Both of them spoke about their increased concerns about safety and that of their families after working with survivors of trauma.

> Jennifer: if I see a young girl who's been raped on the date or something, I will definitely say to my daughter, "just remember when you go on dates, men might do things, don't take a drink from them that is open". So some of the stuff that I'm getting in the session I'm definitely feeding to her.

> Monica: you are concerned about your kids...... I will sometimes say, "you need to keep yourselves safe", because of this or this that has happened, that I heard about it now in this environment. So yea, you sometimes do actually carry certain clients more than you want to.

Shifts in assumptions about other people

Several participants reported changes in their beliefs about other people. Working with survivors of trauma means that these psychologists are exposed to the reality that people can be cruel and do harm to others. In the study, the reality of trauma has shattered the participants' assumptions about the fundamental goodness of other people. In the narratives below, Wendy spoke about her increasing awareness of the capacity of cruelty in others.

> My awareness of people's capacity of cruelty has changed... I think my experiences allowed me to see the most painful side of life... I think it exposes you to the depth of deprivation, psychologically and emotionally that some people experience.

For some female participants, working with survivors of sexual trauma has had an impact on their perceptions about men. This was shown in Wendy and Jennifer's narratives. They both worked with sexual trauma survivors and their assumptions about men changed negatively.

> Wendy: I worked with rape survivors. And I realised after a while I felt quite angry towards men and questioned everything... I became so much more aware the depth of depravity some men think to in such a mindless type of way, you know, especially when I'm working with kids.
> Int.: Did you feel like you've lost faith or lost trust in men?
> WD: Yea, you know. I was fully winded the fact that there are men around and you see examples in your own life.

Similar to Wendy's experience, Jennifer's perception about men has transformed in a negative way. She mentioned that all men could have the potential to do harm.

> And I remember when I was working at rape crisis, at one stage I was thinking all men are rapist and just really terrified of men in general... I suppose if I sit with my

worldview now, is that men are potential perpetrators, doesn't mean that they all are, but there's a potential behind them.

4.1.2 Symptoms Characteristic of PTSD

Previously a diagnosis of PTSD required direct exposure to a traumatic event but the definition has broadened in the DSM-V and includes witnessing a traumatic event or repeated exposure to aversive details of the event. This means that psychologists who work with trauma survivors on a regular basis and who are significantly affected or overwhelmed by their work could be diagnosed with PTSD. Several participants in the study experienced psychological reactions that resemble symptoms of PTSD. These reactions were intrusive memories, avoidance of reminders of the trauma, negative alterations in mood, and alterations in arousal and reactivity (APA, 2013). Each symptom is described below.

Recurrent, intrusive memories

Survivors of traumatic events often experience involuntary and unwanted intrusive thoughts, images or memories of the trauma (APA, 2013). Participants in the study reported experiencing intrusive memories of their clients' trauma narratives.

One of the participants, Monica, told me that she has experienced intrusive thoughts and emotions related to her client's narrative. She said:

> Some clients actually stay with you more than others. So there have been instances when you are going to sleep at night and clients are actually in your thoughts.

Perhaps some survivors' traumatic stories were more intense in nature than other survivors', therefore, Monica remembered some clients' experiences more than her other clients', and she often thought about these certain people. Her thoughts were unconscious and involuntary. The rumination about her clients' trauma were intrusive and out of her control. Additionally, not only the intrusive memories happened when Monica went to sleep, her memories about the clients' trauma were also triggered at different settings:

> When I, for instance see somebody had a terrible motor vehicle accident... When you drive for instance, you think about that specific person and the challenge is to choose facing it at this stage... when you see specific things, for instance on TV, you might have that fleeting feeling that reminds you of that trauma.

Monica's recurrent memories of her client's motor vehicle accident were triggered by trauma reminders such as driving and the specific things she saw on TV. She found her client's

trauma lingered in her memory and the memory was spontaneously triggered by things in her environment.

Many participants' intrusive memories were reflected in nightmares. Wendy, for example, reported that "the nature of [her] dreams has changed" as a result of her work with trauma survivors and that "the content of dreams was more intense". Similarly, Jennifer also reported distressing nightmares as a result of her work with survivors of rape:

> I sometimes dream about rape in different ways. Myself in it, my daughter in it. It's just very distressing dreams, very distressing.

Eugene worked with survivors of torture and he reported that he has experienced in his dreams some of the trauma that his clients went through:

> I would have dreams about violations, about being attacked, being chased.

There was a change in the content and nature of dreams among these participants after working with trauma survivors. The distressing content of their dreams were closely related to the work that they do. In their dreams about trauma, the victims were themselves or their family member, which made the contents of the dream upsetting. Having nightmares about clients' trauma implied a sense of vulnerability of these participants as they could not control the content of their dreams, and that the influence of their clients' trauma was intrusively reflected in their dreams in the forms of threatening and distressing contents.

Negative alterations in mood

Trauma focused therapy involves helping clients to engage with the painful emotions evoked by the traumatic event. This means that in the therapy the psychologist can be confronted with intense feelings of sadness, shame, pain and anger. Empathising with clients can lead to the therapist experiencing similar emotions as the survivors of trauma and these emotions can remain with them long after having seen the client (Figley, 2002). In the study the two distinct negative emotions experienced by the participants were sadness and anger.

Sadness

When I asked the participants about how they feel when working with trauma survivors, almost all of them immediately expressed their feelings of sadness. For example, Eugene:

I'm talking about it (his client's experience) now, and I feel sad about it. I feel sad because it's such a terrible loss, it's tragic, something tragic, that's the word, because it's unwarranted.

Eugene's experience of sadness stemmed from the dreadful nature of his client's traumatic experiences. When Eugene was talking about his client's traumatic story in the interview, I noticed a profound sadness on his face. He emphasised that what made him sad was the terrible trauma that his client went through.

Similar to Eugene's emotion, another participant, Wendy, said:

For me I always feel sad when I work in the field of trauma. I think sad goes to the experience of the clients, especially with kids for example. And sad about the thing that there are such disturbed individuals in the world that would abuse kids the degree they abuse them.

Wendy's sadness was also associated with the experiences of trauma that her clients had to go through. She mentioned that her sadness was persistent and always showed up when she worked with trauma. On a broader level, she was also sad about the fact that there are such "disturbing individuals" that cause the trauma (links to her worldview and perception about others).
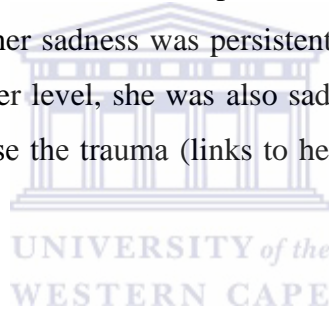
Anger

Quite a few participants reported anger associated with trauma work. Most of them discussed about their anger towards the high incidents of traumatic event in the South African context and the impact it has on many people's lives. For instance, Monica's anger came from the limited helping capacity that she had in the field of trauma as a psychologist:

The anger comes from the fact that you know you try your best to help, but, the real type of change would be if the other person (perpetrators) actually understand what they (victims) are going through and they (perpetrators) need to be able to also help themselves. Also contextually in the South African context, there's lots of violence, lots of suffering... you can only do so much. I think that is where for me the anger comes from.

Monica's anger was a result of frustration. She felt angry because as much as she wanted to help the survivors of trauma, the control was not in her hands. Monica was also angry because of the level of trauma in the South African context. She mentioned that there was only so much she could do as a psychologist to help the survivors on an individual level. Not being able to help on a larger scale left her feeling angry.

Similar to Monica, Wendy's anger was also associated with the context of trauma:

> What makes me angry, I think is that it is always certain patients experience the worst kinds of trauma that pisses me off... the level of violence that so many young people in certain community have to deal with, that becomes a norm, that becomes a bad luck. Watching violence at home and gang violence in the community and almost a complete acceptance that it's the way it is and can't be changed.

Wendy felt angry because some people, for example, adolescents, are more vulnerable to trauma than others and are under greater risk of exposure to trauma in certain communities. She was angry about the fact that people that live in crime prone communities experience trauma so persistently that it has become a way of living. Trauma is rooted in the context and doesn't easily go away. How trauma continuously affects the people in that context made her angry.

Moreover Wendy also experienced helpless rage. When I asked if her feelings of anger has been accumulated from working with trauma, she responded:

> I think sometimes it's a helpless rage, because who do you direct it at?

Wendy felt angry about her clients' trauma, but staying angry would not help to prevent trauma. As a result, she described her anger as a rage, but a helpless one. She felt helpless in that she was angry but she could not confront anyone. There are so many perpetrators in society to be held responsible for trauma, but it is unrealistic to be angry with every single one of them. Trauma happens so rapidly. As much as Wendy was angry, it would not stop the trauma from happening. Therefore her anger was associated with the feelings of powerless and helpless.

Another participant, Eugene, revealed his feelings of righteous anger, which means that he was angry because trauma is unfair and he felt the rights to be angry about it because it happens to innocent people.

> I feel righteous anger, quite a lot, in trying what to do about a situation where it's clear cut. There shouldn't be the trauma against children, children should be treated different, men need to respect their partners and treat them with respect without violence.

He felt that his anger about trauma could be justified because he believed that it is morally incorrect that interpersonal trauma exists and that people harm one another. He was angry because he was not pleased to see the traumatic events that some people were experiencing.

Alterations in arousal and reactivity

Alterations in arousal and reactivity refer to the negative or exaggerated thoughts and reactions associated with the traumatic event (APA, 2013). Several participants reported irritability and outburst of anger. These trauma-related alterations in arousal and reactivity that were experienced by the participants after working with their clients' traumatic material left them feeling irritable, emotional, and reactive, as shown in the narratives below:

> Eugene: I was also quite irritable, so I had low tolerance level... Not generally (low tolerance) for other people but I had a very short fuse. So I would be quick to anger.

> Wendy: It does happen that I get irritable then I start to realise something is going on.

> Kevin: you go home or somebody else just says something to you that irritates you even if it's something normal everyday things that people do or say, and immediately you start feeling what the hell is wrong with these people, then I know I have to take a few steps back cause then why suddenly I want to take it out on someone, what they doing or saying shouldn't have this response from me... If you start feeling irritable, you need to do something about it because that irritability can lead to some other stuff, and you have to deal with it immediately.

Alterations in arousal and reactivity can also manifest in sleep disturbance (APA, 2013). Eugene said that he had trouble with sleeping:

> I was struggling with sleeping, normal signs that comes when one is not processing the internalised trauma.

Apart from having nightmares about clients' trauma, Eugene's sleep pattern was affected. He had difficulty to fall asleep and he was aware that his sleep pattern was disrupted by his trauma work.

Numbing of responsiveness

When people experience a traumatic event, the trauma can affect them emotionally and one of the consequences is the numbing symptom. Numbing of responsiveness is the emotional and psychological unresponsiveness and indifference of stimuli associated with trauma (APA, 2013). One participant, Wendy, experienced diminished responsiveness to her clients' trauma. When I asked her if she finds the harmful things that people do to each other shocking, she said:

> Nothing shocks me. It [clients' trauma] doesn't surprise you. I don't feel shocked anymore.

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As a result of repetitive exposure to clients' trauma at work, Wendy felt that she was desensitised by the ongoing traumatic events. She mentioned that the terrible things that perpetrators do to harm and traumatise others were nothing new. As oppose to having strong negative emotions in relation to clients' trauma, she experienced lack of emotions and felt numb about traumatic events.

4.1.3 Psychosomatic Symptoms

Psychosomatic responses are physical symptoms that are caused or made worse by psychological factors such as stress and anxiety. There is a longstanding interest in the effects of stress on health due to the strain that it places on the adaptive capacity of individuals, which thereby leads to an increased risk of physical manifestations (McFarlane, 2010). In this study, many participants reported psychosomatic complaints that were associated with the stress of their trauma work. Clients' trauma took a severe emotional toll on the participants and their emotional distress was in turn experienced by them as physical symptoms. In the study, the psychosomatic symptoms reported by the participants were: feeling physically drained, tight chest, stiff muscles, asthma, headaches and migraines. The narratives of these symptoms are presented below:

> Kevin: if you have to listen attentively to that [client's trauma], you inevitably pick some of those things up... you feel it in your body... it "sits" there somewhere in the body, sometimes through tension, headaches, the neck and shoulders you can feel the tiredness... And especially if you had a heavy session like that you almost feel like you want to go home and sleep and you feel the kind of draining symptoms of that... because you feel physically tired, but it is actually the emotional stuff... so I think it's combination of the emotional and physical.

> Jennifer: I have a bodily response to that [working with trauma survivors]. It's probably somewhere in my heart, cause I feel it in my chest... it's located in the place of deep sadness... you definitely pick up stuff from clients so you will feel the body sensation.

> Eugene: It [trauma work] affected my health in a way that I was quite tightly wand, and not as relaxed as I could be... I would get very sore muscles, stiff, getting my tension all in my back.

> Monica: I once or twice had migraine before, or migraine starting while I see the client.

> Wendy: I think for me it's the physical symptoms I will develop, at some time, at particular time. It comes out sort of being embodied... My asthma returned... and migraine.

These participants were aware that their psychosomatic symptoms were triggered by the repetitive exposure to their clients' traumatic experiences. Their experiences of the onset, exacerbation, and/or maintenance of psychosomatic symptoms were the manifestation of their work related stress. Their emotional distress and physical symptoms influenced each other synergistically.

4.1.4 Vicarious Posttraumatic Growth

In the process of re-building the assumptive world, individuals may re-examine many aspects in their lives. Meaning making after trauma involves a consideration of the possible lessons and benefits of having survived a trauma (Kaminer & Eagle, 2010). Given the evidence for such positive changes experienced directly by trauma survivors, it is also expected that those who work with trauma survivors will experience VPTG. VPTG is defined as an increased recognition of personal strength, gains in self-confidence, sensitivity, and compassion, improved personal relationships, an enhanced appreciation for what is important in life, and spiritual growth, resulting from the provision of therapy to trauma survivors (Arnold, Calhoun, Tedeschi, & Caan, 2005). In this study, VPTG was evident in the narratives of participants. They experienced enhanced personal growth, greater appreciation of relationships with others, high work satisfaction, and better work efficiency.

Personal growth

Several participants reported experiencing a sense of personal growth as a result of their work with trauma survivors. They seemed to be inspired and fulfilled by trauma work. For example, Monica did not only recognise the personal growth in her clients, but also gained a sense of personal growth from learning from her clients' experiences:

> You begin with a certain stance towards life, towards this profession. As you go alone, you grow, and you change constantly... learning from clients the whole time changes the worldviews on an intimate level but also a broader level... You know how people suffered, you know how people changed... but also how it affects you, your family, your community, etc... It's vicarious growth as well.

Monica has become more and more reflexive in her journey of working with trauma clients throughout the years. On an individual level, she started to have a better understanding of the person she is. On a broader level, she gained a deeper insight into what is happening in society in terms of the traumatic events. Being in the profession as a therapist, she has become aware of how trauma can affect others and herself. Her worldview has transformed positively from constantly learning values and meanings from her clients. Monica reported

her beliefs in the positive transformations of her clients, and to her, the growth of her clients had a vicarious influence. She mentioned that she was able to grow together with the client in the work of trauma, and the growth was mutual and ongoing.

Eugene's experience was similar. Not only being able to help trauma survivors in many different ways, he has also learnt from the work that he does. To his understanding, being a trauma therapist had a personal meaning, and that was, allowing him to become a better human.

> Reclaim their identity, reclaim their power and their strength, which is what I do, for reclaiming my humanity as sitting with someone just had such a horrible time.

Eugene stipulated that through trauma work, he was able to help his clients reclaim their capacity of growth after trauma. Engaging with trauma survivors has allowed him to be more empathetic and understanding. He has found values in trauma work because he felt like his was humanity awakened through helping the people who needed him.

> I've learnt much more by being able to immerse strongly... I learnt about how the most broken, and the poorest of the poor had the greatest capacity to give and to feel and to share and support each other... I'm more able to understand a different point of view.

Eugene's empathic engagement with his clients has made him learn about the values of sharing and support. Working in the trauma field has given him a deeper understanding of what the trauma survivors were experiencing. He has gained a delightful insight into how some people were still able to support one another even in a traumatic situation. He started to value and appreciate the collectiveness of these people and how they were able to unite and support one another when times were difficult.

Greater appreciation of relationships with others

Some of the participants reported that working with trauma survivors has led to them valuing their personal relationships and connections with others. They started to realise how important it is to appreciate the relationships with their friends and family that they have while they still can.

> Eugene: I think the thing trauma work has done is to make you value much more connections, ordinary connections.

> Kevin: you see a client that goes through stuff around domestic violence... you are continuously reminded of those kind of things and then you realise...in terms of your

own family, your own relationships, how important it is for you to work on those kind of things.

These participants reported that they had a greater appreciation for the relationships with significant others. The intensity of trauma work has made them realise the importance of having a closer and empathic connection with people. Because of the unpredictable nature of trauma and the damage it may do to relationships, they started to pay attention to the most ordinary relationships in life. Their narratives outlined their appreciation for the interpersonal connections and it showed that they did not want to take these relationships for granted.

Work efficiency

Work efficiency is the physical or mental effort or activity directed toward the production, completion, or accomplishment of some occupation related task and is defined in terms of inputs and outputs (Lupton, 1975). Good work efficiency can enhance the performance, productivity, and standard of work. Being efficient at work is highly crucial especially for the psychologists because competent practice needs to be ensured in this profession.

Work efficiency was another positive outcome that was identified among the participants. Two participants mentioned that working with trauma survivors has enhanced their work efficiency.

> Eugene: I think one I found I connecting deeply in an emotional level with the solidarity with the person's experience is absolutely necessary. I found some of the best work I do is in that kind of arena.

> Jennifer: I have this very good relationship with anger. They drive me and motivate me to the work I do in the background, it doesn't come up.

Eugene suggested that his quality of work was better when he was emotionally involved as he was only able to help the clients when the connection with them was genuine. Jennifer said that she felt angry when working with trauma survivors. Her anger, however, did not impede the work efficiency. Instead, it stimulated a sense of professional responsibility that motivated her to do her best.

Work satisfaction

Several participants reported experiencing a sense of satisfaction from their work with trauma survivors. Even though the content of trauma survivors' experiences could be quite distressing, some participants showed enthusiasm towards their work and found it satisfying to help their clients.

Jennifer: you have clients that you really enjoy and you can see play a good role in their lives. And that brings you joy, that makes it meaningful that you realise that you are doing something behind what you are doing.

Kevin: I am actually very satisfied in my work, in all spheres of it... even just how your clients develop, that is tremendously satisfying.

Monica: I wouldn't have been in this field if there isn't satisfaction. For me, breaking them down to the smallest little progress you get.

These participants' feeling of work satisfaction stemmed from the difference that they made in helping the trauma survivors. They felt that trauma work was importantly, meaningful and fulfilling because they were able to play an important role in their clients' lives.

Moreover, Eugene described his experience of working with trauma survivors as "honouring". He said,

Honouring would be the word. Honouring of themselves and myself.

Eugene believed that trauma work was not simply a process of delivering psychological services to the survivors. It had a much bigger and deeper meaning behind the therapies. He found his work experience satisfying because not only he felt honoured to help others, he also gained a great sense of accomplishment from doing curative work.
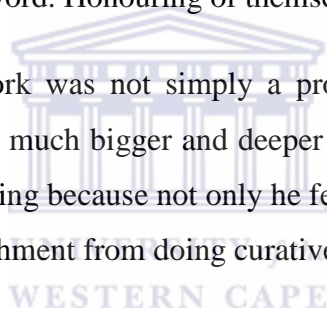
4.2 Part II: Coping with Vicarious Trauma

Participants in the study were asked about the coping strategies that they use to deal with the impact of working with trauma survivors. Even though many participants reported VT symptoms, they also spoke about the strategies that they use to help them cope with the its negative impact. Vast literature has suggested that therapists make use of coping strategies to care for themselves in order to deal with the impact of VT (Bloom, 2003; Figley, 1995; Killan, 2008; Newell & MacNeil, 2010; Pearlman, 1999; Smith, Kleijn, Trijsburg, & Hutschemaekers, 2007; Thorton, 1992). Self-care is defined as "the utilization of skills and strategies by workers to maintain their own personal, familial, emotional, and spiritual needs while attending to the needs and demands of their clients" (Figley, 2002; Stamm, 1999). Self-care includes stress management, training, and self-care plans (Bell, Kulkarni, & Dalton, 2003). In the current study, both practical and psychological self-care strategies were identified in the narratives of the participants.

4.2.1 Practical Self-Care Strategies

The practical self-care strategies that some of the participants used were activities, workload control, supervision, adequate sleeps, taking breaks, and meditation.

Activities

Leisure activities have been found to be effective at reducing symptoms of VT because of their ability to restore health, strength, or well-being (Trippany et al., 2004). All the participants in the study spoke of engaging in leisure activities as a form of coping. They found these activities effectively reduced their work related stress, leaving them feeling rejuvenated. These participants immersed themselves in the leisure activities to relief stress and frustration accumulated from work.

> Tammy: I still go to gym all the time, and socialise with friends... I do boxing, I found that helps. If you have any intense feelings, you box it on the bag.

> Wendy: I go to gym, and it helped a lot, got stuff out of my head because it required so much emotionally... I will watch TV... I love reading... There will be things I can lose my mind, so I don't have to think about it too much.

> Eugene: end of my session I will go to the sea, I will go in the sea find a way to spend 20 minutes there to be able to process for myself the reflected pain.

In addition to leisure activities, several participants mentioned that they kept the activities they did varied. They ensured that the clinical work with trauma survivors was not the only

thing they did. They reported that doing a variety of different tasks helped buffer the negative impact of trauma work.

> Jennifer: Try to get some other work... That feels quite nice, to do some academic work, and it's a nice break from sitting in this room doing this work.

> Eugene: I balance play and family time, fun time and serious time... I do work as an academic, I teach, I train, I supervise... I wanna train, teach, advocate, be on the radio, talk... clinical work, prevention work, advocacy work in the country, outside the country, keep the balance, keep the variety.

> Monica: I have different types of ways of being involved in psychology... so I would have private practice but I'm also doing teaching which is psychology in a more type of distant way.

Participants believed that immersing themselves in a range of different things could divert their focus and dilute their stress. Instead of having face-to-face interactions with the trauma survivors in the therapy all the time, these participants also made plans to do other tasks that they enjoyed to keep themselves busy. Keeping a variety in the tasks they did has effectively reduced the impact of stress that the participants experienced from working directly with trauma survivors.
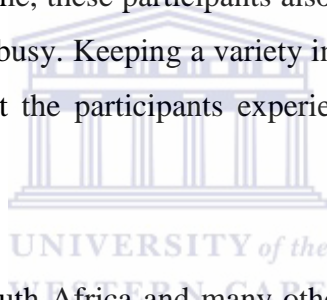
Workload control

Due to the high crime rate in South Africa and many other potentially traumatising events, working in the field of trauma often means that psychologists receive a lot of trauma referrals. In order to minimise the negative effects of trauma work, several participants mentioned that they tried to control their workload.

> Jennifer: It's about being able to say I can't go this through, can't go into your community again.

> Eugene: one has to manage the volume. And so not to take too many clients.

> Monica: for me it's very important in my practice I have very limited practice which basically means I don't see too many clients in one day.

These participants reported that they were aware of the importance in workload management. By managing client volume, they monitored the intensity of their clients' trauma content they engaged with. Having the ability to know when to stop working or seeing too many clients at once has largely minimised their risks of experiencing multiplied stress and harm as a result heavy workload.

Supervision

Supervision is critical to ensure high standards of professional practice. It is "a joint endeavour in which a practitioner with the help of a supervisor, attends to their clients, themselves as part of their client practitioner relationships and the wider systematic context, and by so doing improves the quality of their work, transforms their client relationships, continuously develop themselves, their practice and the wider profession" (Hawkins & Peter, 2012, p. 30). Supervision is strongly encouraged as a coping mechanism for therapists who work with trauma victims as it actively reduces the signs and symptoms of VT (Bell et al., 2003). Supervision also addresses the effects of trauma in a nonjudgmental manner (Cunningham, 2003).

In this study, going to supervision was identified as one of the most dominant coping strategies used by the participants:

> Tammy: you need to deal with the feelings in therapy, or supervision... You feel your button gets pushed for whatever reason, you can chat to your own therapist about that.

> Jennifer: I must process my own emotions with my therapist and my supervisor... I go for therapy and supervision once a week.

Tammy and Jennifer mentioned that they went to therapy because it offered an appropriate space for their feelings and thoughts to be disclosed. Supervision provided them the right time and space to process their work-related distress.

> Wendy: I would go to supervision session, and you also learn to know what is your feeling, what is the feeling in the room and separate and identify what is checked into you, what is your own stuff... you gain more insight into yourself during your own personal therapy and more self-aware.

To Wendy, supervision was a place for her to learn about herself and gain insight into her emotions and thoughts that she often did not realise that she had. She said that going to supervision helped her identify her feelings and personal issues. Supervision helped her to distinguish her material from her clients', which in turn helped her personal life remain separate from her client's traumatic experiences.

> Eugene: I went into therapy...and that helped quite a lot in trying to keep a balance between what was required and for me it was in terms of taking care of my psychological well being and providing service.

Eugene reported that his supervision experience gave him the balance between delivering psychological services and taking care of his own psychological wellbeing. Eugene further emphasised that only when his psychological wellbeing was not affected by clients' trauma, he was able to provide good services. Hence, going to supervision also ensured the quality of his service delivery.

Moreover, two participants indicated that they went to group therapy:

> Tammy: I went to supervision group when I was working in public health which helped a lot. Most of the people there were working in public health. They all had similar cases they all knew how hectic it was.

> Eugene: We have a peer supervision group now... Every second week there's an hour and half supervision, four colleagues, we sit and talk, present our work, eat.

The group therapy that Tammy and Eugene went to provided a comfortable space for them to discuss their issues with people who shared similar experiences from trauma work. The literature on VT has emphasised the need for group supervision or group support (Bell et al., 2003). Group therapy clarifies colleagues' insights, listen for and correct cognitive distortions, offer perspective/reframing, and relate to the emotional state of (Bell et al., 2003).

Other practical self-care plans

Few other practical self-care plans were identified in participants' narratives. For example, Monica mentioned that sleeping was important as it helped her "to trying to get away from all of these things [clients' trauma]".

Whereas Tammy's strategy was to take a break when she felt that the work was overwhelming:

> I did have a mental health day where at a clinic day was so hectic and so intense, that sometimes I needed to lie down and have a sick day basically you sort of just had enough of the day and just relax.

Jennifer reported meditation as her strategy:

> I hold my thumb during meditation and breath especially when I'm feeling overwhelmed with it.

Adequate sleep, necessary breaks, and meditation were reported by these participants as effective in reducing stress by keeping them away from the trauma work for a while until they felt ready and rejuvenated to work with trauma. These strategies have restorative

properties that helped them cope with the intensity of the trauma work and made them feel relaxed and energised.

4.2.2 Psychological Self-Care Strategies

The psychological self-care strategies mentioned by the participants included detaching from work, optimism, sense of humour, and self-reflexivity.

Detaching from work

All participants expressed the need to detach from their clients' trauma material. They showed the ability to mentally separate from the trauma work to ensure that they were not adversely affected. For example,

> Monica: When it actually becomes too overwhelming and most probably too close, I would basically box it and say "you know what, I know this is important but I can't think about it now, I will think about it again in context".

> Wendy: You have to somewhat learn to detach, from experiencing too much of the trauma, otherwise it's going to overwhelm all your capacity to still have a thinking mind... We need to know what our feelings are... leave it where it should be at.

> Jennifer: You definitely learn to cut off...You learn to realise that the world is gonna carry on regardless how many people you try to save.

These participants reported that they were aware that their clients' trauma material could encroach into their lives and affect them personally and professionally. When trauma work was overwhelming, they placed a barrier between work and personal lives to avoid getting the negative impact from work. They believed in deliberately creating a space for work and another for personal life so that the two spaces did not negatively influence each another.

Optimism

Optimism is the generalised expectation that good things will happen in the future (Eichner, Kwon, & Marcus, 2014). Considerable research has focused on the benefits associated with optimism in terms of coping (Scheier, Weintraub, & Carver, 1985; Zeidner & Hammer, 1992). Some participants expressed optimism for the work of trauma. They did not see trauma work as a draining task. Instead, having an optimistic outlook helped them stay on track in the trauma field, to cope and work efficiently.

> Eugene: In general, there's a greater level of goodness in people and in the world... But it does require not being naïve. It requires hard work and fighting when you have

to fight... Not blind hope. I'm very clear about how the world is a terrible place, tragic in many ways, but there are things that have hope.

As a result of listening to clients' traumatic experiences, Eugene started perceiving the world as a terrible place. However, he suggested that there was a higher level of "goodness" in the world. He noted that his optimistic outlook was not a naive one. His optimism was a measured one, and was earned by continuously striving and advocating for people to make their lives easier. It seems to me that implementing change and being able to help the trauma survivors made Eugene hopeful. Indeed, he further added:

> I don't despair cause I really believe quite a lot in the process... This is something that is happening here but there are people who survive, people who will have posttraumatic growth after experiences. I helped a little bit I think, makes a difference, makes a huge difference with the person in their life, despite the unwarrenties... that's what keeps me optimistic, that there is a change.

From Eugene's narratives, the reason that made him optimistic was his clients' change and growth after trauma. This was similar to Monica's optimism as she also firmly believed in the capacity to positive changes in a client's life.

> I'm an optimist. I always think there is hope. So I won't be in this profession if I didn't see that change happening at all… I do feel that there is a lot of positive changes… for me there's always hope, no matter how difficult it seems…I sometimes do lose hope but that's for brief moments and then you look at what's working rather than what's not working.

Both participants showed their optimism about the work they did and how they could make a difference for their clients.

Sense of humour

The use of humour has been documented to be effective for increasing resilience in coping with distress and life strain (Abel, 2002; Martin, 2007; Skinner, Edge, Altman, & Sherwood, 2003). It can also lead to better psychological wellbeing (Doosje, De Goede, Van Doornen, & Golstein, 2010). In this study, several participants reported using humour to cope with VT:

> Jennifer: I have a fairly good sense of humour... It's the balance about seeing the dirt of life and also seeing the beauty.

> Wendy: my friends think I have a sense of humour, sometimes it's dark humour. I think you need it in order to find the light in life... I think it's probably my ability to put people at ease, my sense of humour.

Wendy and Jennifer suggested that having a sense of humour is important as it stoped them from magnifying work stress and helped them focus on delightful things.

Reflexivity

Reflexivity is understood as an aspect of an action wherein the actor indulges in looking into how his or her own presence as well as a wide range of other factors would influence that action (Hedges, 2010). In this study, participants' reflexivity was associated with the awareness on the effect of the process of trauma therapy on themselves and how they might in turn influence the clients. As a result of self-reflexivity, these participants were able to identify their own difficulties and distinguish their feelings and thoughts from those of their clients. From their narratives, these participants were able to remain a professional stance at work and were effective at delivering psychological services to trauma survivors through their awareness of self. For example, in Tammy's narrative:

> When you go deep inside of what is happening and then you look at what or why it's happening for you... there obviously something that happened to you, helplessness or whatever, and then you use it, you work through that stuff.

Tammy said she used self-reflexivity to be aware of her emotions. She was conscious about how her feelings and thoughts could potentially influence the therapeutic process with her clients.

Similarly to Tammy, Monica reported a deeper insight into herself from being self-reflexive:

> As a therapist, you have to be conscious of the feelings the whole time... I think that is a two-way thing. If you in the situation yourself where you actually experiencing certain trauma or challenges, you need to be very very aware of that because that could have an impact on the way you actually deal with your clients... So for me the boundary is interpersonal, intra-psychic is very very important... It has actually helped me to stay in this field and cope.

By means of being aware of one's own difficulties, Monica seemed to understand how her own challenges could have an effect on the therapeutic process with her clients. She was self-reflexive in that she was able to distinguish her difficulties and challenges from that of her clients. Having a boundary in the interpersonal relationship with the clients has helped her remain a professional distance so that her personal experiences and thoughts did not influence her work and that her clients' material did not impact her life.

Apart from remaining a professional boundary, Monica further discussed how she used self-reflexivity to improve her work in trauma:

> If I have a specific traumatic event...it is very very important for me to actually acknowledge that and the impact of that would have on the cancer clients I'm seeing at this stage. It helped me better to understand their experience, not only drawing on my other work with cancer clients but now I have that personal experience myself as well.

Monica suggested that by means of self-reflexivity, she was able to understand how her own experience was related to her client's. She used her personal experience as an advantage to understand her client's situation better.

Chapter 5: Discussion

Trauma work can lead to long-term changes to a therapist's way of experiencing him- or herself, others, and the world, and to symptoms that might parallel those of the client (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). In this study, all participants were affected as a result of working with trauma survivors, that is, by hearing stories of torture, loss, abuse, or devastation. In essence, participants experienced a range of symptoms characteristic of VT including cognitive symptoms, symptoms characteristic of PTSD, psychosomatic symptoms, and VPTG. The symptoms of VT are believed to be a pervasive and cumulative effect of working with survivors of traumatic life events, and are the result of being exposed to stories of trauma over an extended period of time (Cunningham, 1999; Trippany et al., 2004).

5.1 The Constructive Self-Development Theory and VT

This study drew on the Constructive Self-Development Theory (CSDT) to understand the experiences of VT among a group of psychologists who work with trauma survivors. According to CSDT, individuals construct their realities based on the assumptions and beliefs that they have in their cognitive schemas. Trauma challenges an individual's existing schema and triggers cognitive processes that can result in either no change to previous schema (assimilation), positive change to previous schema (positive accommodation), or negative change to previous schema (negative accommodation) (Joseph & Linley, 2008). In the current study, participants shared their idiographic perspectives on their experiences of VT. Based on their own unique cognitive processes of re-building assumptions and beliefs, some experienced symptoms of VT as a result of negative accommodation of clients' trauma material, whereas many others experienced VPTG as a result of positive accommodation. Some participants experienced the cognitive accommodation in both negative and positive ways.

The impact of clients' trauma on therapists is an interaction between individuals and their situations (Saakvitne & Pearlman, 1996). This means that a psychologist's personality, personal history, coping strategies, and so forth, all interact with his or her work situation, to give rise to an individualised expression of VT, which implies that the expression of therapists' VT symptoms is unique to their individual responses and adaptations to trauma. Determining the influences of participants' personality and personal history on their VT symptoms was not the focus of the study. However, participants openly discussed about their

work settings, the nature of their work, and the specific clientele served. These work-related, situational factors played an important role in shaping each therapist's reactions to their clients' traumatic experiences. By nature, trauma work is distinguished from working with other "difficult populations" because of the exposure of therapists to emotionally charged material (Cunningham, 2003, p. 452). Many participants acknowledged that it was almost inevitable to pick up some of the trauma material that clients "left behind" because of the level of engagement with them.

The changes in one's cognitive schema are both pervasive and cumulative (Trippany et al., 2004). As such, trauma has the potential to touch nearly every aspect of a therapist's life and each encounter with the client reinforces beliefs and schema (Helm, 2008). Saakvitne and Pearlman (1996) suggested that five domains of self can be affected as a result of exposure to trauma, namely, cognitive frame of reference, self-capacity, ego resources, psychological needs, and memory and perception (see Chapter 2). In this study, participants' symptoms of VT were the results of changes in these three domains: (1) psychological needs, (2) cognitive frame of reference, and (3) ego resources. Self-capacity, and memory and perception were not affected in the participants.

"Psychological needs" is one of the domains of self that can be affected as a result of trauma. The central psychological needs consist of five aspects: safety, trust, esteem, intimacy, and control (McCann & Pearlman, 1990). These aspects develop and are affected by trauma interdependently. In the study, participants' experienced negative changes in their psychological needs particularly in control, safety, esteem, and trust. They felt that the world was unpredictable, felt unsafe in their lives, felt difficult to maintain a sense of esteem in others, and became suspicious of other people's trustworthiness as a result of trauma work.

Participants in the study experienced profound shifts in perceptions of control because they felt that they had no control over what was happening in the world due to the unpredictable nature of trauma. For example, one participant, Jennifer, no longer perceived the world as a benevolent place. She recognised that there were malevolent people in the world capable of inflicting harm on others. According to Canfield (2008), therapists may also begin to question the meaning and purpose of life as a result of their work with trauma survivors. Indeed, Jennifer mentioned that life was unfair because trauma could happen to anyone, even the good people. Furthermore, Gerding (2012) mentioned that therapists may begin to see the world as hopeless as a result of trauma work. In this study, I found that several participants

were overwhelmed by learning about the worst faces of humanity and started to become more cynical and have less faith in the kindness of human beings.

Clients' trauma also tremendously challenged some participants' sense of safety. They began to see the world as a far more dangerous place than they did before their exposure to trauma. According to CSDT, when an individual experiences VT, schemas are modified in a negative way, and this causes distress and heightened awareness to information that supports the new negatively modified schema (McCann & Pearlman, 1990). As Bloom (2003) explained, the confrontation with the magnitude of trauma shatters people's own protective assumptions as they let in the reality of "It (trauma) really happened." As they wrestle with this reality, they come to recognise that "It could happen to me" and feel all the vulnerability that goes along with that recognition (Bloom, 2003). As a result of an increased awareness of the reality and occurrence of traumatic events, therapists' safety and security can become threatened (Saakvitne et al, 2000).

Many participants also reported a transformation in their assumptions around the trustworthiness of other people including changes in awareness of people's cruelty to do harm. The changes in the assumptions of other people's trustworthiness were especially evident in psychologists who worked with sexual trauma as they started to develop a strong sense of mistrust of men. Research found that working in the sexual assault field can be particularly distressing when compared with other forms of trauma work (Cunningham, 2003; Johnson & Hunter, 1997). Participants' beliefs and assumptions about men were distorted as a result of engaging with the disturbing nature of sexual trauma. Similar to the findings of this study, Farrenkopf (1992), Rich (1997), and Steed and Downing (1998) have also documented sexual trauma therapists' reactions in terms of their decreased trust in others. When the trauma has been interpersonal, therapists may see others as malevolent and evil, untrustworthy, exploitative, or alienating (Bloom, 2003).

A central struggle for the survivor is the need to understand why another person would intentionally inflict harm on others (Janoff-Bulman, 1992). The attempt to find an explanation for why people can be so hurtful towards others reflects an attempt at schema accommodation – trying to reconcile the old schema with the new information. Very often, the search for causal explanations for the perpetrator's action may focus on the intentional state of the perpetrator (Kaminer & Eagle, 2010). For example, the two participants who work with sexual trauma developed explanatory accounts for the actions of perpetrators. One

participant reported that the men acted in a mindless way therefore caused harm, while the other believed that there must be a potential in all men to cause harm. All these explanatory accounts constructed by these participants suggest that they believed the perpetrators of trauma are deviant and disturbed in nature, i.e., because of the males' intension and the way they are, they inflicted sexual trauma. According to Bloom (2003), in the face of vicarious exposure to clients' trauma, it may be increasingly difficult to maintain a sense of esteem about others, leading to pervasive suspiciousness of other people's motives and behaviour.

Participants' changes in their psychological needs were consistent with their negative shifts in the cognitive frame of reference. Cognitive frame of reference refers to "frameworks for interpreting experience (or schema), including customary ways of making sense of events (causality), orientation towards the future (hope), and usual source of reinforcement (locus of control)" (McCann and Pearlman, 1990, p. 62). When a person's frame of reference is disturbed, beliefs about other people, self, and the world are affected, as well as beliefs about causality and higher purpose (Rosenbloom, Pratt, & Pearlman, 1995). After working with trauma survivors, participants' pre-existing, inarticulate beliefs about the world and others were shattered as a result of profound shift in their cognitive frame of reference, which in turn disturbed their psychological needs to control, feel safe, and have trust in others.

Symptoms characteristic of PTSD

One of the reactions of VT is the symptoms characteristic of PTSD. The vivid recounting of trauma by the survivor and the clinician's subsequent mental imagery of clients' trauma, i.e., the cognitive representation, may result in a set of symptoms and reactions that parallel PTSD (Figley, 1995, Pearlman & Saakvitne 1995). Excessive negative appraisals of the trauma is one of the key factors that maintains PTSD (Ehlers & Clark, 2000). In the study, symptoms that resembled PTSD that participants experienced were recurrent and intrusive memories, numbing of responsiveness, alterations in mood, and alterations in arousal and reactivity.

Part of the re-experiencing symptoms of PTSD involves recurrent and intrusive memories of the trauma (APA, 2013). Participant experienced recurrent and intrusive memories in many different ways including persistent thoughts about clients' trauma, hypersensitivity to media portrayals of trauma reminders, and nightmares about the client's trauma. Kaminer and Eagle (2010) suggested that trauma-related intrusive memories happen in a way that the survivor is unable to voluntarily control. Indeed, participants found that memories and thoughts about their clients' trauma continually intruded into their consciousness despite their best effort to

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block these out. Their symptoms are consistent with the established findings of various others studies on VT, in that therapists often experience intrusive imagery of their clients' trauma (Kassam-Adams, 1999; Pearlman & Mac Ian, 1995; Morrison, 2007; Rich, 1997; Schauben & Frazier, 1995; Steed & Downing, 1998).

Participants reported numbing of responses. Numbing in response to trauma reminders one of the symptoms of PTSD (APA, 2013). For many trauma survivors, talking about or remembering the trauma feels as dangerous as actually experiencing it. They may thus try to avoid the distressing feelings associated with the trauma by numbing themselves emotionally, resulting in feeling cut-off or emotionally detached much of the time (Kaminer & Eagle, 2010). Some participants in this study reported having similar restrictive reactions as a result of hearing the traumatic stories their clients share. One participant, Wendy, reported that she started to feel numb and emotionless about her clients' trauma. Figley (1995) suggested that numbing symptoms that are experienced by therapists who help trauma survivors involve efforts to avoid thoughts and feelings. Wendy's numbing of responsiveness was shown by distancing herself emotionally and switching off feelings and emotions about trauma. Her affectless manner of handling the clients' traumatic material enabled her to avoid dealing with the unpleasant feelings associated with the distressing contents of her clients' trauma.

Another symptom of PTSD is the experience of persistent trauma-related emotions (APA, 2013). All participants spoke about the emotions that they experienced as a trauma therapist. Engaging with clients on a deep and empathising level has led to participants experiencing similar emotions as their clients'. In the study, the most profound negative alterations in emotions were sadness and anger. Some participants were sad about the traumatic experiences that the clients had to go through, while some were sad about the world in general because of their shattered assumptions after repeated exposure to clients' trauma. Most participants' anger stemmed from the frustration of their inability to help the survivors on a larger scale. Because of the nature of private practice, seeing clients individually could not help them achieve transformation on a community level. In their own words, they experienced "helpless rage", which imitated the recurring feelings of helplessness of their clients. Helplessness often comes along with a sense of hopelessness, expressed as "there's nothing I can do" (Bloom, 2003). Indeed, participants felt that their capacity to help was limited. Knowing that trauma happens so rapidly in certain communities but unable to stop it through the work they do, they felt angry about it. Many types of trauma-related emotions

have been documented in the literature of VT. Common ones include feelings of anxiety, helplessness, grief or loss, irritability, and guilt (Cunningham, 2004; Sommer, 2008).

As a result of the overwhelming emotional symptoms, many participants mentioned that they struggled to manage their emotions when interacting with others. Such reactions were shown in participants' feelings of irritability and outburst of rage towards their family or other people. Irritable or aggressive responses are part of the trauma-related alterations in arousal and reactivity characteristic of PTSD (APA, 2013). People who are processing a particular trauma are easily irritable or angry in response to minor frustrations or perceived hostility from others (Kaminer & Eagle, 2010). Participants reported that they often responded to people with annoyance and anger without a profound reason, particularly after work. Even though all participants acknowledged that their irritability and anger were unreasonable and inappropriate, they felt impulsive and experienced lack of control of their reactions at the very moment. Furthermore, sleep disturbance is another feature of trauma-related alterations in arousal and reactivity (APA, 2013). One participant experienced this symptom as he struggled to sleep as a result of trauma work.

5.3 Psychosomatic Symptoms

Studies suggested that trauma therapists can experience physical symptoms such as somatic problems, gastrointestinal disturbances, colds and flu (Collins & Long, 2003; McKenzie, Gurris, & Traue, 2007). Physical symptoms are produced or aggravated by mental factors, particularly emotional stress (Wright, 1977). All participants mentioned that trauma counselling was a demanding and stressful task. Listening to graphic descriptions of horrific events, bearing witness to people's cruelty to one another, and witnessing and participating in traumatic re-enactment took a severe psychological toll on them. As a result of empathic engagement with clients' trauma material over time, they were under great stress to deliver professional service while ensuring that they were not negatively affected by clients' trauma. Participants experienced symptoms such as feeling physically drained, tight chest, stiff muscles, asthma, headaches, and migraine. The pre-existing somatic symptoms that one participant (Wendy) experienced, for example, asthma, has dissipated, but reappeared once she started working with traumatic material. Stress is known to cause emotional exhaustion and lead to negative feelings (Cottrell, 2001). Under great stress, participants perceived clients' trauma in a negative way and in turn experienced unpleasant physical symptoms. Their physical reactions reflected their mental state and their negative appraisals about trauma work.

5.4 Vicarious Posttraumatic Growth

The concept of VT emphasises the negative as well as the positive impact of bearing witness to traumatic events (Bloom, 2003). PTG is a potential consequence of the cognitive effort to redefine beliefs and rebuild the assumptive world after an experience of trauma (Calhoun & Tedeschi, 2006; Janoff-Bulman, 1992). It has been assumed that trauma often threatens or challenges the core beliefs individuals hold that define their assumptive worlds (Janoff-Bulman, 1992). However, sometimes individuals' explanatory accounts of trauma may serve to re-establish a sense of trust, control and purpose, as opposed to shattered assumptions (Kaminer & Eagle, 2010). PTG can thus be understood as growth defined by positive changes in perceptions of self and the world (Joseph & Linley, 2008). PTG is often parallel with the negative psychological impact of trauma (Kaminer & Eagle, 2010).

Little is known about the process of psychological growth that can follow vicarious exposure to trauma (Barrington & Shakespeare-Finch, 2013). Yet, from the limited research available, evidence suggests that growth can also occur as a result of VT, through similar meaning-making processes that follow direct trauma (Tedeschi & Calhoun, 1996). Therapists can experience significant positive symptoms from their experiences of working with trauma survivors, known as VPTG (Hyatt-Burkhart, 2014; Splevins, Cohen, Joseph, Murray, & Bowley, 2010). VPTG is a newly emerged concept and was found to be strikingly similar to reports of growth following directly experienced trauma (Arnold, 2005). Perceived growth amongst clinicians can be divided into three areas: changes in self-perception, changes in interpersonal relationships and changes in life philosophy (Tedeschi & Calhoun, 1996). In this study, participants reported positive transformations in all three areas. They experienced both personal and professional VPTG, included personal growth, greater appreciation of relationships with others, work satisfaction, and work efficiency. Participants who experienced VPTG rebuilt their cognitive schema in a positive manner by attributing positive meanings to the trauma they heard from the clients.

According to CSDT, one of the components of self that can be affected by trauma is the "ego resources", which refers to the capacity for empathy and self-awareness. Participants experienced positive transformations in their ego resources as many of them achieved profound personal growths, particularly in the strengthening of their capacity to empathise and be self-aware. Arnold (2005) reported that therapists recognised their own growth and development by learning from clients' triumphs over trauma and movement toward strength

and self-reliance. Being aware of their clients' resilience, many participants found themselves to be more understanding, compassionate, sensitive, and have better tolerance of other people's situations. Increased levels of compassion, empathy and related improvements in interpersonal relationships have been described as an important component of positive outcomes after trauma (Calhoun & Tedeschi, 1999). Moreover Herman (1995) reported that therapists' exposure to traumatic material can enrich their self-understanding and their ability to understand others. This is similar to the findings of the study in that participants felt working with the survivors has made them more insightful and knowledgeable about self and society. They mentioned that they were growing along with their clients because they were working on how they could improve as a therapist while helping the survivors of trauma.

Disruptions within interpersonal relationships are often cited as a symptom of VT (Robinson-Keilig, 2014). However, some participants in the study showed otherwise. They started to value the relationships in their lives that they previously took for granted. Listening to clients' trauma has allowed them to gain a richer emotional insight into the pain and distress of other people and therefore stimulated their sense of compassion and empathy. These participants started to value the interpersonal relationships because they realised that trauma could happen to anyone and it is therefore important to care for others while they still can. According to Janoff-Bulman (1992), greater appreciation of things that were taken for granted is a changed philosophy of life, which forms part of the cognitive schema change after trauma. A change of philosophy of life can result in a re-ordering of priorities. These include decisions to spend less time and emotional energy on work and more on family and other relationships. In this study, some participants changed their priority to working on and maintaining relationships. VT enables therapists to form new relationships or deepen existing relationships (Herman, 1995). Participants started to devote more time and energy in the relationships in their lives because they felt that it is important to reconnect and appreciate the relationships that they neglected.

Studies have indicated that helping professionals often have decreased productivity at work (Morrison, 2007; Pearlman & Saakvitne, 1995) and low work satisfaction (Coffey, Dugdill, & Tattersall, 2003) as a result of VT. Some may even leave their profession (Bell et al., 2003). The intense nature of trauma work challenges psychologists' ability to provide effective services and maintain personal and professional therapeutic relationships (Collins & Long, 2003). In contrast, participants in the study mentioned that they were driven by their work in trauma and were motivated to perform better. They also experienced great work

satisfaction as a result of seeing their clients' improvement. These participants successfully integrated and transformed their VT experience in a meaningful way and in turn experienced positive influence of trauma work. Being able to psychologically accommodate new trauma-related material reduces cognitive dissonance (Splevins et al., 2010), and may have important clinical implications, such as enhanced clinician well-being, role retention, and improved therapeutic outcomes (Barrington & Shakespeare-Finch, 2013). Participants were able to feel motivated, feel important about their role as psychologists, and experience the joy the profession brought them as a result of helping others. However, higher work efficiency and work satisfaction as a result of working with trauma survivors have rarely been documented in the literature of VT.

5.5 Coping with Vicarious Trauma

Just as the unique individual expression of VT symptoms, participants also had individual expressions of coping with VT. Participants, although at times experiencing considerable occupational stress, generally coped well and productively using a range of coping strategies. Strategies to manage VT as suggested by Saakvitne et al. (2000) involve three levels: anticipating, addressing, and transforming the symptoms of VT. Anticipating involves arranging things ahead of time to anticipate stress and its impact. Addressing VT involves doing things for self-care, self-nurturing, and escape. Transforming VT refers to doing things to transform the negative impact of the work into a connection with some positive aspect of meaning, spirituality, and community. Participants in the study were able to identify their signs of VT and adopt self-care strategies to address the symptoms. Many of them were also able to transform the pain of VT into meaningful thoughts and in turn benefited professionally and personally from their positive attitudes. These coping strategies, whether practical or psychological, has largely helped the participants cope with VT, leaving them feeling rejuvenated, energised, motivated to stay in the field of trauma counselling.

Anticipating vicarious trauma

Anticipating VT is the first step for the therapists towards protecting themselves from the impact of trauma work on them professionally and personally. This involves being aware of the reality of VT (Saakvitne et al., 2000). When therapists are able to identify strategies to prevent VT from becoming severe and problematic they are less likely to experience VT symptoms (Cunningham, 2003; Morrison, 2007). All therapists should have a professional

awareness of preventive measures that can be used to address the symptoms of VT (Newell & MacNeil, 2010).

Several participants showed the ability to anticipate and be aware of first signs of VT through self-reflexivity. Using a reflexive practice approach is widely acknowledged to be the most effective tool in the prevention of VT (Gilmore, 2011). Participants were able to recognise the aspects of their work that made them most vulnerable to VT, and thereby identified specific approaches to minimise or counteract the negative effects of trauma work before it affected their work or personal lives. For example, one participant, Tammy, mentioned that when she felt helpless, she would then know it was time to work through her emotions. She used negative emotions as an indicator for coping with VT. These participants made self-reflexivity a habit and something that came natural with their career. Ongoing self-reflexivity not only helped them to stay in the field and cope, but in an ethical sense, it also helped them withdrew any personal issues in the therapy in order to deliver effective psychological services that were professional and responsible for the wellbeing of their clients. As Cunningham (2003) mentioned, addressing signs of VT does not only alleviate the negative impact on the clinician, but also ensures the quality of services for the clients who seek psychological assistance. Awareness is the essence of reflective practice. Through reflexivity, the participants understood themselves and their clients better. Trauma therapists, being conscious of what they are doing and why they are doing it is the only way to guarantee growth and change (Gilmore, 2011).

Addressing signs of vicarious trauma

Addressing VT involves the utilisation of self-care strategies (Saakvitne et al., 2000). In the study, many participants used self-care strategies in the form of leisure activities. Several participants reported exercising as a coping strategy, including going to gym and boxing. Exercising is an important way to integrate mind-body self-care practices into therapists' life style (Giberovitch, 2014). In the literature, doing leisure activities is one of the most common coping strategies for VT (Gerding, 2012). Studies have shown the significance of leisure activities in reducing VT (Bober & Regehr, 2006), such as spending time with family, vacation, hobbies, and exercise (Jordan, 2010). Moreover, some participants reported that the self-care strategies they used were relaxing and self-soothing, for example, meditation and having a sense of humour. These strategies were used by the participants to ensure their mental wellbeing. Meichenbaum (2006) mentioned that practicing self-soothing activities that

involve mindfulness and nurturing is an effective way to cope with VT. Humour is a way to honour and respect personal needs and engage in restorative activities and practices that nourish a therapist's body, mind and soul (Giberovitch, 2014). Further, there were self-care strategies used by participants to escape from the stress of their work, include adequate sleep, mentally detaching from work, and taking breaks. The strategies that helped the participants escape from work at appropriate times were the general bio-behavioural self-care strategies. Common ones in the literature include adequate sleep, a well balanced diet, and taking small breaks during the day (Jordan, 2010).

Self-care strategies that the participants used did not only help them address the effects of VT, but also maintain a sense of balance. The balance refers to having a balance between work and personal life, and the ability to balance work, rest and play (Saakvitne et al., 2000). A sense of balance is considered to be one of the key components to preserving a sense of identity and overall wellbeing (Saakvitne et al., 2000). All participants mentioned that they participated in a variety of leisure activities outside work and many of them found it helpful to do academic work such as training and lecturing, apart from the clinical work of trauma. This helped them organised their time evenly on their schedule instead of focusing exclusively on the intense clinical work that could potentially overwhelm them. Having a diversity of trauma-related work allowed the participants to have some outlets for emotional discharge outside of their clinical role, and helped them maintained the necessary balance as a professional. Many participants also indicated that balance could be achieved by deliberately controlling their workload. Even though there is a high demand in psychological patients seeking trauma counselling, these participants were aware of how to set limits to workdays, and were able to find a comfortable pace when they worked. In the literature, several authors pointed to the importance of maintaining a balance between work and personal life in helping to reduce the symptoms of VT, include Figley (1995), Hesse (2002), Pearlman & Saakvitne (1995), and Regehr and Cadell (1999).

Connection with oneself, with others, or with something bigger is another way to cope (Saakvitne et al., 2000). In the study, Wendy achieved the connection with self through reading, watching TV, and having some time to herself; Tammy had the connection with others through socialising with friends; and Eugene experienced the connection to something bigger through engaging with nature and going in the sea. Trippany et al. (2004) suggested that any activities which assist the individual's personal tolerance levels, for example, journal writing, personal counselling, emotional support from partners, will assist the individual to

reconnect to emotions. In the study, all participants reported that they have been going to supervision in forms of regular supervision, case discussion, or group supervision, when they felt overwhelmed by work. Supervision is strongly encouraged as a coping mechanism and is one of the most common coping strategies used by clinicians who work with trauma victims (Gerding, 2012). Supervision, particularly in the form of group therapy has been suggested to be an informal and important time for individuals to process traumatic material with supervisors and peers (Bell et al., 2003). Participants reported that they shared their work-related experience in a space they felt safe, supported, and understood. As Rosenbloom, Pratt and Pearlman (1995) stated, "supervision should foster an atmosphere of respect, safety, and control for the clinician who will be exploring the difficult issues evoked by trauma therapy" (p. 77). Supervision allowed these participants to connect and communicate with colleagues who are also in the field. Such communication is part of the connection and breaks the silence of unacknowledged pain. Being able to connect with other professionals in the field allowed these participants to be aware of their own issues and experiences, and helped them acknowledged their needs to cope. The need to talk, confess, and release stored tension is powerful and important for health (Bloom, 2003). The participants' strong belief in the effectiveness of supervision in reducing VT replicates the results of Bober and Regehr's (2006) study. Vast literature suggested that peer consultation, supervision, and professional training reduce the sense of isolation and increase feelings of efficacy (Cerney, 1995; Pearlman & Saakvitne, 1995; Talbot, 1989). It is important to connect with others and have the form of social support instead of coping in isolation (Bloom, 2003). Going to supervision made the participants felt that they were not alone, as these connections offset isolation and increased validation and hope.

Transforming the pain of vicarious trauma

Transforming VT includes things therapists do to transform the negative impact of the work into a connection with some positive aspects of meaning and community. Strategies include create meaning, infuse meaning in current activities, challenge negative beliefs, and participate in community building (Saakvitne et al., 2000). Several participants indicated their optimistic attitude towards trauma work because they believed in clients' resilience and transformation. They believed that trauma work is not just a job that deals with clients' disheartening experiences, but an opportunity to facilitate change. Unlike the participants who experienced great negative shifts in the perceptions about others and the world as a result of engaging with clients' trauma, these participants who showed optimism were better

able to challenge negativity. They minimised self-blame, blame in others, and overcame feelings of shame, guilt, incompetence and frustrations that they experienced as a psychologist. They focused on finding meaning and hope by giving attention to clients' signs of resilience. They transformed their thoughts about trauma by learning and growing from their work experience. According to Gilmore (2011), whilst difficult and demanding, there are gifts in trauma work, and that is therapists' sense of hope, their admiration for human resiliency, and their recognition of the difference the therapeutic relationship can have in someone's healing process and life.

Chapter 6: Conclusion and Recommendations

6.1 Conclusion

This study has explored the experiences of VT among clinical and counselling psychologists and identified some of their coping strategies used to manage the impact of VT. The dominant themes encountered in the narratives of participants include shattered assumptions about the world and others; symptoms characteristic of PTSD such as intrusive memories, avoidance of reminders of the trauma, negative alterations in mood and alterations in arousal and reactivity; and psychosomatic symptoms such as physically drained, tight chest, stiff muscles, asthma, headaches, and migraine. In general, participants coped effectively to ameliorate their VT symptoms using physical and psychological self-care strategies. Participants were able to anticipate, address and transform the signs of VT. Additionally, this study highlighted VPTG as positive symptoms of VT. Some participants reported that working with trauma also contributed to their personal growth, improved relationships, higher work satisfaction, and higher work efficiency. Hence, working with trauma survivors does not only lead to negative reactions manifested in VT, but can lead to positive transformations. Trauma work can be a vicariously rewarding experience as it allows psychologists to witness growth and resilience.

6.2 Recommendations and Directions for Future Research

Given the prevalence of trauma in South Africa and the likelihood that psychologists encounter trauma survivors, it is crucial for psychologists to recognise their vulnerability to VT (McCann, Sakheim & Abrahamson, 1998). Psychologists have the responsibility of ensuring the wellbeing of trauma survivors, but more importantly, the responsibility to make choices in their own personal and professional lives that support positive and transformative strategies to cope with the effects of VT. It is believed that strong ethical principles of practice, knowledge of theory, on-going training, development of competence in practice strategies and techniques, awareness of the potential of VT, and the need to take deliberate steps to minimise the impact, all serve as protective factors (Bloom, 2003). Building on this perspective, I recommend that the information on the risk of VT in a clinical setting and its common coping strategies can form part of the psychoeducation for students pursuing a Masters degree in counselling or clinical psychology. This educational material can be infused with lectures such as psychological interventions and crisis management. For professionals who have already been working as clinical or counselling psychologists, issues about VT can be addressed as part of supervision and training. It has been suggested that the

best preventive measures against VT is to educate therapists about them, including a clear understanding of the phenomena themselves, their risk factors, and symptoms (Figley, 1995).

The study looked exclusively at psychologists' experiences of VT. However, there is a growing body of studies that focus on the experiences of other categories of professionals that work with trauma survivors (Bloom, 2003). VT is not a fixed response. Different population may experience the challenge of trauma work differently. Future research may include other professionals in the sample such as hospital personnel, social workers, counsellors, volunteers who work with trauma survivors and identify whether there are differences in the VT response between these sample groups. Furthermore, additional research is needed to explore the differences of VT symptoms in professionals who work with trauma offenders other than trauma survivors. Although survivors and offenders both present traumatic material, there are definite differences in the content presented. For example, Pearlman and Saakvitne (1995) suggested that clinicians who treat sexual offenders, and those who treat survivors of sexual offence may experience different effects as those who treat offenders may need to manage more intense emotions such as anger and disgust while remaining appropriately empathic. Identifying differences in VT responses may help developing beneficial and tailored information on coping strategies for professionals who work with different trauma populations.

Research on VT has predominantly focused on the negative impact and the damage it can do to an individual's personal and professional life. The positive implications of trauma work and the concept of VPTG are often not the primary focus of research in this area and the knowledge about those aspects is limited. According to the findings of this study, working with trauma survivors can have positive consequences for psychologists. The concept of VPTG is evident even though it has only been coined into the literature recently (Seligman & Csikszentmihalyi, 2000). From a positive psychology perspective, it is important for researchers to investigate the reciprocal aspect of VT in future research, by exploring the impact that trauma survivors' resilience has on psychologists' well-being and work experience. In this regard, VT should be seen as a response that can be potentially beneficial to psychologists as a result of working with trauma survivors.

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Appendix A - Information Sheet

UNIVERSITY OF THE WESTERN CAPE

Private Bag X17, Bellville 7535, South Africa

Tel: +27 21-959, Fax: 27 21-959

Project Title: A qualitative study exploring the experiences of vicarious trauma and its related coping strategies among a group of South African psychologists

What is this study about?

This is a research project being conducted by Xin-cheng Sui at the University of the Western Cape. I am inviting you to participate in this research project because your participation in this study may provide me with a better understanding of the issues around vicarious trauma. Vicarious trauma is the pervasive changes that occur within clinicians over time as a result of exposure to trauma survivors' traumatic material. These include changes in the clinician's sense of self, spirituality, worldview, interpersonal relationships, and behaviour. The purpose of this research project is to get an in-depth understanding of the unique experiences of each psychologist regarding vicarious trauma, as well as to explore what coping strategies these professionals use and whether they are coping effectively.

What will I be asked to do if I agree to participate?

You will be asked to attend an interview session with me that will take no longer than an hour. You will be provided with the interview questions before the actual interview. This will allow you to prepare for the questions in order to minimise the risk of negative emotional consequence that may arise from talking about your experiences of vicarious trauma. The interview will be conducted at a mutually convenient location. Questions that will be asked in the interview focus on two broad themes: (1) experiences of vicarious trauma, and (2) coping with vicarious trauma.

Would my participation in this study be kept confidential?

I will do my best to keep your personal information confidential. To help protect your confidentiality, the research process is guided by strict ethical considerations of the University of the Western Cape and will be adhered to at all times. You will be asked for

permission to record the conversation during the interview. The recorded conversation will be used for the purpose of data analysis only. All your personal detail will remain confidential. To ensure confidentiality, I will ensure that audio files and interview transcriptions will be kept in a safe place, and the data will be saved in password-protected computer files. When I write the report about this research project, your identity will be protected to the maximum extent possible by using pseudonyms.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalised or lose any benefits to which you otherwise qualify**.**

What are the benefits of this research?

The results of the study may help the investigator learn more about vicarious trauma and its related coping strategies. This study is expected to have practical implications for training, supervision and clinical practice for psychologists in South Africa to enhance the efficiency of psychological service delivery to traumatised population. I hope that, in the future, professionals who work with traumatised individuals may benefit from this study through improved understanding of vicarious trauma and the coping mechanisms they can use.

What are the risks of this research?

Speaking about experiences of vicarious trauma could be potentially distressing for some individuals. If you feel distressed during the interview, you may indicate this to the researcher. The interview will be stopped and you will be given a chance to decide whether or not you want to stop completely, re-schedule, or carry on. The researcher's action of risks can be found below.

Is any assistance available if I am negatively affected by participating in this study?

If you are negatively affected by the study such as feeling emotionally distressed, you may withdraw from the study and will be immediately provided a list of contact details of mental health care providers who will be available to provide you counselling service. A follow up phone call or a visit will also be available from the researcher to maximise the protection from any emotional harm or unpleasant feelings.

What if I have questions?

This research is being conducted by Xin-cheng from the psychology department at the University of the Western Cape. If you have any questions about the research study itself, please contact me at:

4 Cameronians Avenue, Door de Kraal, Bellville

082 747 1339

suixc@hotmail.com

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department

Michelle Andipatin

Psychology department, University of the Western Cape

Private Bag X17

Bellville 7535

021 959 2454

mandipatin@uwc.ac.za

Dean of the Faculty of Community and Health Sciences

University of the Western Cape

Private Bag X17

Bellville 7535

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.

Appendix B – Informed Consent for Participants

Title of Research Project:

A qualitative study exploring the experiences of vicarious trauma and its related coping strategies among a group of South African psychologists

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Participant's name…………………………………….

Participant's signature…………………………………..

Witness……………………………………………………...

Date…………………………………………………….

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Dr. Anita Padmanabhanunni

University of the Western Cape

Private Bag X17, Bellville 7535

Email: apadmana@uwc.ac.za

Thank you for volunteering to participate in this study.

Appendix C - Semi-structured Interview Questions

Dear Research Participant,

Thank you for considering participating in this study. This study focuses on psychotherapist's experience of vicarious trauma and their coping strategies. Traumatic events do not only impact the survivors but can also affect the professionals who provide psychological care because they are exposed to clients' trauma material. Vicarious trauma is the permanent transformation in the inner experience of the therapist as a result of empathic engagement with clients' trauma material. It involves changes in the professionals' sense of self, spirituality, worldview, interpersonal relationships, and behaviour. Professionals may also develop symptoms that are similar to those of PTSD as a result of vicarious trauma.

Below are examples of the types of questions you can expect to be asked during the individual interview:

1. How do you describe your experiences of working with survivors of trauma?

2. What types of traumatic events do your clients present with?

3. Are there specific forms of trauma that you find particularly challenging to work with?

4. Do you feel that you are affected emotionally by working with trauma survivors?

5. In what way does your work with trauma survivors impact on your personal life?

6. Has working with trauma survivors affected your pre-existing beliefs about yourself, other people, and the world around you?

7. When you hear a client's traumatic experience, do you struggle to distance yourself from the trauma story?

8. Does a client's trauma experience have any influence on your relationships with others (colleagues, friends, family, etc.)?

9. Have you ever experienced intrusive symptoms of your clients' trauma?

10. What are some of the coping strategies you use?