

**SECONDARY TRAUMATIC STRESS AMONG TELEPHONE COUNSELLORS
IN SOUTH AFRICA**

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DECLARATION

I declare that this is my original work, it has not been submitted before for any other degree at any university. All references from previous works have been acknowledged.

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ABSTRACT

This study explored Secondary Traumatic Stress (STS) in a sample of telephone counselors in South African. The ultimate aim for the study was to provide baseline information for further research regarding the reduction of risk of secondary traumatic stress for telephone counselors. Participants completed two instruments: The Professional Quality of life scale (ProQol) (Stamm, 2010) and a short biographical questionnaire. Results indicated that the majority of counsellors within the sample reported experiencing a low to average level of symptoms associated with STS and a relatively high level of compassion satisfaction (CS). It was noted that STS was inclined to decrease, as CS increased. A number of factors were perceived to have a buffering effect against the development of STS. These factors included physical and mental health, adequate training, adequate supervision and support from colleagues, religious / spiritual grounding and social interaction. The results confirm that these specific factors of resilience need to be considered when designing interventions to buffer against the development of STS and burn out in telephone counselors within South Africa.

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CHAPTER ONE: Introduction

Whilst therapists have been counselling and treating victims of trauma and violence for many decades, countless acts of violence have historically been kept secret, left unreported, the victims often feeling too ashamed to seek help and subsequently being left to fend for themselves (Herman, 1992; March & Amaya-Jackson, 1993; Sexton, 1999; Taylor & Furlonger, 2011; Terr, 1995). It is only in recent years that significant numbers of survivors of violent crimes, including domestic violence, rape, child abuse, childhood sexual abuse, genocide, war and political violence have been encouraged to seek help in the form of psychotherapy (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Sommer, 2008). Research indicates that the universally burgeoning number of trauma related cases is placing increased strain on the expertise and personal coping resources of psychotherapists, leaving them feeling overwhelmed and unprepared, thereby placing them at increased risk of developing secondary traumatization and possible burnout (Dunkley & Whelan, 2006b; Figley, 2002; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Stamm, 2002; Stamm et al., 2011; Wilson & Thomas, 2004). While attempting to heal the wounds of their clients, these counselors are themselves at risk of becoming wounded (Dalenberg, 2000; Hilfiker, 1985).

In the current, post-apartheid context, the prevalence rates of exposure to traumatic life events for the average South African can be great, especially considering those exposed to situations such as those associated with widespread poverty, violent crime, HIV/AIDS and oppression, to name but a few (Figley, 2002; Stamm, 2002; Swartz, 1998). Beyond the deleterious psychological consequences of traumatic exposure, literature shows that it is also a significant harbinger to a plethora of somatic symptomatology (Alloy, Riskind, & Manos, 2005; Corey, 2005; Figley, 2002; Friedman & Schnurr, 1995; Herman, 1992; McCann & Pearlman, 1990; Sommer, 2008; Stamm, 2002).

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One solution to the increased workload on psychotherapists has been the introduction of trained, nonprofessional lay trauma counselors (Ortlepp & Friedman, 2002). It is clear that while all South Africans are at risk of secondary traumatic stress (STS), burn out and compassion fatigue the incurred risk is significantly augmented for those working directly with trauma on a daily basis, as is the case with trauma counselors (Stamm, 2002; van Deroort Lipsky & Burk, 2009). This risk is cogently expected to be augmented for those counselors who receive little, if any formal training and supervision, as is often the case with telephone counselors, who usually work on a voluntary basis (Dunkley & Whelan, 2006a). While research in the area of STS among face-to-face counselors is increasing, there is currently a paucity of research in the area STS among telephone counselors, with very little research having been conducted within South Africa. This area has historically been neglected, resulting in a global lack of descriptive research measuring the prevalence and influencing factors of STS and the subsequent impact on professional performance and quality of life of telephone counsellors (Dunkley & Whelan, 2006b). The main objective of this study was to explore STS in telephone counselors within a South African context. The study investigated various factors, including personal history of trauma and supervisory support, influencing the prevalence of STS and burnout in telephone counselors, as well as the impact that STS has on the counselor's professional quality of life. Within the context of the aforementioned considerations, one of the central objectives of the study was to provide baseline information for further research and intervention regarding the reduction of risk of STS for telephone counselors in South Africa.

CHAPTER 2: Theoretical Framework and Literature review

2.1. Introduction

The ‘*wounded healer*,’ a term first used to describe psychotherapists by Jung, refers to the innate vulnerability of the therapist (Jung, 1951). It is the experiences of painful vulnerability that contribute to the skill, sensitivity and insight of the effective therapist. Thus the image of the ‘wounded healer’ is not one of a damaged therapist, lacking in the strength or skill of another, but it is a capacity attributed to all caregivers who open themselves to authentically engage in the practice of psychotherapy (Wheeler, 2007).

Exposure to traumatic events, primary or secondary, seems to be commonplace and even inherent to being human (Figley, 2002). Research conducted in the USA using a random sample of adults, indicated that 60,7% of men and 51.2% of women had experienced at least one traumatic event that would meet the category A criterion for the diagnosis of PTSD, according to the DSM-V (APA, 2013). The incidence of exposure is exponentially increased for those who live in extreme situations, such as those brought about by severe poverty and dread disease such as HIV/AIDS which are currently so prevalent in South Africa. Yet despite life being traumatic by its very nature, the general majority of people seem to cope relatively well, without any pathological symptomatology. Everyone exposed to daily traumatic events are at risk of harm, but the risks are significantly augmented for those who work with victims of trauma; for these individuals there is unavoidable risk of direct, personal day to day exposure as well as the high risk of work-related secondary exposure. Yet, despite this amplified risk, most counsellors’ stay relatively healthy and are able to efficiently continue doing their work. It would seem that exposure to traumatic events does not guarantee the development of pathology (Figley, 2002).

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2.2. Definitions of Trauma

The definition of the term “trauma” varies significantly in accordance with various disciplines. In general conversational language, the word trauma is usually associated with any distressing event or experience, while a more medical definition would associate the word trauma with an injury of a purely physical nature. A psychological definition of trauma tends to include any incident that results in either severe physical harm to the body or severe shock to the mind, or both. This definition embraces the understanding that both mental and physical shock are likely to produce indelible psychological consequences for the individual concerned, even after healing and recovery has occurred (Kirmayer, Lemelson, & Barad, 2007; Matsumoto, 2009). Thus the idea of trauma has been extended, becoming a psychophysiological process, a physical and emotional experience which includes a plethora of situations of extremity with varying individual consequences (Kirmayer et al., 2007). Psychological trauma is often associated with feelings of “intense fear” and an overwhelming sense of helplessness, powerlessness, “loss of control, and threat of annihilation (Herman, 1992, p. 33).” This approach posits that traumatic experiences may produce intense and enduring changes in psychological arousal, memory, cognition and emotion. Furthermore, these normally integrated functions may become disconnected from each other. In these situations, the traumatised individual may experience feelings of deep emotion but have no memory of the traumatic event. The individual may be in a constant state of agitation, irritability or hyper vigilance without understanding why. Alternatively the individual may have a clear recollection of the details regarding the traumatic event without having any emotional connection to the event at all (Herman, 1992).

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2.3. Defining PTSD

Symptom clusters characteristically associated with exposure to traumatic events are categorised in the Diagnostic and Statistical Manual for Mental Disorders (DSM-V) as one of the Trauma and Stressor-Related Disorders, and can be further classified as either Acute Stress Disorder (ASD) or Post Traumatic Stress Disorder (PTSD), depending on the duration of the characteristic symptomatology. ASD is differentiated from PTSD by the symptom cluster of ASD enduring for duration of between 3 days to 1 month following exposure to the traumatic event (APA, 2013).

Diagnostic Criteria for PTSD, as stated in the DSM-V:

Posttraumatic Stress Disorder (APA, 2013, pp. 272-272).

Note: The following criteria apply to adults, adolescents, and children older than 6 years.

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

Note: In children, there may be frightening dreams without recognizable content.

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

Note: In children, trauma-specific re-enactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").

3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.

4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).

5. Markedly diminished interest or participation in significant activities.

6. Feelings of detachment or estrangement from others.

7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition. Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify if:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (APA, 2013, pp. 271-272).

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2.4. Confusion regarding nomenclature

The DSM -V as well as The American Psychiatric Association's diagnostic disorders manual (APA, 2013) note that posttraumatic stress disorder (PTSD) is likely to occur when a person has either been exposed to a traumatic event directly or indirectly, as is the case for a parent of a traumatised child (Frances, Pincua, & First, 2000). In both of these cases the individual may experience the effects of trauma, albeit through different social pathways. Trauma experienced via the latter pathway is currently referred to as secondary traumatic stress (STS), which is seen to form part of a broader concept known as compassion fatigue (Figley, 2002; Stamm, 2010; Wilson & Thomas, 2004). It is however evident that the symptoms associated with STS are usually not as severe as the symptoms associated with PTSD (Lerias & Byrne, 2003). While the one aspect of compassion fatigue is associated with STS, the other refers to symptoms typical of burnout (BO), including exhaustion, anger, irritability and depression (Stamm, 2002). Compassion fatigue is the most recent term adopted by the field of traumatology associated with the "cost of caring" for others in emotional pain (Figley, 2002). Throughout the literature, various terms have been used to refer to this phenomenon known as secondary traumatic stress (STS), reflecting a lack of conceptual clarity regarding this condition. In the field of traumatology, the nomenclature used to describe symptoms associated with STS is often perceived as interchangeable with terms such as; compassion fatigue (Figley, 2002; Stamm, 2002), secondary victimization (Figley, 2002), vicarious traumatization (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995) and traumatoid states (Wilson & Thomas, 2004). Research conducted by Jenkins and Baird (2002), focused on attempting to clarify the aspects differentiating vicarious trauma (VT) from STS and compassion fatigue (CF). The research posited that vicarious trauma involved changes in cognitive schemas, while STS and compassion fatigue was associated with symptoms predominantly socio-emotional in nature (Jenkins & Baird,

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2002). This having been said, there still seemed to be no definitive data suggesting that the constructs are conceptually distinctive from each other. While the two constructs can be cogently explained as representing different phenomena, they are frequently researched and referred to in the literature as though they are one and the same (Baird & Kracen, 2006; Jenkins & Baird, 2002; Lerias & Byrne, 2003).

While VT and STS both refer to trauma-related conditions occurring as a result of working with survivors of traumatic experiences and both infer symptoms similar to that of PTSD, the constructs seem to differ with regard to several core aspects, some of which will be discussed in this paper. It is significant that Figley (1995) defined STS by focusing predominately on symptomatology while Pearlman and Saakvitne (1995) focused mainly on the theoretical underpinnings of VT as a syndrome of self-perceived change using constructivist self-development theory (Jenkins & Baird, 2002; Pearlman & Mac Ian, 1995). STS is seen to focus largely on the counsellors observable reactions, while VT focuses on the more subtle disruptions of thinking. While STS is associated with significant shifts in cognitive functioning as a result of exposure to the traumatic experience of the patient, it is the sudden onset of PTSD symptomatology that is of central importance (Jenkins & Baird, 2002).

Symptoms associated with STS were initially identified in the family and significant others of sexual assault survivors and combat veterans but the concept currently applies to professionals providing support to survivors of all forms of traumatic experience and symptoms can occur after severe exposure to the traumatic experiences of as few as one survivor (Figley, 2002; Jenkins & Baird, 2002). The symptoms of VT, on the other hand, are associated specifically with mental health professionals working predominantly with victims of childhood sexual abuse and survivors of incest. It is focused chiefly on the symptoms associated with prolonged exposure to the traumatic experiences of many trauma survivors

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over a prolonged period of time (Jenkins & Baird, 2002; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995).

2.4.1. Vicarious Trauma (VT)

The term vicarious traumatization (VT) was first introduced to the field of traumatology by McCann and Pearlman in 1990 (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995). It was used to describe a syndrome occurring amongst face-to-face counsellors and therapists of victims of violence, particularly of victims of incest and sexual assault. Constructivist self-development theory (CSDT) provides a conceptual framework for understanding the potential impact of VT on the trauma counselor. VT is seen to be an enduring “transformation in the inner experience of the therapist that comes about as a result of empathic engagement with clients’ trauma material (Pearlman & Saakvitne, 1995, p. 31).” The term has subsequently been applied to all individuals working with survivors of traumatic experiences. VT became a term used to describe the symptoms experienced by the counsellor, in response to hearing about the traumatic experiences of the victim. These symptoms, experienced by the therapist can potentially develop into a form of traumatization (Wastell, 2005). The predominant symptomatology of VT involve disruptions in the counsellor’s frame of reference, “identity, worldview, and spirituality...affect tolerance, fundamental psychological needs, deeply held beliefs about self and others, interpersonal relationships, internal imagery, and ...physical presence in the world (Pearlman & Saakvitne, 1995, p. 280)” The vicarious exposure to the traumatic experience was thought to change the cognitive schemas of the counsellor, regarding both self and others. These changes become evident in all aspects of the therapist’s life, both professional and personal and appear to be cumulative and enduring in nature (Baird & Kracen, 2006; Pearlman & Saakvitne, 1995). Five key areas of psychological needs are usually disrupted namely trust, safety, control, esteem and intimacy (Jenkins & Baird, 2002; Pearlman & Saakvitne, 1995).

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2.4.2. Secondary traumatic stress (STS)

Secondary traumatic stress (STS), a term introduced to traumatology by Figley (1995), who extended the concept of VT by using the term STS to describe the spontaneous reaction that individuals may develop as a result of helping, or attempting to help victims of trauma (Baird & Kracen, 2006; Craig & Sprang, 2010; Figley, 2002). It is important to note that the theoretical framework underpinning this research reflects Figley's principles which led to the enhancement in the understanding of Secondary Traumatic Stress. The most recent literature suggests that STS and secondary traumatic stress disorder (STSD) are associated with symptoms triggered by exposure to and involvement with individuals who have experienced traumatic situations (Craig & Sprang, 2010; Stamm, 2002, 2010; Wastell, 2005; Wilson & Thomas, 2004). Symptoms associated with STS are regarded as being almost identical to those of PTSD, even though the counsellor is one step removed from the trauma rather than being directly involved with traumatic event (Figley, 2002; Wilson & Thomas, 2004). It has been suggested that PTSD be regarded as a primary disorder and that STSD be seen as a secondary form of the same disorder (Figley, 2002), even though it is evident that the symptoms associated with STS are usually not as severe as the symptoms associated with PTSD (Lerias & Byrne, 2003).

A significant factor associated with STS is that of establishing and maintaining an empathetic connection with the trauma survivor (Wastell, 2005). Through empathic interaction with the traumatized individual, the counsellor circuitously experiences a degree of the emotional injuries experienced by the victim. The definition of STS posits that through the empathetic connection with the victim, the counsellor is able to experience and conceptualise the situation from the perspective of the victim (Wastell, 2005; Wilson & Thomas, 2004). Three content domains have been identified for symptoms of STS these are; the re-experiencing of the victims traumatic experience, the avoidance of reminders of the traumatic experience or

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the emotional numbing in response to the reminders and the symptoms of constant arousal (Figley, 2002; Jenkins & Baird, 2002). In an attempt to reduce stigmatization, STS is currently seen as a “normative occupational hazard” for professionals working with trauma survivors and has consequently been classified as forming part of a concept currently known as compassion fatigue (Figley, 2002).

2.4.3. Compassion fatigue

The word *compassion* is associated with feelings of intense sympathy and sorrow for the suffering or pain of another. It is further associated with an accompanying urge to help, to assuage the discomfort and to provide relief for the one who is suffering (Goldman & Sparks, 1996). It can be cogently argued that emotions of sympathy, pity and sorrow are unprofessional and inappropriate for a therapist to exhibit when forming a therapeutic alliance with a client, and that a realistic understanding regarding the limitations of the therapists’ ability to alleviate the discomfort and pain experienced by the client is paramount (Egan, 2007). This having been said, a large body of research reveals that it is the therapist’s ability to express sincere compassion, empathy and a willingness to understand and help, that mobilises the clients subsequent affinity and trust of the therapist and deepens the therapeutic alliance, increasing the likelihood of therapeutic change (Dalenberg, 2000; Figley, 2002; Wilson & Thomas, 2004). Traumatology literature posits that it is the therapist’s sincere emotional involvement with the trauma client and the clients perception of the therapists’ involvement that appear to be fundamental to successful therapy (Dalenberg, 2000; Wilson & Thomas, 2004). Empathy is perceived to be the instrument through which the counsellor imbibes the traumatic material and consequently feels affectively compelled to respond. This absorption of the client’s traumatic experiences inevitably leads to emotional strain on the therapist. This phenomenon, associated with the inevitable “cost of caring” for those in emotional pain is what is known as compassion fatigue (CF) (Wilson & Thomas, 2004).

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These “costs of caring” associated with CF can be categorised into two conceptual constructs; STS and Burnout, the latter being associated with symptoms such as exhaustion, muscle tension, decreased self-esteem, a personal sense of failure, lack of assertiveness and a generalised feeling of being overwhelmed by work (Stamm, 2010). Compassion fatigue is perceived to be a situation in which care givers expend a great deal of energy over a prolonged period of time, providing compassion to others. In the professional world of counselling, it is often similar to that of a mother-child relationship in that the focus of attention is unidirectional, focused primarily on the welfare of the vulnerable client. This unidirectional caring is the source of much caregiver exhaustion. When these care givers are not able to get enough personal support to act as a buffer against the constant strain that they experience, a total sense of exhaustion can result, this is what is referred to as burnout (Figley, 1995; Friedman & Schnurr, 1995; Skovholt, 2012).

2.4.4. Compassion Satisfaction

The theory regarding Secondary Traumatic Stress explains the injurious effects of being exposed to the traumatic experiences of another through the act of compassion. Yet counsellors continue to assist those in need, despite the deleterious effects of their work. This drive that compels a person to willingly continue to help those in distress, despite potential harm to the self, is what has become known as *compassion satisfaction* (Figley, 2002; Stamm, 2002, 2010; Stamm et al., 2011). Compassion satisfaction is the term used to describe the pleasure that a caregiver derives from being able to do his/her work effectively (Stamm, 2010).

Research indicates that a combination of hardiness and social support of the caregiver are associated with less PTSD symptomatology (King, King, Fairbank, Keane, & Adams, 1998; Williams, Helm, & Clemens, 2012). Hardiness has been defined as being associated with a

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sense of control, commitment and “change as challenge” (King et al., 1998). Subsequent research prompted Stamm to cite competency and control as key factors in reducing caregivers’ risk of developing negative reactions to their patients’ traumatic experiences (Stamm, 1999). Competency and control are associated with an individuals’ knowledge regarding the nature and management of trauma and traumatic material. He further proposed that positive support by colleagues could further enhance and sustain these factors of competency and control and are significant elements of structural and function social support (Stamm, 1999). Functional and structural social support included issues of living, such as visiting friends, loving relationships, spiritual wellness and continuing education. Research indicates that individuals’ with good functional and structural support are perceived to have higher degrees of control and seem to be less at risk of developing the negative effects of caregiving (Rudolph & Stamm, 1999). Subsequent to their research, Rudolph and Stamm proposed that by enhancing levels of competency and control, counselling facilities could significantly reduce the risk of secondary traumatic stress and enhance the protective capacity of their caregivers (Rudolph & Stamm, 1999).

With exposure to trauma challenging an individuals’ sense of control, and given that lack of control results in emotional distress, it compels us to question the reason why the majority of trauma caregivers are perceived as being fulfilled and even energised by their work (Dalenberg, 2000; Figley, 2002; Stamm, 1999; Wilson & Thomas, 2004). Craig Higson-Smith, and colleagues, working with Survivors of Violence at the South African Truth and Reconciliation Commission observed, not a negation of a struggle, but a celebration of hope. Their observations were of caregivers, working in conditions of dire poverty, amidst unimaginable trauma and yet they “pressed on, often with joy (Burnette, 1997; Stamm, Higson-Smith, Terry, & Stamm, 1996)”. It thus became apparent that that there is some form of protective aspect associated with being satisfied with doing the work of caring. It is

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evident that in order to comprehend the meaning associated with the deleterious *costs of caring*, it becomes necessary to grasp the perceived significance associated with the positive, *benefits* derived there from (Figley, 2002; Stamm, 2002). Early research conducted on disaster workers, indicated that 33 of the 95 workers perceived a sense of personal meaning and growth from their work (Raphael, Singh, Bradybury, & Lambert, 1983). Subsequent research indicated that specialized training on trauma significantly increased compassion satisfaction of the therapists, while decreasing the level of burnout and compassion fatigue experienced by these therapists (Sprang, Clark, & Whitt-Woosley, 2007). Previous research suggests that the trauma counsellors perception of their training as being adequate played a significant role in increasing the feelings of proficiency and control within the counselling context (Ortlepp & Friedman, 2002).

Physical health and mental wellness is perceived to have a significant buffering effect against the development of STS (Williams et al., 2012). It is therefore of utmost importance that physical and mental wellbeing be sufficiently addressed by educators during the training of the counsellors, as well as by facilitators within the counselling organisation (Myers, Mobley, & Booth, 2003; Williams et al., 2012). A balance between work, leisure activities and rest has been found to significantly reduce the incidence and impact of STS (Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995; Trippany, White Kress, & Wilcoxon, 2004). The restorative power of rest, such as may be experienced through regular vacations, has been found to reduce the impact and deleterious effects of STS and VT (Trippany et al., 2004). Physical and creative activities, as well as social interaction with loved-ones and friends are perceived to aid in creating a sense of personal identity (Trippany et al., 2004). Research indicates that personal interaction with supportive peers and family assist the counsellor to maintain the ability to trust others (Trippany et al., 2004). These issues are of particular significance as it is the trauma counsellors sense of self identity and trust in the world that is

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often questioned as a consequence of VT and STS (Pearlman & Mac Ian, 1995; Trippany et al., 2004).

Associated with the questioning of self-identity and basic trust in the world, the spiritual wellbeing of the trauma counsellor is at great risk of being challenged. This is considered to be one of the most damaging threats to the trauma therapists' sense of well-being (Brady & Guy, 1999). Spirituality is assumed to have both religious and existential components. This indicates that spirituality refers to the individuals relationship with God, their Creator or a higher power, coupled with a sense of meaning and purpose for life and a sense of meaning beyond oneself (Frankl, 1959; Moberg, 1979). While the definitions associated with spirituality may vary, most agree that spirituality is questioned and often disrupted or altered by traumatic experiences (Brady & Guy, 1999). Spirituality is an essential part of recovery work (Neuman & Pearlman, 1996) and a strong sense of spiritual wellness and spiritual strength is associated with enhanced compassion satisfaction, improving the therapist' ability to bear witness to clients' suffering and still remain healthy and strong (Wittine, 1994). It is of utmost importance that the trauma therapist have a clear understanding of her/his own spirituality and that existential dilemmas associated with suffering and meaning of life have been addressed (Sargeant, 1989).

2.5. Personal history of Trauma

A factor afforded significant attention in research and in current traumatology literature is that of the therapists' personal history of trauma. Those caregivers, with their own history of traumatization are perceived as being more susceptible to STS and VT, possibly due to the potential trigger of traumatic memories and the intense empathic responses stimulated by the pain experienced by the survivor (Figley, 1995; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). This sentiment has been supported by a large body of research, reporting

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that therapists and other caregivers' with a personal history of trauma are at increased risk for developing trauma symptoms (Adams, Figley, & Boscariono, 2008; Baird & Kracen, 2006; Camerlengo, 2002; Kass-Adams, 1994; Paxton, 1995; Pearlman & Mac Ian, 1995; Saakvitne, Tennem, & Affleck, 1998; K. W. Saakvitne, 2002; Schauben & Frazier, 1995). While conflicting evidence has been produced by a body of research reporting that caregivers' own history of trauma did not contribute significantly to the prediction of trauma symptomatology (Follette, Polusny, & Millbeck, 1994; Schauben & Frazier, 1995), research shows that multiple levels of vulnerability to traumatisation exist when trauma is shared between therapist and the client (Saakvitne et al., 1998). Individuals respond to traumatic events through a personal frame of reference, shaped by personal experience, psychological needs and personal emotional style. When trauma is shared between therapist and client, a client may introduce a source of anxiety as yet unconsidered by the therapist. The client's adaptations to the trauma may conflict with the therapists' own defences or they may coincide with the therapists' greatest anxieties, increasing the therapists' emotional load and over burdening the therapists' psychological coping capacity (Saakvitne et al., 1998). Research indicates that caregivers with a history of personal childhood abuse and trauma were found to experience an increased severity of anxiety symptoms compared to those without a history of childhood trauma and abuse (Brewin, Andrews, & Valentine, 2000).

It would seem that therapists', who were abused, either during childhood or young adulthood, may not have fully recovered from these traumatic experiences. As a result, they are predisposed to re-experiencing some of the features of their past traumatic experiences, especially when they come into contact with recent critical events, such as those of their clients' (Lerias & Byrne, 2003). While a clear, definitive understanding of trauma reenactments and the possible function served thereby is yet to be established, it has been theorized that survivors of trauma have an almost biological compulsion to relive or re-

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experience the traumatic event from the past. This theory posits that survivors of trauma have a type of uncontrollable addiction to trauma (Levy, 1998; van der Kolk & Greenberg, 1987).

While many reenactments appear to be consciously and deliberately chosen, they have an uncanny concurrent quality of involuntariness (Herman, 1992). Several writers warn of the psychological vulnerabilities characteristic of trauma survivors, placing them at increased risk and increased susceptibility of becoming re-traumatized (Herman, 1992; Levy, 1998; van der Kolk & Greenberg, 1987).

2.5.1. Trauma reenactment

In pursuit of a clearer understanding of the purpose of reenactments, it has become evident that a multidimensional approach must be used. A clear conceptualization and understanding of the many different ways in which reenactments can occur will also assist with understanding why previously traumatized counselors sometimes do not achieve mastery and will help to organize and focus preventative strategies and clinical intervention for STS in counselors. Levy provides a useful, multidimensional theoretical framework for conceptualizing and understanding traumatic reenactments (1998)

Levy's reenactment model identifies supervision and therapeutic intervention as fundamental to successful identification and management of trauma reenactment (1998). Reenactments are seen to be partially caused by powerful unconscious forces that must be verbalized and understood in order to be re-mediated. Thus, in order to assuage the deleterious effects of the reenactments and to break their repetitive cycle, the therapist/supervisor needs to help the individual to understand why they occur. Reenactments are reported to often lead to a feelings of re-victimization and related feelings of shame, helplessness, and hopelessness. Consequently, an important goal of supervision for the caregiver is the identification of

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symptoms and the facilitation of an understanding and control of reenactments (Levy, 1998).

To break the pattern, the individual must process and work through the entire traumatic experience with the support of the supervisor. Once the trauma has been integrated, the patient's feelings will be less intense and more manageable, and the counsellor will be able to exercise better judgment as well as use less rigid defenses.

2.5.2. Counter-Transference

Research indicates that many therapists attempt to suppress their subjective, affective counter-transference experiences triggered by the trauma survivor in a defensive attempt to reduce the anxiety associated with the traumatic inter-relational experience (Dalenberg, 2000). The inevitable deleterious consequences associated with this uninvolved, emotionally removed therapist, even in the short term, are the manifestation of symptoms often associated with burnout (Dalenberg, 2000). Furthermore, research indicates that the suppression of affect during the clinical setting places the therapist at risk for developing dissociative symptoms outside of the therapeutic environment, which are often manifested as a disguised form of PTSD (Dalenberg, 2000; Pearlman & Saakvitne, 1995; Stamm, 2002). The caregivers' role often places them in the position of helpless witness to the clients' suffering. This suffering may take the form of a graphic account of a past childhood abuse, or the caregiver may be witness to the clients current self-injurious behaviour. In either instance, the caregivers' counter-transferential response is usually significantly intense, especially for an inexperienced caregiver. Rescue fantasies coupled with an intense preoccupation with the clients' life are common reactions experienced by an inexperienced caregiver (Neumann & Gamble, 1995). Inexperienced care givers are often prone to experiencing an intense desire to be of value to their clients, which is often tinged with a fear of failure or a sense of being unable to help. This often stems from a sense of insecurity regarding his/her own competence as a caregiver (Neumann & Gamble, 1995). Another form of counter-transference associated

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with trauma work refers to the caregivers' perception that their own sense of reality is being replaced by that of the client (Kauffman, 1992). This type of countertransference may be especially problematic to caregivers who are themselves survivors of violence or childhood abuse. These caregivers may inadvertently switch roles with the client, identifying more closely with the client role than with that of caregiver. These traumatic transference and counter-transferential dynamics may result in the caregiver feeling helpless and traumatised (Neumann & Gamble, 1995).

2.6. The use of the telephone for counselling

For many decades the telephone has been used as a means of providing a wide range of services. Apart from its' commercial, pre-recorded use which included providing information on the weather, time and sport, the retail industry make extensive use of the telephone to facilitate customer service. Such services enable customers to access information, help or to order products over the telephone, without having to physically attend the business location. While the telephone may not allow for the same type of personal interaction as a face-to-face conversation, in a vast array of industries, the telephone provides a service to help the elderly, the disabled, those who do not have access to transport, those having a personal crisis and those who are new to their communities. It can be used to provide referrals to health care, organizations and agencies as well as providing a service, providing information, advice, support and counselling (Coman, Burrows, & Evans, 2001). Telephone counselling affords the community a number of advantages. These positive features include, enhanced client access even in rural areas where no formal counselling facilities are available, the provision of immediate crisis support, the ability to provide support between face-to-face counselling sessions as well as client anonymity which, to a victim of trauma, may be of paramount importance (Coman et al., 2001; Flynn, Taylor, & Pollard, 1992; Hunt, 1993).

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2.6.1. A South African perspective: The impact of telephone counselling on South African issues.

In a multicultural environment such as that which exists in South Africa, it is of fundamental importance to explore the impact of cultural norms on attitudes regarding counselling and the use of the telephone. Research suggests that some cultures, such as Middle Eastern and Southern European, are considered 'high-contact cultures' where people tend to interact at closer distances, have closer personal space and talk to each other openly about personal issues in social conversation. Other cultures, such as Asia and Northern Europe, are perceived to be predominantly 'non-contact' cultures, where interpersonal contact is infrequent and rarely used and personal or private issues are seldom discussed in general conversation (Dibiase & Gunnoe, 2004; Hall, 1996; Lustig & Koester, 1996). The African culture is focused on collective wellbeing and not the individual in isolation. "I am because we are; and because we are, therefore I am (Nobles, 1998, p. 37)." This concept of *Ubuntu* was the core of the traditional worldview (Bracks, Hill, & Brack, 2012; Tutu, 1999). *Ubuntu* posits that to be human is to be helpful and deeply caring toward others and "speaks of the very essence of being human (Tutu, 1999, p. 31)" Yet, because of urbanization and the subsequent breaking up of families, many traditional African people have lost the ability to rely on community members for support and aid in distress, forcing them to rely on healthcare workers for support.

In the current post-apartheid environment that faces South Africans, mental health provisions, like general health care has changed from a previously colonial-based paradigm to a more universal, democratic primary care approach (Bracks et al., 2012). This poses the government with the massive challenge of decentralizing the available mental health care resources. Non-African, rural communities have traditionally had a paucity of health care facilities and an

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even greater scarcity of mental health care resources (Petersen et al., 2009). Decentralization and integration of mental health care into the primary health care system is successfully increasing access and improving the quality of mental health care to impoverished South African communities (Petersen, Lund, Bhana, & Flisher, 2011). These strategies form part of the transformation of the South African health care system, included in the policy guidelines for mental health care set by the Department of Health in 1997. While psychiatric symptom management and psychological monitoring by primary health care nurses within the primary health care (PHC) clinics has successfully increased access to services and enhanced the quality of life in many impoverished communities, significant gaps in everyday psycho-social rehabilitation continue to exist. The fundamental lack of human resources has resulted in under-servicing of rural areas, lack of support of PHC nurses in emergency management of psychiatric cases, as well as the general lack of awareness, identification, support and management of the more common psychological disorders related to depression, anxiety and trauma (Petersen et al., 2011).

Mental disorders related to trauma are a particularly heavy burden for South African mental health care professionals due to the multiple forms of trauma exposure (Kaminer & Eagle, 2010). South Africans are currently still reeling in the aftermath of apartheid, where incarceration with or without trial, torture and violent politically justified attacks were commonplace. Current South African communities are faced with significantly high rates of criminal and sexual violence, child and domestic abuse (Bracks et al., 2012). Review of literature on PTSD in South Africa, cited trauma-related disorders as a significant public health issue for South Africa (Edwards, 2005). In light of the aforementioned conditions, and with the current burgeoning access to cellular technology in the rural areas of South Africa, it becomes evident that a facility such as toll-free telephone counselling becomes a much

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needed resource to fill the gap and provide much needed support and help to individuals left without access to any other formal mental healthcare resources.

2.6.2. The relevance of telephone counselling for trauma survivors

The anonymity of the telephone is particularly useful for clients such as trauma survivors who may be reluctant to seek face-to-face counselling due to their fear of being recognised by someone within their rural community. These clients are able to access the benefits of telephone counselling services whilst maintaining their anonymity (Coman et al., 2001). A survivor of sexual abuse is often left with feelings of self-loathing. They may feel ashamed, untouchable, dirty, unlovable and unworthy of being shown love, resulting in a sense of utter isolation and extreme loneliness (Herman, 1992). The traumatic event can often lead to a sense of disconnection with the world, this has the effect of “shattering the construction of the self that is formed and sustained in relation to others.” (Herman, 1992, p. 51). It can destroy the survivors’ belief of ever being able to feel safe again. The survivor may feel unable to leave their home, unable to feel comfortable away from the solitude of their own bedroom. The individual may lose their trust and faith in basic humanity, not only doubting the motives of others but doubting their faith in themselves as well (Herman, 1992). In cases such as these, telephone counselling can assist the patient to feel supported and heard, while also allowing them to rediscover appropriate forms of communication with others (Horton, 1998; Zur & Nordmarken, 2010). “A positive sense of self is rebuilt only in connection with others” (Herman, 1992, p. 61).

2.6.3 Crisis-line counselling services

Crisis-line counselling is a service that is available 24 hours a day and is used predominantly by people in acute distress. These services are usually run by volunteer lay-counsellors who have been given some degree of training, enabling them to assist the caller to manage the

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situation regarding which they made the call. In most cases, the objective is that the caller will feel that he/she is not alone and has been supported and guided through the crisis.

Treatment is usually not on-going; the caller may speak with a different counsellor each time they call. The caller and the counsellor are both anonymous which usually facilitates full disclosure of details regarding the crisis.

2.6.4. Comparing telephone counselling to ‘face-to face’ counselling

While telephone counselling plays an important role in providing mental health services and support to previously difficult to reach individuals in difficult circumstances or from inaccessible areas, as mentioned earlier in this paper, there are features associated with face-to-face counselling that are distinctly absent from its telephonic equivalent. The first noticeable difference is the absence of non-verbal communication (Coman et al., 2001). The loss of non-verbal communication denies the client and the caregiver the opportunity to evaluate or to respond to each other’s facial expression or body language (Hines, 1994). With the only means of communication being purely verbal, the telephone counsellor needs to be especially attuned to listen to every sound, every inflection, every silence as well as qualities of speech including tone, pitch and speed in order to establish any degree of empathic connection with the client (Coman et al., 2001). Effective therapy has been described as not merely being involved with an interpersonal relationship but rather *being* an interpersonal relationship (Patterson, 1985). The lack of physical presence and connection with the client in telephone counselling is a feature that may reduce the efficacy of counselling by reducing the closeness of the interpersonal relationship. Caregivers need to gain an understanding of the client and their problematic situations contextually (Egan, 2007). The age of the client, the way they are dressed, the clouded look in their eye, and their physical state of health are but a

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few of the features that may be completely overlooked, misunderstood or misinterpreted by the telephone counsellor, hindering the counsellors ability to gain an accurate empathic connection with their client. Empathy has been described as a process involving three phases; the empathic resonance, expressed empathy, and received empathy (Rogers, 1970). This highlights the relational nature of empathy. An empathic counselor, not only senses the client's world but also be able to communicate that sensing to the client. This process requires a significant amount emotional involvement with client. Almost fifty years ago Carl Rogers posited that “accurate empathy” was one of the essential features of the therapeutic relationship. Empathy requires the therapist to accurately understand the patient’s world affording the patient the experience of being “fully seen and fully understood (Yalom, 2002, p. 18).” This having been said, one needs to question the degree of empathy established through telephone interaction.

If empathy is the “psychobiological capacity to experience another person’s state of being and phenomenological perspective at any given moment in time (Wilson & Lindy, 1994, p. 27)”, it stands to reason that empathic processes will predispose a face-to-face counsellor, through empathic connection with their client, to experience the “inner turmoil and psychic states of clients (Wilson & Thomas, 2004, p. 119)”. Given the aforementioned reduction of empathic connection inherent in the telephone counselling relationship, coupled with the lack of continuity experienced by the majority of crisis-line counsellors, mentioned earlier in this paper, it seems reasonable to expect a reduction in incidence of Secondary Traumatic Stress experienced by the telephone counsellor.

While relatively little research has been conducted in this field, a body of available research on telephone counsellors indicate that generally, the levels of secondary traumatisation in telephone counsellors were found to be low (Dunkley & Whelan, 2006a; Mauldin, 2001).

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Despite these results, Mauldin (2001) posited that rather than exhibiting chronic STS symptoms, telephone counsellors are more prone to developing spikes in PTSD symptoms, which seem to last for short periods of time. McCann and Pearlman (1990) similarly posited that these VT symptoms are possibly transient in nature. Research indicates that despite the average ranges for mean STS scores often being low, this is not an indication that individual telephone counsellors are precluded from experiencing STS (Dunkley & Whelan, 2006a). Research conducted by Dunkley & Whelan (2006) indicated that 4.8% of the sample had total scores in the 'high average' range and 3.2% in the 'very high' range for symptoms indicative of STS.

2.7. Rationale for current research

Research indicates that there is a universal burgeoning in the number of trauma related cases, with survivors needing support and counselling. This places increased strain on the expertise and personal coping resources of psychotherapists and counsellors and positions them at increased risk of developing STS and burnout. While research in the area of STS among face-to-face counsellors is increasing, research in the field of telephone counselling has historically been neglected, resulting in a global lack of descriptive research measuring the prevalence and influencing factors of STS and the subsequent impact on professional performance and quality of life of telephone counsellors (Dunkley & Whelan, 2006a). An even greater paucity of research in the field of telephone counselling exists in South Africa. With poverty and HIV/AIDs placing increased strain on the country, telephone counsellors play a very important role in South Africa, providing a much needed service to individuals who, due to various circumstances were previously either difficult to reach or in difficult circumstances or from inaccessible areas, often bereft of any formal health care services. It is for these reasons that research is sorely needed to inform and protect these valuable members of the healthcare team.

CHAPTER THREE: Methodology

3.1. Aim and objectives of the study

The broad aim of this research study was to understand the relationship between telephone counselling and Secondary Trauma in a sample of telephone counsellors in a South African context.

The specific objectives of this study were to:

- establish the prevalence of STS and Burnout in a sample of South African telephone counsellors
- To investigate the relationship between CS and spirituality.
- To identify factors associated with reduced levels of STS
- To investigate the use of debriefing services
- To identify protective factors to increase CS and decrease the risk of STS.

The ultimate aim for the study was to provide valuable, baseline information for further research regarding the reduction of risk of STS for telephone counselors.

3.2. Methodological approach

A quantitative, survey approach was used in this study. This quantitative, descriptive research project used self-completion questionnaires to objectively gather specific information needed for the research. Self-completion questionnaires ensure confidentiality and can potentially maximise honesty of response which is particularly useful when covering issues which may be viewed as socially unacceptable, such as was the case in this research where counsellors did not want to be perceived to be deleteriously affected by their work (Barker, Pistrang, & Elliot, 2002). By using objective measures on the sample of telephone

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counsellors, it was anticipated that this study would provide statistically circumscribed findings in terms of the prevalence of STS and BO and associated risk factors, within the defined population of study.

Non-parametric, Spearman Rank Order Correlation was used to measure the relationship between the variables due to the ordinal level of the data used in this research (Pallant, 2010). Using a correlational design, this study analysed the relationships between several pertinent aspects relating to the telephone counsellors (such as length of service, previous history of trauma, specialised training in PTSD and use of debriefing services) and prevalence of STS, BO and CS, measured by the ProQol. A correlational research design was used because it enabled the researcher to statistically examine and describe the relationship between the variables in the study (Tredoux & Durrheim, 2002).

Caution was exercised in interpreting these correlations, so as not to discount the impact of unknown factors, antecedents or co-variants on the variables measured and in not ascribing a causal relationship between the variables. This contains the outcomes of the study in that the use of correlational research design precludes the determination of causal relationships and the identification and influence of potential extraneous variables on the relationship between the variables (Tredoux & Durrheim, 2002). A correlational design was appropriate and valuable in the context of this study, in that it allowed for a statistical exploration of relationships between factors associated with telephone counselling and STS. Being an embryonic research area, this provided useful data to chart the way forward in terms of further research in this field.

3.3. Sample

A convenience sample, rather than using a truly random sample was used in this research (Howell, 2008). More specifically, telephone counsellors from 4 different organisations were asked to participate in this research on a voluntary basis. It was hoped that the results obtained from these volunteers would reflect what would have been obtained in a truly random sample (Howell, 2008). The counsellors worked predominantly on a part-time, voluntary basis.

The sample was selected from four different telephone counselling centres in South Africa. The demographics of total population of telephone counsellors working at the 4 selected telephone counselling organisations reflected the demographics of the South African population, i.e. 79.6% Black, 9% Coloured, 2.5% Indian or Asian and 8.9% White (Statistics South Africa, 2011). The sample (N=104), however comprised mainly (39.4 %) White counselors, 32.7% of the counselors were Black, 22.1 % were Indian/Asian and 5.8% were Coloured. These demographics are summarized in Table 1 of the following chapter. The organisations were selected to represent crisis-line counsellors working with adults and children with general issues requiring counsel, from various areas across South Africa. While these telephone counselling centres do not exclusively deal with trauma survivors, exposure to traumatic life events has become common place for the average South African (Kaminer & Eagle, 2010; Swartz, 1998), making trauma a common issue for many individuals requiring these services. The age range of the sample was approximately between 25 years and 66 years of age. 34.6% of respondents were 25 years of age or below, 26.9% of the sample was

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between 26-35 years of age, 13.5% were between 36-45 years and 11.5% between 46-55 years, 8.7% between 56-65 years, and 4.8% over the age of 66 years (see Table 1).

Table 1: Demographic characteristics of participants (n=104)

Characteristic	Frequency (n)	Percentage (%)
Race		
Indian	23	22.1
Black	34	32.7
Coloured	6	5.8
White	41	39.4
Age range (years)		
25 or less	36	34.6
26-35	28	26.9
36-45	14	13.5
46-55	12	11.5
56-65	9	8.7
66+	5	4.8

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3.4. Instruments:

Two instruments were used in this study:

1. A biographical questionnaire to document age, gender, length of service, personal history of trauma and other biological information about each participant was used.
2. The Professional Quality of life scale (ProQol) was used to measure Compassion Satisfaction, Burnout and Secondary Traumatization / Vicarious Traumatization.

3.4.1. The Professional Quality of life scale

The theoretical framework underpinning this research reflects the principles that led to the enhancement of the Compassion Fatigue Test in 1995 (Figley, 1995) to the Compassion Satisfaction and Fatigue Test in 1996 (Figley & Stamm, 1996) and ultimately guided the creation of the Professional Quality Of Life Test, developed in 2010 (Stamm, 2010), which was utilized as a research instrument for this current paper.

The Professional Quality of Life Scale, (ProQol) has become the most frequently used measure of positive and negative effects of working with people who have experienced extremely stressful events (Stamm et al., 2011). The measure has replaced the Compassion Fatigue Self -Test developed by Charles Figley in the late 1980s. The updated test was developed in line with the efforts of the counselling profession to shift focus onto enhancing professional quality of life rather than remaining fixated on the negative effects of counselling (Cummins, Massey, & A., 2007). This paradigm shift was a direct drive toward heightened awareness of prevention, as exclusive focus on remediation has been the historical trend.

The ProQol has been shortened from 66 items to 30 Likert scale items, consisting of three subscales: Compassion Satisfaction, Burnout, and Secondary Trauma (Stamm et al., 2011).

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The Compassion Satisfaction subscale measures the positive feelings derived from being able to contribute to the greater good of society and being able to work with others in a helping capacity. Higher scores on this scale relate to the individuals increased satisfaction related to their perceived ability to be an effective caregiver. The Burnout subscale measures feelings of hopelessness and frustration associated with perceived ineffectiveness in the workplace or with dealing with clients. Burnout is measured as one of the elements of compassion fatigue. The Secondary Traumatic stress subscale assesses symptoms associated with work-related, secondary exposure to traumatic events. This subscale is regarded as the second component of Compassion Fatigue (CF). Each subscale is psychometrically unique, measuring separate constructs allowing for correlations between the three subscales to be determined (Stamm, 2010).

Good internal validity is reported for the ProQol measure in studying the effects of Secondary traumatic stress, burnout and compassion satisfaction among helping professionals. There is good construct validity (Stamm, 2010; Stamm et al., 2011). Cronbach's Alpha scores were calculated to determine the reliability of the ProQol subscales of the sample used in this study. The alpha reliability for the ProQol was found to be good with a secondary traumatic stress alpha scale reliability score of .77 (n=10), a compassion satisfaction reliability alpha score of .78 (n=9) and a moderately good burnout alpha reliability score of .41 (n=10).

3.5. Procedure (Ethical issues)

In order to conduct this study, ethical clearance was sought and granted by the University of KwaZulu-Natal, Humanities & Social Sciences Research Ethics Committee. (Appendix 1). The director of each telephone counselling organisation was first contacted regarding the study and once permission had been granted by the director, all subsequent communication occurred via the Human Resources (HR) co-ordination officer of the various organisations.

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The HR officer contacted participants, either directly or they were contacted via e-mail and asked to participate in the study. The data collection was in the form of structured questionnaires. The instruments were self-administered. Participants of the study were given standardised information regarding the purpose of the study, ensuring anonymity, as well as providing instructions on how to complete the questionnaires provided. Each participant was required to sign an informed consent form, prior to participation in the study. The participants were given no time limit to complete the questionnaires. Questionnaires were sealed in envelopes and anonymously collected by the HR officer who then arranged for them to be collected or mailed to the researcher.

3.6. Ethical considerations

Written consent was taken from each participant and a letter was given to each participant, prior to the administration of the instruments, notifying them that participation in this study was entirely voluntary and informing them that they were free to withdraw from the study at any stage, without penalty, should they have so desired. This document also assured each participant of confidentiality and anonymity and explained how the questionnaires were to be stored and disposed of after the mandatory five year period.

The document also provided the participants with contact details of Ms Phumelele Ximba, and permission to contact her, should they have felt that this study violated any ethical codes of conduct. The contact details of my supervisor, as well as those for myself were also included in the letter. In the event that participants may have experienced any emotional distress or should severe STS symptoms have been identified, referrals to the psychology clinic at the UKZN Centre for Applied Psychology would be arranged.

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3.7. Data Analysis

Once the data was collected, it was coded and entered for analysis. The data was analysed using a statistical computer program –Statistical Package for the Social Sciences (SPSS), version 21.0. Descriptive statistics were used to describe the sample in relation to frequencies, percentages, means and standard deviations. Particular attention was paid to Pearson's Correlation Coefficient (r), in order to investigate the relationship between the scores on the PROQOL subscales and previous history of Trauma.

The purpose of the analysis was to establish the prevalence of STS and burnout in telephone counsellors. It also was to determine the relationship between STS and various variables such as traumatic history, spirituality, supervisory support, length of service etc. Non-parametric, Spearman Rank Order Correlation was used to measure the relationship between the variables due to the ordinal level of the data used in this research. The relationship between Secondary Traumatic Stress (STS), as measured by the ProQol, and previous history of trauma, as measured by the questionnaire, was one of the relationships investigated using Spearman Rank Order correlation (ρ). Availability and usage of debriefing facilities at the various call centres and the corresponding effect on incidence of STS and Burnout was also explored.

CHAPTER FOUR: Results

4.1 Introduction

This chapter presents the findings of the current study, focusing specifically on the aims and objectives of this research, as defined in chapter 3 of this paper. Using SPSS (Version 21.0), descriptive statistical analysis (values, frequencies, means, percentages) was carried out on the demographic data and other characteristics of the sample. Where respondents failed to answer a question, this was recorded as “missing” data and is indicated where appropriate. It was interesting to note that certain questions elicited a higher “missing data” score. This intriguing phenomenon will also be explored within this chapter.

4.2. Sample characteristics

The racial and age demographics of the sample are summarised in Chapter 3 and presented in Table 1. Other significant features of the sample relate to criteria such as; length of service as a counsellor, training in PTSD and religious / spiritual beliefs. These characteristics are presented in Table 2.

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Table 2: Descriptive summary of the sample (n=104)

Characteristic	Frequency	Percentage (%)	Valid %
Length of service as a counselor (Years)			
1-7	85	81.7	81.7
8-10	9	8.7	8.7
11-15	2	1.9	1.9
16-20	6	5.8	5.8
21+	2	1.9	1.9
Training in PTSD			
Seminars/conferences	27	26	26.5
Academic classes	44	42.3	43.1
Self-study	12	11.5	11.8
Other	3	2.9	2.9
No training	16	15.4	15.7
Total	102	98.1	100
Missing	2	1.9	
Belief / faith category			
Spiritual (non-secular)	14	13.5	
Christian	57	54.8	
Jewish	2	1.9	
Hindu/Buddhist	12	11.5	
Muslim	8	7.7	
Both Non-secular + Christian	2	1.9	
Atheist (no religion)	8	7.7	

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4.2.1 Length of service

The descriptive summary of the sample, presented in Table 2, revealed that the majority of the sample (81.7%) had served as a counsellor for between 1-5 years, 8.7% between 8-10 years, 5.8% between 16-20 years, 1.9% between 11-15 years and 1.9% for over 20 years.

4.2.2 Training in PTSD

It was of interest to note that a large percentage of participants (43.1%) had received formal training in PTSD by attending academic classes, 26.5% had received informal training by having attended seminars or conferences on PTSD and 11.8% reported having some knowledge on PTSD via self-study methods. It is concerning to note that a sizable percentage of participants (15.7%) reported having had no training or knowledge of PTSD at all.

4.2.3 Religiosity

The religiosity of participants revealed that the vast majority of the sample (91%) regarded themselves as being religious or spiritually minded, with only 7.7% of participants being atheistic or non-religious. The majority of participants (54.8%) listed their belief or faith category as Christian, 13.5% of respondents regarded themselves as Spiritual (non-secular) by religion, 11.5% of Eastern / Hindu religion, 7.7% Muslim and 1.9% of the participants were of Jewish faith.

4.2.4 Previous history of trauma and use of debriefing or trauma counselling

One of the main aims of this research was to investigate the relationship between STS and previous history of trauma. In order to explore the possible relationship between these two variables, it was imperative to ascertain the incidence and prevalence of exposure to traumatic experiences of the sample. It was of interest, specifically to the counselling facilities, as well as for this research, to ascertain the availability and usage of de-briefing

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facilities within the telephone counselling facilities. It was also of interest to ascertain the perceived usefulness of de-briefing services and the possible reasons why de-briefing facilities are not utilized with greater frequency within these facilities. A summary of these statistics are presented in Table 3.

TABLE 3

Frequency and percentage of sample with a previous history of trauma, use trauma counselling and debriefing services & social support

Characteristic	Frequency (n)	Percentage (%)	Valid%
Have you had a personal traumatic experience in the past?			
Yes	74	71.2	72.5
No	28	26.9	27.5
Total	102	98.1	100.0
Missing	2	1.9	
If “Yes,” did you receive any psychological therapy after the traumatic event?			
Yes	40	38.5	50.6
No	39	37.5	49.4
Total	79	76	100.0
Missing	25	24	
Who do you talk with about your work			
Supervisor	45	43.3	44.1
Colleague	20	19.2	19.6
Spouse/partner	12	11.5	11.8
Spiritual leader	1	1	1.0
Family	6	5.8	5.9
Friend	9	8.7	8.8
Other	3	2.9	2.9
No one	6	5.8	5.9
Total	102	98.1	100.0
Missing	2	1.9	

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(Table 3 Continued)

Characteristic	Frequency (n)	Percentage (%)	Valid%
Is de-briefing offered to counselors at your organization?			
Yes	97	93.3	
No	7	6.7	
If de-briefing is offered, do you use the service?			
Yes	59	56.7	58.4
No	42	40.4	41.6
Total	101	97.1	100.0
Missing	3	2.9	
If "No," why not?			
Confidentiality concerns	3	2.9	7.1
It doesn't help	1	1	2.4
Not for me	1	1	2.4
Don't like the person offering the service	3	2.9	7.1
Other (Eg. haven't needed it)	34	32.7	81.0
Total	42	40.4	100.0
Missing	62	59	
If "Yes" did it help?			
Yes	50	48.1	86.2
No	2	1.9	3.4
Unsure	6	5.8	10.3
Total	58	55.8	100.0
Missing	46	44.2	

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The results presented in Table 3 indicate that the vast majority of the sample (72.5%) reported having experienced a personal traumatic experience in their past, with only 27.5% of the sample reporting that they had no previous trauma history. It was of great concern to note that, of those respondents who reported having experienced previous personal trauma, only 50.6% of these had received psychological therapy thereafter, 49.4% did not receive any post-trauma therapy or counselling (n = 79).

Debriefing and the use thereof was of particular interest to the directors of the telephone counselling organizations. The large majority of participants (93.3%) reported that debriefing services were offered at their organization with only 6.7% reported not having debriefing services available to them. It was concerning to note that 41.6% of respondents stated that although debriefing was offered, they did not use the service, with 57.4% of the respondents reported having used the debriefing service. Of those respondents who answered yes to having used the debriefing service, 86.2% said it helped, 3.4% said that it did not help at all and 10.3% of the participants said that they were unsure whether the debriefing helped or not.

4.2.5. Social Support

When asked who participants prefer to talk with about their feelings regarding the nature of their work with trauma clients, it was encouraging to note that the majority of participants (44.1%) reported preferring to speak with a supervisor and a large percentage (19.6%) reported preferring to speak with a colleague. 11.8% of participants preferred to speak with their spouse or partner, 8.8% speak to a friend, 5.9% prefer speaking to a family member and it was of some concern that 6 participants (5.9%) reported not speaking to anyone about their feelings regarding trauma clients.

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4.3 Prevalence of STS, BO & CS

The ProQol consists of three subscales; Compassion Satisfaction (CS), Burnout (BO) and Secondary Traumatic Stress (STS) (Stamm, 2010). Each subscale is psychometrically unique and can be rated; low, average, moderate or high according to criteria stipulated within the manual. The sample frequency and percentages of each subscale is presented in Table 4.

TABLE 4: Frequency and percentage of ProQol subscales; STS, BO and CS

	N	Low n (%)	Ave n (%)	Mod n (%)	High n (%)
STS	104	74 (71.2)	28 (26.9)	2 (1.9)	0
BO	104	86 (82.7)	18 (17.3)	0 (0)	0
CS	104	5 (4.8)	25 (24)	64 (61.5)	10 (9.6)

The results presented in Table 4 indicate that 98% of counsellors within the sample reported experiencing a low to average level of symptoms associated with STS. Two participants within the sample (1.9%) reported experiencing a moderately high level of STS symptoms. While 71% of the sample reported a moderate to high level of compassion satisfaction, 28.8% of the sample reported a low to average level of CS.

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4.4. Relationship between variables

Non-parametric, Spearman Rank Order Correlation was used to measure the relationship between the variables due to the ordinal level of the data used in this research.

Table 5 Spearman Rank Order correlation between ProQol subscales; STS, BO & CS, length of service and PTSD training

Scale	1	2	3	4	5
1. Length of service	-	.02	-.04	-.02	-.06
2. Training in PTSD		-	.15	-.04	.06
3. STS			-	.19*	-.06
4. BO				-	.06
5. CS					-

Due to the exploratory nature of the study, a .05 significance level was used in the analyses. Although the potential impact of a Type I error caused by the number of comparisons made, was recognized, it seemed appropriate at this early stage of research of STS in telephone counsellors in South Africa, to open future research possibilities by generating areas for investigation.

There was also a small positive correlation between BO and STS, $\rho=0.19$, $n=104$, $p<0.05$, with high levels of BO associated with high levels of STS. Virtually no relationship was found between PTSD training and CS, $\rho= .06$ and this did not reach statistical significance at the $p<0.05$ level. A very low negative correlation was found between Training in PTSD and BO, $\rho = -0.04$. While this result was not statistically significant, the negative correlation could infer that a higher level of PTSD training would result in a lower level of BO. A negative correlation was found to exist between Compassion satisfaction and STS, while the correlation was weak, it indicates that the STS is inclined to decrease as CS increases.

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While the variables STS and BO were scored as ordinal data, the variables “previous history of trauma” and “use of debriefing services” were scored as discrete data, requiring a yes/no response. For this reason the relationship between Secondary Traumatic Stress (STS), as measured by the ProQol, and previous history of trauma, as measured by the questionnaire, could not be measured using Spearman Rank Order correlation (ρ). Instead the association between the use of debriefing services and the previous history of trauma was measured using chi-square analysis. A chi-square test indicated that the proportion of participants who used the debriefing service and had a previous history of traumatic experiences was not significantly different from those who used the service and had no history of trauma. There appears to be no association between the use of debriefing services and a previous history of trauma.

4.5 Factor Analysis of Compassion Satisfaction subscale

The reliability analysis revealed that the “Compassion Satisfaction” subscale of the ProQol questionnaire has a satisfactory internal consistency, with a Cronbach alpha coefficient of .78, which indicates homogeneity of items within the scale. The nine items of the “Compassion Satisfaction” subscale of the ProQol were subjected to principal components analysis using SPSS version 21. Principal components analysis revealed the presence of two components with eigenvalues exceeding 1, explaining 38.6% and 15.3% of the variance respectively. Inspection of the screeplot revealed a clear break after the second component. It was decided to retain two components for further investigation. The two-component solution explained a total of 53.9% of the variance, with Component 1 contributing 38.6 % and Component 2 contributing 15.3%. To aid the interpretation of the two components, Varimax rotation was performed. The rotated solution revealed that both components show a number of strong loadings and all variables loading substantially on only one component. Closer inspection of the two factors revealed that Factor 1 constituted 5 items relating to feeling

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effective as a helper. Factor 2 constituted 4 items related to personal satisfaction resulting from being a helper. All the loadings of items on Factor 1 and 2 are above 0.5, indicating a strong effect. Factor loadings are presented in Table 6

Table 6: Factor Loadings of Compassion satisfaction items of the ProQol questionnaire

Item	Loading
Factor 1: Feeling effective as a helper	
27. I have thoughts that I am a success as a helper	.78
20. I have happy thoughts and feelings about those I help and how I could help them	.74
16. I am pleased with how I am able to keep up with helping techniques and protocols	.65
24. I am proud of what I can do to help	.64
12. I like my work as a helper	.51
Factor 2: Personal satisfaction	
3. I get satisfaction from being able to help people	.82
6. I feel invigorated after working with those I help	.71
18. My work makes me feel satisfied	.58
22. I believe I can make a difference through my work	.57

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CHAPTER FIVE: Discussion

The findings of this study will be discussed in relation to the relevant literature and structured according to the research aims presented in Chapter 3. The overall aim of this research study was to understand the relationship between telephone counselling and Secondary Traumatic Stress in a sample of telephone counsellors in a South African context.

The specific objectives of this study were to:

- establish the prevalence of STS and Burnout in a sample of South African telephone counsellors
- To investigate the relationship between CS and spirituality.
- To identify factors associated with reduced levels of STS
- To investigate the use of debriefing services
- To identify protective factors to increase CS and decrease the risk of STS.

The ultimate aim for the study was to provide valuable, baseline information for further research regarding the reduction of risk of STS for telephone counselors.

It should be noted that all of the findings presented in this study should be interpreted with caution. Being a self-selected group of “general” telephone counsellors, the results are rendered questionable. Individual exposure to specifically “trauma related” cases was not specified, making it impossible to predict how the responses would have differed, had this question been addressed. This unanswered question is an unfortunate limitation of the sampling and will be discussed, together with other limitations of the study in chapter 6.

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5.1. Prevalence of STS in a sample of South African telephone counsellors

The results of this study replicated findings from other research that indicated that, despite the exposure to traumatic experiences, the levels of secondary traumatisation in telephone counsellors were generally found to be low (Dunkley & Whelan, 2006b; Mauldin, 2001). These results seemingly endorse the aforementioned premise that the reduced empathic connection inherent in the telephone counselling relationship, coupled with the lack of continuity with any one client, experienced by the majority of crisis-line counsellors, mentioned earlier in this paper, ultimately reduces the incidence of Secondary Traumatic Stress experienced by the telephone counsellor. It should, however be noted that while 98% of counsellors within the sample reported experiencing a low to average level of symptoms associated with STS, only 71.2% of the sample indicated low levels of STS. The remaining 28.8% of the sample reported an average to moderately high level of STS symptoms (refer to Table 4). Perhaps, as posited by Mauldin (2001) and McCann and Pearlman (1990), these results reiterate that the STS symptoms, experienced by telephone counsellors, tend to be acute and transient in nature. As indicated by Dunkley & Whelan (2006), this study similarly indicated that, while the majority of STS scores were low, this did not preclude individual counsellors from experiencing more severe symptoms associated with STS.

5.2. Factors associated with reduced levels of STS

Factor analysis of the Compassion Satisfaction subscale of the ProQol revealed two distinct factors constituting CS, these being; the feeling of being effective as a helper and a feeling of personal satisfaction regarding being a helper. Increased levels of CS are seen to have a buffering effect against the development of STS and BO (Figley, 1995; Stamm, 2002). This was indicated by a negative correlation existing between CS and STS in the results of this study. Results from this study further indicated that the vast majority of the sample, 91%

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regarded themselves as being religious or spiritually minded, with only 7.7% of participants being atheistic or non-religious. Furthermore, the participants in the sample indicated that the majority of the sample, 44.1% had a supervisor with whom they could share their work stress. An additional 19.6% of the sample reported having the benefit of a colleague to speak to. Religious/spiritual grounding, supervision, support from colleagues and friends were perceived to have reduced the risk of STS and BO in this study. Similarly, these same factors have been cited in the literature as well as in a large body of research as playing a protective role, buffering against the incidence of STS and BO (Dunkley & Whelan, 2006a; Figley, 1995; King et al., 1998; Neuman & Pearlman, 1996; Rudolph & Stamm, 1999; Saakvitne et al., 1998; Stamm, 1999; Wittine, 1994). Research conducted by Rudolph & Stamm (1999) indicated that it was a combination of functional and structural social support that was perceived to increase levels of competency and control and decrease the risk of developing the negative effects of caregiving. Functional and structural social support was identified as being inclusive of; visiting friends, supportive relationships, spiritual life, positive support by colleagues and continuing education (Rudolph & Stamm, 1999). Having a clear understanding of one's own spirituality and having addressed existential questions associated with human suffering and personal meaning of life has been documented as providing a buffer against effects of STS on the trauma counsellor (Sargeant, 1989).

Subsequent research by Sprang et al. (2007) indicated that training on trauma was instrumental in decreasing the level of STS experienced by these counsellors. Similarly, results from the current study concurred with these findings with 84% of the sample reporting that they had received some form of training on Trauma and PTSD (See Table 2). Length of service was another factor associated with reduced risk of developing STS in this study, with the majority of the sample, 81.7% having served as a counsellor for a mere one to five years (Table 2). This concurs with a large body of research indicating a strong positive relationship

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between the risk of incurring symptoms of STS and exposure to traumatic experiences over a prolonged period of time (Jenkins & Baird, 2002; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995).

The reduction of empathic connection inherent in the telephone counselling relationship, coupled with the lack of continuity with clients experienced by the majority of crisis-line counsellors, also provides reasonable explanation for the generally low incidence of Secondary Traumatic Stress experienced by telephone counsellors.

5.3 Prevalence of Burnout.

As mentioned earlier in this paper, the Burnout subscale measures feelings of hopelessness and frustration associated with perceived ineffectiveness in the workplace or with dealing with clients (Stamm, 2010). The results of this study indicated that, like STS, levels of BO within the sample, was reported as being predominately low, with 82.7% of the results indicating a low level of symptoms associated with BO. The low levels of BO, indicated in this study, could be attributed to the aforementioned results indicating that the majority of participants (43.1%) had received formal training in PTSD by attending academic classes, 26.5% had received informal training by having attended seminars or conferences on PTSD and 11.8% reported having some knowledge on PTSD via self-study methods (refer to Table 2). While the result presented in Table 5 was not statistically significant, it inferred a very low negative correlation between Training in PTSD and BO, $\rho = -0.04$. This inferred that high levels of training in PTSD could result in lower levels of BO. This reiterates the findings of previous research indicating that specialized training in trauma significantly decreased the level of burnout experienced by the therapists (Sprang et al., 2007). It also compares favourably with a body of research indicating that symptoms of Burnout are reduced by

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increased levels of competency and control, which is associated with an individuals' knowledge regarding the management and nature of trauma and traumatic material (King et al., 1998; Stamm, 1999).

5.4 Relationship between STS and previous history of trauma

The results of this study emulate findings from a body of research suggesting that, despite a previous history of trauma, the majority of counsellors seem to function well psychologically (Follette et al., 1994; Ortlepp & Friedman, 2002; Pearlman & Mac Ian, 1995). Similarly, when comparing this study to other research conducted on telephone counsellors, the levels of secondary traumatisation were also found to be low (Dunkley & Whelan, 2006a; Mauldin, 2001; Ortlepp & Friedman, 2002). The current study indicates that there appeared to be no association between the use of debriefing services and a previous history of trauma. This indicated that the participants with a previous history of trauma did not seem to use the debriefing services any more than participants without a previous history of trauma. This would suggest that a previous history of trauma did not predispose these participants to developing STS.

CHAPTER SIX: Conclusion, Limitations and Recommendations

6.1 Conclusion

Telephone counselling occupies a valuable and permanent place within the counselling landscape (Coman et al., 2001; Taylor & Furlonger, 2011). The advantages of telephone counselling include benefits such as enhanced client access, especially to rural areas where previously no formal counselling facilities were available, the provision of 24 hour crisis support, the ability to provide on-going support between face-to-face counselling sessions, essential anonymity for victims of trauma, not to mention convenience, cost-effectiveness and prompt client satisfaction (Coman et al., 2001; Dunkley & Whelan, 2006a; Flynn et al., 1992; Hunt, 1993).

Within the current South African context, the dearth of mental health care facilities in rural communities coupled with the high rates of criminal and sexual violence, child and domestic abuse (Bracks et al., 2012), poses an immense challenge for the government in decentralizing the available mental health care resources (Petersen et al., 2009). Psychological support for individuals exposed to trauma is a particularly heavy burden for South African mental health care professionals due to multiple forms of trauma that people in these areas are exposed to (Kaminer & Eagle, 2010). With the rapidly increasing access to cellular technology in the rural areas of South Africa, toll-free telephone counselling provides the ideal opportunity to breach the gap and deliver much needed support and counsel to individuals within these previously neglected areas. The implication for the telephone counsellors is that this digital environment brings with it not only advantages for the client, but potential deleterious consequences to the counsellor (Coman et al., 2001; King et al., 1998). The most nefarious of these consequences for the telephone counsellor is that of STS.

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The results of this study reiterated findings from a body of previous research indicating that, despite the exposure to traumatic experiences, the levels of secondary traumatisation in telephone counsellors is generally found to be low, especially when compared to that of face-to-face counsellors (Dunkley & Whelan, 2006a; Mauldin, 2001). This has been attributed to a number of factors, including the possible reduction of empathic connection inherent in the telephone counselling relationship, coupled with the lack of continuity with clients experienced by the majority of crisis-line counsellors. It was of some concern; however that despite these factors, 28.8% of the sample reported average to moderately high levels of STS symptoms. This concurs with previous research indicating that while the majority of STS scores are generally low, this does not preclude individual counsellors from experiencing more severe symptoms associated with STS (Dunkley & Whelan, 2006a). The sample used in the present study comprised part-time, lay counsellors who, on average adopted their telephone counselling responsibilities over-and-above their other full-time employment commitments. The low incidence of STS obtained in this research concurs with previous research indicating that a combination of diverse working environments and roles may have a buffering effect on these counsellors protecting them from the development of STS (Ortlepp & Friedman, 2002). Another explanation, suggested in previous research, implies the possibility that the counsellors in this study may be, “faking good” in an attempt to regard themselves and be regarded by others as being competent and resilient, impervious to the deleterious effects of their profession (Myers et al., 2003; Taylor & Furlonger, 2011). This would suggest that these counsellors may be experiencing higher levels of distress than this data suggested. Further research is needed to gain greater clarity regarding issues such as these.

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6.1.1 Protective measures

When considering the current sample of telephone counsellors, it is evident that adequate supervision, support from colleagues, religious / spiritual grounding and support as well as social activities have significantly reduced the risk of STS and BO in this study. Thus this study supports the findings of a large body of research and literature indicating the protective role of these factors against the incidence of STS and BO (Dunkley & Whelan, 2006a; Figley, 1995; King et al., 1998; Ortlepp & Friedman, 2002; Rudolph & Stamm, 1999; Saakvitne et al., 1998; Stamm, 1999; Trippany et al., 2004; Williams et al., 2012). This study also reiterates the findings of a growing body of previous research indicating that specialized training in trauma significantly decreases the level of burnout experienced by the therapists (King et al., 1998; Sprang et al., 2007; Stamm, 1999). Research indicates that the perception of training as being adequate plays a significant role in increasing the feelings of satisfaction for the therapists (Ortlepp & Friedman, 2002).

The evidence obtained in this study is reiterated by previous research, presented in the literature and compels us to conclude that greater emphasis needs to be placed on the reduction of risk of VT and STS within the counselling organizations. This is particularly apparent in telephone-counselling organizations where training is generally brief and the majority of the counselors, inexperienced.

6.1.2. Enhancing physical and mental wellness

Due to the compelling evidence presented in the literature citing personal physical and mental wellness as a significant mediator of VT and STS (King et al., 1998; Myers et al., 2003;

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Pearlman & Saakvitne, 1995; Trippany et al., 2004; Williams et al., 2012), it compels us to conclude that significantly more attention and effort be afforded to the promotion of wellness of telephone-counselors, who provide a much needed service to a large percentage of the population within Southern Africa. A wellness course, offered during the training phase of counselling, has been found to be highly beneficial in increasing levels of physical and mental health and thereby reducing the risk of acquiring STS (Myers et al., 2003; Williams et al., 2012). Mental and physical wellness should, therefore become an integral part of the training program, ensuring that each student is able to draft an individualized, personal wellness plan thus enhancing the mental and physical wellbeing of each counselor. Similarly, once counselors are qualified, the role of implementing and maintaining physical and mental wellness should be implemented by the supervisors within the organization. Each supervisor should ensure that they themselves, as well as each individual counselor follow a holistic wellness plan. Personal difficulties can be shared and discussed together as part of the process of supervision (Sommer, 2008; Williams et al., 2012).

Once in the working environment, the role of the organization in promoting wellness and preventing STS is paramount. The risks and deleterious consequences associated with counselling becomes the responsibility of the organization as whole and no longer that of the individual in isolation (Ortlepp & Friedman, 2002; Sexton, 1999). Organized activities focused at increasing awareness and promotion of physical and mental wellbeing have been shown to improve social cohesiveness between fellow counselors ultimately improving the work environment and giving the counselors an opportunity to develop a network of support. Improved working environment and social support networks are cited as playing an integral role in reducing the risk of STS and VT (Brady, Guy, Poelstra, & Brokaw, 1999; Schauben & Frazier, 1995; Sexton, 1999; Trippany et al., 2004; Williams et al., 2012). It is of particular

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significance when considering the implications of feeling isolated, confused, misunderstood and alone as are often the first symptoms associated with VT and STS (Trippany et al., 2004).

Supportive groups

Support group meetings provide an opportunity for peer supervision and the sharing of experiences, thereby normalizing STS and VT and removing the fear and isolating effects of internalized stigma (Trippany et al., 2004). Research cites peer supervision as one of the most commonly used methods of preventing and managing signs of VT and STS (Pearlman & Mac Ian, 1995; Trippany et al., 2004). These support groups allow for an opportunity to openly share experiences, vent feeling, express fears, concerns and frustrations. It provides an opportunity to feel genuinely understood and supported, reducing the risks associated with feeling isolated and alone. The solidarity of a group offers protection against the fear and despair that may be elicited by traumatic experiences (Herman, 1992). “Trauma isolates; the group re-creates a sense of belonging (Herman, 1992, p. 214).” Yalom describes group acceptance as an “adaptive spiral,” where the acceptance of the group members increases each member’s sense of self-esteem and concurrently each member becomes more tolerant and accepting of the other members (Yalom, 1995, 2002). These supportive group meetings also serve as a safe, intimate stage on which to share coping skills and to discuss relevant literature and innovations within the field (Trippany et al., 2004). As such, each member is strengthened by being able to draw upon the shared resources of the group and in turn is able to benefit from the “collective empowerment” which in turn enhances individual integration (Herman, 1992, p. 216).

With research indicating that caregivers often attempt to hide or ignore their counter-transference experiences which may be triggered by trauma survivors (Dalenberg, 2000),

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peer supervision provides an opportunity to relieve the anxiety associated with these countertransference reactions (Trippany et al., 2004). In countertransference reactions where the caregiver perceives that their own sense of reality is being replaced by that of the client (Kauffman, 1992), group peer supervision provides an opportunity to regain a sense of perspective. This is especially useful for caregivers who were childhood victims of abuse themselves. By discussing these countertransference reactions in the group, these peer support groups prevent the caregiver from inadvertently switching roles with the client, and making the error of identifying more closely with the client role than with that of caregiver. This ultimately assists in preventing the caregiver from feeling completely overwhelmed, helpless and traumatised (Neumann & Gamble, 1995). “It is important for caregivers to have a variety of peer support resources to allow easy access to share with others the burden of bearing witness to traumatic events (Yassen, 1995, p. 194).”

Individual Supervision and training

A close working alliance with a supervisor assists the caregiver by encouraging an exploration of unconscious reactions to a client’s traumatic material (Pearlman & Mac Ian, 1995; Sommer, 2008; Williams et al., 2012). Developing a safe, supportive, respectful relationship with a supervisor is of particular importance when trauma-related concerns amplify intrapersonal and interpersonal tension (Brady & Guy, 1999). The exploration of powerful feelings evoked through countertransference, inevitably explores painful material that needs to be handled with care. As such, a balance needs to be attained that enables exploration of needs and support of the caregiver, but avoids supervision becoming therapy (Wheeler, 2007). While the supervision is not intended as therapy for the caregiver, the well-being of the caregiver and the subsequent impact on the client, the professional therapeutic

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relationship as well as the relationship between the supervisor and the caregiver must be explored. A common concern involves the fear that “the supervision will become authoritarian when the focus is on the client only and negligent when the client is side-lined (Mander, 2002, p. 44).” Another concern is that the supervisor may use the position of authority to influence the caregivers’ decision to take time-off when they are feeling overburdened or distressed. Senior staff members need to be available to address such supervisory issues when they arise, not only to ensure adequate caregiver support, but also to enable the supervisor to make informed decisions about whether the work of the caregiver is likely to be impaired or even harmful for the client (Wheeler, 2007).

The knowledge that a regular time has been set aside to process and manage emotions and anxiety evoked by trauma work has proven to be highly beneficial in assisting to diminish the effects of VT and STS (Brady et al., 1999; Pearlman & Saakvitne, 1995). Adequate supervision as well as on-going professional trauma-related education has been cited as being fundamental in assisting to broaden caregivers’ professional resources and reducing symptoms associated with STS (Brady et al., 1999). For the caregiver, the power of relating a personal narrative to an understanding supervisor improves and restores personal self-awareness, ultimately reconstructing both personal and professional quality of life (Brady & Guy, 1999). The therapeutic properties of supervision occur within the context of the healing relationship. This relationship provides a safe space in which alternative models of the self, in relation to others can be explored and developed (Saakvitne et al., 1998).

By encouraging mindfulness in supervision, the caregiver is encouraged to become more aware of personal sensations, emotional triggers and thoughts. This improves the caregivers’

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ability to see others for who they are, rather than projections from their own pre-existing relational templates. Through mindful supervision, previously ignored or suppressed feelings can be used as powerful informational tools to improve interpersonal dynamics (Christopher & Maris, 2010).

Creating meaning

The current research, congruent with previous research, highlights the importance of the ability to create meaning in life, thereby enabling the caregiver to contextualize the suffering endured by their clients and reduce the risk of developing STS (Harrison & Westwood, 2009; McFarlane & van der Kolk, 1996). “In some way, suffering ceases to be suffering at the moment it finds a meaning... (Frankl, 1959, p. 117).” This *meaning*, attributed to suffering, may be found in the form of personal sacrifice and commitment to family, the belief in a higher purpose, a divine plan or the acceptance of a personal challenge to transcend personal suffering and to help others to survive in spite there of (Frankl, 1959; Harrison & Westwood, 2009). Exposure to traumatic experiences influences the caregivers’ spiritual/religious development. The caregiver is forced to re-evaluate the meaning and purpose of life, as old values and core beliefs are often called into question (Decker, 1993). Trauma work is believed to affect the spirituality of the caregiver more deeply than the effect on any other realm of functioning (Brady & Guy, 1999; Decker, 1993; Neuman & Pearlman, 1996). When the therapist is forced to re-evaluate their own sense of meaning and hope, their view of the world may become jaded with pessimism and suspicion of human intention and motive (Herman, 1992). It is for these reasons that the role of religion and the spiritual-self needs to be considered when designing interventions aimed at improving compassion satisfaction and reducing secondary traumatic stress and burnout in telephone counsellors.

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6.2 Limitations

This study, while producing interesting findings, is limited by several specific considerations. The main limitation of the study is that it is not generalizable to all telephone counsellors within South Africa, as the study was based on a small sample of predominantly young, inexperienced telephone counsellors from two geographical regions. The study showed many statistically insignificant findings but a larger study covering more telephone counselling facilities from more geographic regions and demographic profiles would be needed to be able to generalise the findings more broadly.

Another limitation that was noted regarding this study and is documented as being evident in several studies on STS and VT, is embedded within the research design of the study. It has been suggested that a large body of research (Craig & Sprang, 2010; Dunkley & Whelan, 2006a; Mauldin, 2001; Pearlman & Mac Ian, 1995), including the current study, do not include a control group (individuals who were not affected by exposure to distressed individuals), thereby questioning the validity of the study (Gershuny & Thayer, 1999). This omission would preclude availability of reference criteria from which to draw conclusions for the research (Lerias & Byrne, 2003).

Yet another methodological limitation of this study is the inclusion of telephone counsellors who have been exposed predominantly to traumatic events, together with those who have not been exposed to the same sort of traumatic events. Results obtained by analysing the effects of exposure on counsellors who have been subjected to different conditions, may not produce accurate or interpretable data (Lerias & Byrne, 2003).

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The adequacy of the measures used in this study, especially those used in the questionnaire are deficient in several aspects. The question relating to individual exposure to past traumatic experiences was not adequately defined for the participants. It would be expected that individual definitions and subjective understanding of personal traumatic experience would vary substantially from one individual to the next. A future recommendation would be to enhance the accuracy of the research by providing participants with a list of traumatic events from which to choose and select. The question relating to the use of debriefing services was also not adequately explored. The question did not clarify reasons for needing these services or the type of services offered. These limitations in design made results difficult to interpret and less reliable than would have been desired.

There were without doubt other psychological, demographic and developmental variables that might have impacted on the telephone counsellors' predisposition to, or protective factors against developing STS, that occurred outside of the counselling environment (e.g. psychiatric illness, styles of coping, education, high levels of violence within the community, poverty and racial conflict etc...), that were omitted from the research design for this study, given its relatively limited scale and scope. Pre-trauma personality disorders or traits, such as borderline traits may contribute to an increased risk of developing STS and BO. This might have skewed the findings of the study. Racial and ethnic differences were also not examined and for future research it would be useful to explore such differences as well as whether cultural differences influences incidence of STS and BO.

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6.3. Recommendations

STS has become accepted as being a natural consequence of working with distressed clients, especially those distressed due to trauma, and has thus become a crucial issue for counselling professionals. This behoves researchers to investigate STS with greater rigor especially amongst an essential, crucial group of professionals such as telephone counsellors, who have historically been neglected and require particular research attention. Possible future research could focus on a sample of telephone counsellors who have been indirectly exposed to the same types of trauma clients. Comparative data could then be obtained from those who develop subsequent symptoms of STS and those who do not.

Although the findings of this study were somewhat inconclusive, a growing body of research indicates that exposure to secondary trauma places the counsellor at increased risk of developing STS (Dunkley & Whelan, 2006a; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995). These studies, together with the finding in this study suggest that supervision, adequate PTSD training and religious/spiritual grounding has a protective effect against the development of STS and as such, requires further investigation.

In order for more accurate recognition of the condition and more appropriate interventions within the supervisory context, telephone counsellors and supervisors need to become more aware of the differences and similarities between STS and other conditions such as burnout, compassion fatigue and post-traumatic stress disorder. The importance of protective factors enhancing CS and reducing the incidence of STS has been highlighted in this study. Future interventions could involve religious institutions in collaboration with health promotion specialists in the formulation of effective strategies and interventions to enhance a sense of spiritual/religious well-being. Religion is shown to promote a sense of optimism and hope (Chaundhry, 2008), enhancing a sense of well-being and creating a sense of meaning for

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individuals exposed to high levels of stress and trauma. Religion could serve an important function in assisting the telephone counselor to cope with stressors at work and in dealing with stressful life events. It offers guidance, support and hope, which appears to be crucial considering that a large percentage of the sample in this study indicated that they were religious (Chaundhry, 2008).

The literature shows that adequate supervision, support from peers as well specialized training in trauma as well as social activities significantly buffer the risk of STS and BO among telephone counselors. It stands to reason that the promotion of physical and mental wellness of telephone-counselors must become a priority for organizations utilizing the services of telephone counselors within South Africa. Well researched wellness courses, offered during the training phase of counselling as well as to trained counselors, could prove to play a fundamental role in the continued health and well-being of the telephone counselor. Social cohesion between peers can be improved through the introduction of social activities within the organization. This improved bond between fellow counselors would increase the likelihood of developing a supportive peer network which is shown to increase CS while reducing the incidence of STS (Trippany et al., 2004). These activities could serve as harbinger to the development of supportive peer groups, which would provide the telephone counselor with the benefit of being able to draw upon the shared resources of the group and in turn is able to benefit from the “collective empowerment” of the group (Herman, 1992).

A final consideration for the enhancement of mental and physical wellbeing is linked to an increase in CS. It has been shown that the two factors constituting CS are associated with the feeling of being effective as a helper and a feeling of personal satisfaction regarding the helping role. It is the first factor associated with CS that is linked to the individual’s belief that he/she possesses the relevant job skills and the feeling that he/she can perform the tasks required of a telephone counselor (Bandura, 1977). This fundamental need for a sense of

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proficiency highlights the ethical responsibility shared by employers, educators and individual counselors to provide adequate, trauma-related training and continued education and support to these, highly valued service-providers.

It is hoped that this study not be regarded as having occurred within a vacuum, but that it is evident that issues such as STS and BO affect real people, providing a much needed service to members of a society in which we live. As such it is hope that, through the implementation of these few simple measures, the telephone counselor can, in the near future receive the support and services needed to prevent and ameliorate the effects of STS and BO, while increasing the incidence of CS.

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APPENDICES

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APPENDIX A: Biographical questionnaire

BIOGRAPHICAL QUESTIONNAIRE

Please read the following and circle the letter that best applies to you

1. Your present age:

- a) 25 or less
- b) 26-35
- c) 36-45
- d) 46-55
- e) 56-65
- f) 66 or greater

2. Length of service as a counsellor:

- a) 1-5 years
- b) 8-10 years
- c) 11-15 years
- d) 15-20 years
- e) 21 years or more

3. Your ethnic/cultural heritage:

- a) Asian/ Indian
- b) Black/ African
- c) Coloured
- d) White
- e) Other (specify)

4. Note your training in Post -Traumatic Stress disorders

- a) Seminars/conferences
- b) Academic classes
- c) Self-study
- d) Other (please specify)
- e) No training

[Type text]

5. Your belief or faith category

- a) Spiritual (non-secular)
- b) Christian
- c) Judaism
- d) Eastern religion (Buddhist, Hindu)
- e) Muslim
- f) Atheist(no spiritual or religious beliefs)
- g) Other (specify)

6. Who do you talk with about your feelings regarding the nature of your work with trauma clients (circle all that apply)

- a) Supervisor
- b) Colleague
- c) Spouse/ significant other
- d) Priest/ spiritual leader
- e) Family member
- f) Friend
- g) Other (specify)
- h) I do not share my thoughts with any one, I keep the impact of my work to myself.

7. Is de-briefing offered to counsellors at your organisation?

- a) Yes
- b) No

8. If de-briefing is offered, do you use the service?

- a) Yes
- b) No

9. If No, Why not?

- a) I'm worried about confidentiality
- b) I don't think it helps
- c) It may help some people but it doesn't help me
- d) I don't like the person offering the service
- e) other (explain)

[Type text]

10. If Yes to question 8, Did it help?

- a) Yes
- b) No
- c) Unsure

7. Have you had any personal traumatic experiences in your past?

- a) Yes
- b) No

8.If yes, did you receive any psychological therapy after the traumatic event?

- a)Yes
- b)No

[Type text]

APPENDIX B: Professional quality of life scale (ProQol)

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

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

		Never	Rarely	Sometimes	Often	Very Often
		1	2	3	4	5
1.	I am happy.					
2	I am preoccupied with more than one person I [help].					
3	I get satisfaction from being able to [help] people.					
4	I feel connected to others.					
5	I jump or am startled by unexpected sounds.					
6	I feel invigorated after working with those I [help].					
7	I find it difficult to separate my personal life from my life as a [helper].					
8	I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].					
9	I think that I might have been affected by the traumatic stress of those I [help].					
10	I feel trapped by my job as a [helper].					
11	Because of my [helping], I have felt "on edge" about various things.					
12	I like my work as a [helper].					

[Type text]

		Never	Rarely	Sometimes	Often	Very Often 5
		1	2	3	4	
13	I feel depressed because of the traumatic experiences of the people I [help].					
14	I feel as though I am experiencing the trauma of someone I have [helped].					
15	I have beliefs that sustain me.					
16	I am pleased with how I am able to keep up with [helping] techniques and protocols.					
17	I am the person I always wanted to be.					
18	My work makes me feel satisfied.					
19	I feel worn out because of my work as a [helper].					
20	I have happy thoughts and feelings about those I [help] and how I could help them.					
21	I feel overwhelmed because my case [work] load seems endless.					
22	I believe I can make a difference through my work.					
23	I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].					
24	I am proud of what I can do to [help].					
25	As a result of my [helping], I have intrusive, frightening thoughts.					
26	I feel "bogged down" by the system.					
27	I have thoughts that I am a "success" as a [helper].					
28	I can't recall important parts of my work with trauma victims.					
29	I am a very caring person.					

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APPENDIX C: Ethical clearance – approval form



27 July 2012

Mrs Mary Rogers (901302620)
School of Applied Human Sciences

Dear Mrs Rogers

Protocol Reference Number: HSS/0652/012M
Project Title: Vicarious traumatization among telephone counselors in South Africa

In response to your application dated 27 March 2012, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number. Please note: Research data should be securely stored in the school/department for a period of 5 years.

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

Yours faithfully

.....
Professor Steven Collings (Chair)
/ms

cc Supervisor: Dr Anthony Collins
cc Academic Leader: Professor JH Buitendach
cc Admin: Doreen Hattingh

Professor S Collings (Chair)
Humanities & Social Sc Research Ethics Committee
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Founding Campuses: ■ Edgewood ■ Howard College ■ Medical School ■ Pietermaritzburg ■ Westville

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APPENDIX D: Informed Consent Form

Date:

Dear Participant,

Thank you for considering participating in this research study. I am currently a Clinical Psychology Masters student at the University of KwaZulu-Natal. For purpose of my degree, I am conducting a research study.

The title of this research is "Vicarious traumatization among telephone counselors in South Africa."

This research aims to develop a deeper understanding and provide valuable, baseline information for further research regarding the reduction of risk of vicarious traumatization for telephone counselors in South Africa.

TERMS OF AGREEMENT

Your participation is completely voluntary.

Your responses will be kept confidential, and your identity will not be revealed at any time. Pseudonyms will be used, and any individual information that may uniquely identify you will not be included. Should the questions raise any emotionally difficult issues for you, we will provide you with adequate counselling and emotional support.

Should you agree to participate in this study, you will be requested fill out two questionnaires, indicating your response to questions by placing an 'x' in the relevant box for each question. Should you agree, you are free to withdraw from the study at any time. A copy of the informed consent will be given to you. Copies of the final research will be made available to you at your request.

This research will be used to aid research focused on improving the lives of telephone counselors in South Africa.

Your participation is greatly appreciated.

If you require additional information, please feel free to contact either of the following:

Mary Rogers (Researcher)

Anthony Collins (Supervisor)

Home: 031 7657568

Work: 031 260 2539

Cell: 082 5596740

Cell: 082 459 0881

E-mail: rogers.mary7@gmail.com

E-mail: collinsa@ukzn.ac.za

Declaration:

I, _____ (full Name),

Hereby confirm that I understand the contents of this document and the nature of the study, and I consent to participating in this research project.

I understand that my information will be kept anonymous and that I am free to withdraw from this study at any time, without penalty, if I wish to do so.

Signature:

Date: