Title: The Secondary Consequences of the Helping Profession: An Exploration of Trainee Psychologists' Attitudes and Perceptions Towards Vicarious Trauma.

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DECLARATION

Unless specifically indicated to the contrary, this research report is the result of my own work.

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To my friends, family, and my beloved who continuously encouraged me throughout this process even when I doubted myself- thank you. To my supervisor, Prof Duncan Cartwright, who always offered efficient supervision and guidance throughout my Masters journey- thank you. And lastly, thank you God for helping me persist during this process. I would not have made it through my Masters studies had it not been for Him.

CONTENTS

ABSTRACT

The primary objective of this research was to initiate exploratory research in to the attitudes, perceptions, and experiences of trainee psychologists with regard to vicarious trauma. This research focused on exploring student psychologists' understanding of vicarious trauma, which included an exploration of its symptoms, consequences, risk factors, and coping methods. A central focus of this study was also to gain an understanding of the challenges that student psychologists experience during their M1 year, as well as their knowledge/awareness of vicarious trauma. An underlying aim was to generate suggestions for education and training programmes in order to increase such knowledge so that trainee psychologists are better prepared to cope with the secondary consequences of the helping profession. The understanding of vicarious trauma was situated within Constructivist Self-Development Theory described by Trippany, Kress and Wilcoxon (2004). Semi-structured, open-ended interviews were conducted with six respondents. Braun and Clarke's (2006) method of qualitative thematic analysis was used to analyse and interpret the data. A prominent finding of this research was that the participants had a basic understanding of vicarious trauma in terms of its symptoms and consequences, but struggled to conceptualize the phenomenon. It was evident that the student psychologists believed vicarious trauma to be a severe consequence of the helping profession but felt that more could be done during their education and training to increase knowledge and awareness of the concept and ultimately their ability to cope with it should they experience it. Suggestions offered by the participants included seminars on vicarious trauma, group mentoring and debriefing sessions, and more exposure to trauma cases in order to gain practical knowledge rather than theoretical knowledge without the know-how. It was concluded that there is a need within masters training programmes to incorporate a focus on vicarious trauma, which will act as a buffer to decrease risk.

INTRODUCTION

In more recent years, there has been a growing interest in and awareness of the secondary consequences of the helping profession such as compassion fatigue, burnout, secondary traumatic stress, and vicarious trauma. Research has indicated that vicarious trauma is a very real threat to the well-being of mental health professionals, and that its impact can have far reaching consequences across interpersonal, cognitive, behavioural, social, and professional domains (Cunningham, 2004; Courtois, 2002; Shackelford, 2006 as cited in Newell & McNeil, 2010). There is a body of literature that describes the symptoms of vicarious trauma (VT) that mental health professionals may begin to notice within themselves (Trippany, Kress & Wilcoxon, 2004, and Williams, Helm & Clemens, 2012), however this is based on the assumption that mental health professionals are aware of and knowledgeable about vicarious trauma. There is literature highlighting the important role that education and training programmes play in creating this awareness of vicarious trauma and increasing trainee mental health professionals' knowledge of the phenomenon (Newell & McNeil, 2010). The existing body of literature further highlights a gap regarding a focus on trainees' attitudes, perceptions, and experiences of vicarious trauma (Baker, 2012). Therefore, as a result of the existing body of literature, the focus of this research involved exploring the attitudes, perceptions, and possible experiences of trainee psychologists who were involved in their first year Clinical and Counselling Masters studies. The scope of this research dealt with exploring student psychologists' knowledge and understanding of vicarious trauma and other related phenomena, the emotional challenges that these students faced during their M1 year, their coping methods, their beliefs about personal risk of vicarious trauma, and, very importantly, what they felt could be done during their M1 year to better equip them to cope with the consequences of mental health work and ultimately decrease their risk for vicarious trauma. The chapters within this dissertation have been structured in a way that aims to explore varying elements of this research

problem. Chapter one discusses the literature on vicarious trauma, and outlines various research findings exploring VT within the field of mental health. The chapter then progresses to contextualize this specifically with reference to trainee psychologists, and to highlight the need for awareness during training. Chapter two explores the methodology of this research process, including sample selection, data collection, and data analysis. The third chapter provides the research findings, which are then interpreted and explored further in chapter four. The researcher has also added a personal reflection in chapter five, which reflects on the researcher's journey through the research process while simultaneously engaging in Clinical Psychology Masters training. Chapter six concludes the research dissertation by summarising the core literature and research findings. It is important to state that this Masters thesis drew on the researcher's honours research project, resulting in an overlap of content. This was approved and accepted by the researcher's supervisor.

CHAPTER ONE

1 LITERATURE REVIEW

1.1 The Risks Associated with being a Mental Health Professional

There are a variety of emotional and psychological risks associated with mental health services engaging with vulnerable populations. The problem is that these risks have been largely overlooked in educational and training contexts (Cunningham, 2004; Courtois, 2002; and Shackelford, 2006; as cited in Newell & MacNeil, 2010). These risks include changes to one's perceptions of self, others and the world as well as negative impacts on one's professional life. Newell and McNeil (2010) thus highlight how training in both the professional and educational spheres of mental health are important to adequately prepare mental health practitioners, such as nurses, psychologists and social workers, especially those in training, for the negative psychological effects of dealing with clients' trauma and thus their personal experiences of vicarious traumatization. This has been defined by McCann and Pearlman (1990) as cognitive changes occurring within mental health workers as a result of engaging empathically with clients' trauma material. Moulden (2007) understood vicarious trauma to be the impact that occurs within the mental health worker as a result of listening to the trauma content and experiences of their clients. Such an impact is thought to result from the emotional demands of being vicariously exposed to clients' personal trauma experiences (Jenkins & Baird, 2002). Research has shown that VT involves significant changes and disruptions in the counsellor's identity, values, beliefs, perceptions and memory system (Trippany, Kress & Wilcoxon, 2004). It is a fairly new concept only described by McCann and Pearlman in 1990 (Figley, 1995; Rasmussen, 2005). However, since its inception it has gained more attention within the literature.

1.2 Working with Vulnerable Populations

In the year 2000 the global mortality rate due to violence was 28.8 per 100 000 populace (Doolan, Ehrlich & Meyer, 2007). In South Africa violence is the second leading cause of premature death, with a prevalence rate of 73 per 100 000 in the year 2000 (Doolan, Ehrlich & Myer, 2007). This has been predicted to grow to 157.7 per 100 000 by 2013 (Doolan, Ehrlich & Myer, 2007). Violence is therefore a significant public health concern not only because it has direct effects on one's physical wellbeing, but because both victims and witnesses may suffer from the long-term psychological effects of emotional trauma (Doolan, Ehrlich & Myer, 2007). It is estimated that approximately 3.5 million people seek medical and mental health care globally per annum due to violence (Seedat et al, 2009). These statistics indicate how violence is a rising global concern and as a result, the occurrence of vicarious traumatization amongst mental health practitioners is becoming more prevalent world-wide and especially in South Africa, where the overall injury-death rate due to violence is nearly twice the global average (Seedat et al, 2009). Although many mental health practitioners work in diverse environments such as family or personal therapy as well as crisis support, there is an increasing likelihood of encountering clients who have experienced trauma and are still trying to work through their trauma-related issues (Kadambi & Truscott, 2004; Sommer, 2008). Sommer (2008) indicates that mental health professionals encounter traumatized clients on a daily basis therefore it is important to adequately prepare and train these professionals in order to reduce their risk of experiencing VT.

Trainee and professional counsellors and psychologists in South Africa provide a dedicated service to vulnerable populations such as the abused, neglected, or mentally ill. However, in order to help these vulnerable populations, a strong therapeutic alliance must be formed between the client and counsellor (Newell & MacNeil, 2010). This requires extensive

knowledge of the client's personal history, including past and/or present factors resulting in trauma; and an ability to listen and engage empathically with that client's trauma (Morresette, 2004; Rothschild & Rand, 2006 as cited in Newell & MacNeil, 2010). This chronic over exposure to the trauma of others can take its toll on the emotional, physical, psychological and professional well-being of trainee and professional mental health workers (specifically trainee psychologists in this study). This has been explored in the literature through related concepts known as Secondary Traumatic Stress (STS), compassion fatigue, burnout, countertransference and VT (Newell & MacNeil, 2010).

1.3 Types of Secondary Reactions

1.3.1 Secondary Traumatic Stress

Secondary Traumatic Stress (STS) is conceptualized as a disorder experienced by those who work with clients suffering from Post-Traumatic Stress Disorder (Figley, 1995; Baird & Kracen, 2006). Jenkins and Baird (2002) describe STS as the sudden negative reactions mental health professionals may experience because they are helping trauma survivors. This is consistent with the work of Figley (1983, as cited in Jenkins and Baird, 2002), who defines STS as the emotional duress experienced by those having close contact with trauma survivors leading to stress resulting from helping or wanting to help the person who has experienced the trauma. Descriptions of STS focus on the behavioural symptoms which mimic those of PTSD presenting in the primary victim/s of trauma whereas conceptions of VT emphasize the cognitive changes that occur in mental health professionals (Newell & MacNeil, 2010). The symptoms of STS are closely related to PTSD but the difference lies in whether the individual is a primary or secondary victim (Jenkins & Baird, 2002). Jenkins and Baird (2002) also highlight a key difference between STS and VT in that STS has a sudden onset that could result from exposure to one client's case whereas VT has a cumulative effect. Furthermore, VT

requires chronic exposure to traumatic material, which results in cognitive and affective shifts following this exposure. For example, developing the belief that the world is a dangerous place (Aparicio, Michalopoulos, & Unick, 2013).

1.3.2 Compassion Fatigue

Another term which is used interchangeably with STS and VT is 'compassion fatigue'. It is wrongly used interchangeably because compassion fatigue occurs when counsellors and therapists experience emotional and physical fatigue because they are constantly using empathy when treating traumatized clients (Figley, 1995, 2002; Rothschild & Rand, 2006 as cited in Newell & MacNeil, 2010). Compassion fatigue does not encompass the negative physical and psychological effects of STS and VT; it only involves empathic exhaustion with regard to client interaction. It accumulates over time, which differs from STS, and may have a sudden onset of symptoms. Compassion fatigue is similar to VT due to cumulative process involved (Trippany, Kress & Wilcoxon, 2004). One of the main difficulties associated with using the term 'compassion fatigue' is that physical fatigue is not always present, and the individual does not have to be involved in daily empathic work to experience it. In other words, compassion fatigue is not limited to the field of mental health as it can be experienced in other professions (Newell & MacNeil, 2010).

1.3.3 Burnout

Jenkins and Baird (2002) conceptualize burnout as a "defensive response to prolonged occupational exposure to demanding interpersonal situations" (p.424) which results in psychological distress. Newell and MacNeil (2010); Trippany, Kress and Wilcoxon (2004); and Pines and Aronson (1998 as cited in Newell & MacNeil, 2010) substantiate this description of professional burnout which they describe as a general phenomenon involving physical,

emotional and psychological exhaustion that can occur in any social service setting; it is not specific to trauma-related work as is the concept of VT. The first distinction between VT and professional burnout is that burnout may occur in persons working across a variety of fields whereas VT only occurs amongst those who work with trauma survivors (Trippany, Kress & Wilcoxon, 2004). Secondly, burnout describes a sense of feeling overloaded and overworked whereas VT refers to a counsellor's reactions specifically related to the client's trauma. Thirdly, burnout also progresses gradually and incorporates emotional exhaustion, depersonalization and a reduced sense of accomplishment (Newell & MacNeil, 2010). This contrasts to VT which often involves a sudden onset of symptoms but the symptoms are usually undetectable, thus building up over time and suddenly culminating in the negative symptoms that the mental health professional experiences (Trippany, Kress & Wilcoxon, 2004). The reason for the interchangeable use of the terms VT and Professional Burnout is that they may present with similar physical, behavioural and emotional symptoms, work-related issues and interpersonal problems (Trippany, Kress & Wilcoxon, 2004). Both VT and burnout can undermine the quality of the therapeutic alliance because of a decline in client care on the part of the mental health practitioner (Raquepaw & Miller, 1989 as cited in Trippany, Kress & Wilcoxon, 2004).

1.3.4 Countertransference

Trippany, Kress and Wilcoxon (2004) and Harrison and Westwood (2009) describe countertransference (CT) as the mental health practitioner's short-term emotional reaction to a client due to their own personal unresolved conflicts/experiences. This is distinctly different from VT, which involves a personal reaction to the trauma of the client rather than a reaction based on past personal experiences (Trippany, Kress & Wilcoxon, 2004). Although VT may involve some form of countertransference, for example in cases where the counsellor is a survivor of trauma, VT does not lead to countertransference nor is countertransference an

automatic component of VT (Figley, 1995 as cited in Trippany, Kress & Wilcoxon, 2004). Furthermore, vicarious traumatisation differs from CT in that VT is a cumulative process extending beyond the therapy session which influences various aspects of the psychologist's life (Harrison & Westwood, 2009).

1.4 Exploring Vicarious Trauma

1.4.1 Symptoms

Within the past two decades, researchers have begun to synthesize and integrate literature on VT which has clarified its effects (Neuman & Gamble, 1995; Pearlman & Saakvitne, 1995; Iliffe & Steed, 2000; Regehr et al., 2004; Canfield, 2005; and Sommer, 2008). For example, Baird and Kracen (2006) synthesized findings of studies conducted between 1994 and 2003 to capture the nature of VT and STS and what various researchers believe contributes to the development thereof. Some of the contributing factors common across different researchers include personal trauma history; amount of exposure in terms of case load and working hours; one's perceived coping ability which acts as a protective factor if the coping mechanism is adaptive; and the role of supervision (Sommer & Cox, 2005; Baird & Kracen, 2006). Kassam- Adams (1999, as cited in Sommer, 2008) identified that mental health professionals who deal with cases of sexual abuse report more trauma-related symptoms and significant problems with interpersonal relationships. Psychologists working with domestic-abuse survivors reported suffering from physical symptoms such as headaches, nausea and exhaustion; as well as psychological symptoms such as feeling horrified and experiencing intrusive thoughts or imagery resulting in psychological distress (Illife and Steed, 2000; Sommer, 2008).

In a study conducted by Arnold, Calhoun, Tedeschi & Cann (2005) 90% of the psychotherapists who were interviewed reported that they experienced intrusive thoughts and

images related to the client's trauma at some stage during their career. A further 71% said they had experienced negative emotional responses such as sadness, anger, fear, helplessness, avoidance and shock during and after sessions with traumatised clients. All the psychotherapists in the study felt some degree of physical exhaustion and doubted their effectiveness as mental health practitioners (Arnold et al, 2005). Such studies indicate the negative impact of VT on the psychologist's psychological health and their worldview thus creating intra- and interpersonal problems (McCann & Pearlman, 1990; Trippany et al, 2004, as cited in Williams, Helm & Clemens, 2012). As a result, psychologists may begin to distrust people that they previously trusted and they may feel unsafe in environments that were previously unthreatening (McCann & Pearlman, 1990, as cited in Williams, Helm & Clemens, 2012). These overall feelings of distrust and threatened safety may cause interpersonal conflict in significant relationships and also have the potential to undermine the therapeutic relationship with clients (Williams, Helm & Clemens, 2012).

Other authors have also outlined a vast array of symptoms related to vicarious trauma (Adams et al., 2003; Collins & Long, 2003; and Lerias & Byrne, 2003). Mental health professionals may experience symptoms such as loss of energy, difficulty maintaining relationships which links back to intimacy issues, hopelessness and despair, cynicism, intrusive thoughts or nightmares, increased emotionality or a lack of emotion, changes in one's world view, and even the risk of dissociation and depersonalization (Saakvitne & Pearlman, 1995, as cited in Williams, Helm & Clemens, 2012; Lerias & Byrne, 2003). Other symptoms may include feelings of personal vulnerability and distressing emotions such as anxiety, fear, shame, or rage; somatic symptoms such as headaches, nausea, sleep difficulties, or changes in sexual functioning; increased arousal due to feelings of unexplained anger, anxiety, and irritation; and an avoidance of places or triggers associated with the traumatic experience (Adams et al., 2003;

Lerias & Byrne, 2003; Collins & Long, 2003). In general, the above symptoms of vicarious trauma can be divided in to emotional, cognitive, and behavioural symptoms (Way et al., 2004).

It is evident that VT can cause significant disruptions to the psychologist's daily life and psychological functioning but the impact of VT may extend beyond the personal effects by also impacting on the professional health of the psychologist (Williams, Helm & Clemens, 2012). This may lead to blurred therapeutic boundaries, the risk of misdiagnosis, an inability to attend to the needs of the client and a lack of enthusiasm and commitment to the therapeutic process (Sexton, 1999; Trippany et al, 2004, as cited in Williams, Helm & Clemens, 2012). Over exposure to clients' trauma may result in 'empathic strain' which occurs when psychologists find it difficult to empathize while maintaining appropriate boundaries and objectivity (Wilson & Lindy, 1994, as cited in Arnold, Calhoun, Tedeschi & Cann, 2005). As a result of empathic strain, psychologists (and mental health practitioners in general) may withdraw from their clients and downplay the severity of the trauma or they may begin to over-identify with their clients' trauma (Arnold, Calhoun, Tedeschi & Cann, 2005). Trippany, Kress and Wilcoxon (2004) indicate that as the vulnerability of the mental health practitioner increases, so do the chances of clinical error. Trainee and professional psychologists begin to doubt their skills, knowledge and capabilities and they may lose focus of the client's needs, strengths and resources. As the experience of VT becomes more severe, psychologists may begin to avoid discussions of the client's traumatic experience/s or they may become too intrusive, pushing the client before they are ready (Trippany, Kress & Wilcoxon, 2004).

1.4.2 Predictors/Risk Factors

Adams et al. (2001) conducted a study using the Traumatic Stress Institute Belief Scale to investigate the factors that contributed to social workers' experiences of vicarious trauma. The results reflected that social support is an important mediating factor in the social workers' experiences and intensity of vicarious trauma. Furthermore, the younger social workers within the sample who had less work experience presented with higher levels of vicarious trauma (Adams et al., 2001). Interestingly, a personal trauma history was not found to be a significant contributing factor to the experience of vicarious trauma. Other studies, however, offer a contrasting argument for the role of a personal trauma history and the risk of vicarious trauma. For example, Collins and Long (2003) described how a personal trauma history and a lack of experience increases the risk of mental health workers experiencing vicarious trauma. Rasmussen (2005) and Baird and Kracen (2006) offer support to the findings of Collins and Long (2003) because they also recognize that personal trauma history is a contributing factor to the risk of vicarious trauma.

1.5 Research on Vicarious Trauma: From General Findings to Trainees

The literature explores multiple professions within the field of mental health care and the effects that empathic caring may have on these various professionals. For example, Dunkley and Whelan (2006) conducted a study on the vicarious trauma experiences of telephone counsellors. The results indicated that telephone counsellors' experiences of VT were considered to be low and was significantly mediated by professional support, which played an essential role in alleviating the effects/symptoms of VT (Dunkley & Whelan, 2006). It was also found that the positive and negative effects of VT were mediated by the telephone counsellors' coping style which they employed to process and manage the traumatic material they were exposed to (Dunkley & Whelan, 2006). Telephone counsellors who employed less productive

coping styles- such as avoidance, withdrawal, substance abuse, and denial- experienced more distress and more severe VT symptoms compared to those who employed adaptive/productive coping styles, such as using humour and accessing emotional and social support (Dunkley & Whelan, 2006).

A study conducted by VanDeusen and Way (2006) examined the effects of working with sexual abuse survivors and/or offenders on mental health practitioners. The results indicated that clinicians who were new to the field experienced more significant shifts in their cognitions around intimacy and trust, compared to those who had more years of experience (VanDeusen & Way, 2006). This is supported by other literature stating that practitioners with less experience report higher levels of VT effects/symptoms (Pearlman & MacIan, 1995; Adams et al., 2001; Collins & Long, 2003; and Parker & Henfield, 2012). The study's results also indicated that practitioners' personal trauma history was associated with more cognitive disruption and the negative effects of VT which is once again supported by previous literature (Pearlman & MacIan, 1995; Collins & Long, 2003; Rasmussen, 2005; and Baird & Kracen, 2006).

Dussich (2003) conducted a study on VT amongst police officers in Japan and the results highlighted the cumulative physical and psychological toll that tragic and violent events can take on police officers who are exposed to trauma on a daily basis. Hyman (2004) also conducted a study exploring the symptoms of VT in a sample of Israeli forensic police officers who were exposed to human remains from victims of violent crimes. The findings showed elevated psychological distress within this population which was significantly linked to avoidant coping styles (Hyman, 2004).

Parker and Henfield (2012) conducted a qualitative study exploring school counsellors' perceptions of VT. One of the key findings was professional school counsellors' confusion surrounding VT. In general, the participants had an idea of what VT was but found it challenging to pin point a specific definition (Parker & Henfield, 2012). Three of the six participants reported not knowing much about VT and described it as being synonymous with burnout, personal reactions to students' issues, and transference (Parker & Henfield, 2012). Such findings suggest that, should trainees not receive awareness of VT during their studies it could have implications for the future of psychology students whose knowledge, attitudes and perceptions are somewhat shaped through training programs. Thus, the level of awareness and knowledge needs to begin in training programs and failing to do so may result in mental health professionals experiencing difficulty when it comes to understanding VT and distinguishing it from other related concepts such as compassion fatigue, burnout and transference. Parker and Henfield's (2012) study further identified that participants perceive level of experience as a determinant of a counsellor's experience of VT. Participants described that a lack of training or the need for further training may be related to experiences of VT (Parker and Henfield, 2012). Five out of six participants discussed the importance of receiving more training. Three out of six participants described having no trauma-related classes during their training programs; and some participants highlighted that a lack of life and/or work experience may place a novice therapist at great risk for experiencing VT (Parker and Henfield, 2012). These findings imply that the novice student therapist is at risk for experiencing VT because they are not able to effectively distinguish between various secondary consequences of the helping profession, they have little life and/or work experience, and even as professionals they may require further training. This research differs from the above study by focusing specifically on trainee psychologists and their understandings and perceptions of VT.

Emery, McLean and Wade (2009) conducted a study on a population of clinical psychologists using the Therapist Belief Scale. They identified the relationship between psychologists' beliefs and burnout, identifying that there are four therapy-related beliefs employed by psychologists, especially trainees, which are unhelpful in clinical practice and may contribute to an increased risk of VT and burnout (Emery, McLean & Wade, 2009). The first belief is a low tolerance for distress, referring to both the therapist's distress and the distress of the client (Emery, McLean & Wade, 2009). This means that psychologists are have a low threshold for feelings of distress, whether their own or the distress of their clients. Applying this to trainee psychologists, it could be a risk factor for developing VT as trainees have higher levels of distress regarding clinical work and their ability to be an effective practitioner. Coupled with having to cope with the distress of their clients, this could be a significant factor influencing trainees' risk for experiencing VT. This resonates with the work of Adams and Riggs (2008) who researched the role of defense style employed by trainee psychologists. Their research indicated that if student psychologists have an immature/negative defense style to cope with distress, such as reaction formation and pseudo-altruism, they are particularly vulnerable to experiencing VT (Adams & Riggs, 2008). Their results also indicated that using a self-sacrificing defense style to cope with distress resulted in significantly more trauma symptoms experienced by trainee psychologists. Etherington (2009) suggests that because trainee psychologists are less self-aware and uncomfortable with the intense feelings evoked by clinical practice, they are more likely to employ maladaptive coping styles and protective defenses, which further increases the risk of VT.

The second belief an inflexibility regarding the application of therapeutic techniques which has been found to lead to significant distress in the psychologist (Emery, McLean & Wade, 2009). In their training years, student psychologists' tend to adopt a rigid and inflexible

approach to therapy due to doubting their professional competence and abilities. As a result, they may experience high anxiety around choosing and adapting therapeutic techniques for their clients. These levels of anxiety around clinical practice may make student psychologists more susceptible to experiencing VT due to their poor coping strategies. The third belief refers to concerns over the responsibility of outcome whereby psychologists believe that client progress is their responsibility (Emery, McLean & Wade, 2009). This has a particular application to training psychologists who measure their clinical ability according to the progress of their clients. This may cause significant distress, in turn creating an increased risk for VT. The final belief refers to the need for control in the therapy setting (Emery, McLean & Wade, 2009). This need for emotional and therapeutic control has been associated with professional distress. These distressing beliefs are associated with younger, less experienced psychologists and are also associated with higher levels of burnout (Emery, McLean & Wade, 2009).

A significant number of studies have been conducted with regard to vicarious trauma experiences/symptoms across a variety of mental health professions. The literature available indicates that there is a consensus regarding the significant psychological, emotional, physical, and cognitive impact on mental health workers when working with traumatized populations, especially manifesting in vicarious trauma (Collins & Long, 2003; Baird & Kracen, 2006; and Moulden, 2007). This research study explores where the trainee mental health worker fits within this literature, as a large portion of the literature focuses only on professionals without a voice offered to the trainee.

1.6 The Need for More Awareness

A common thread amongst the terminologies that are used interchangeably with VT is stated by Pearlman (1999, as cited in Sommer, 2010): "Vicarious Traumatisation is neither a reflection of inadequacy on the part of the therapist nor of the toxicity or badness on the part of the client" (p.52). This quote indicates that VT consists of a complex interplay between a variety of factors which leads to the psychologist's experience of its symptoms/effects. For example, VT is not necessarily a result of poor training or insufficient skills on the therapist's part, nor is it only a result of engaging with trauma cases.

Due to the evidence indicating how VT can have various negative effects on mental health practitioners, educators have an ethical obligation to inform trainees (whether they are social workers, psychiatric nurses or student psychologists, for example) of the risks associated with working with traumatised clients (Sommer, 2008). Munroe (1999, as cited in Sommer, 2008) highlighted the American Psychological Association's guidelines which state that mental health trainees should not only be warned about the potential harm of working with traumatised clients but they should also be trained to cope effectively with this exposure to trauma (Sommer, 2008). Although a variety of trauma guidelines do exist such as collaborative supervision, supportive working environments, personal coping mechanisms and self-care strategies, it is not enough to simply instruct mental health professionals and trainees (Sommer, 2008). Active preventative measures and interventions have to be implemented as a regular component of the working environment (Sommer, 2008).

The risk of experiencing VT could be minimized through educational training on how to manage one's response to client's trauma material (Sommer, 2008). Therefore, it is important that training and professional mental health practitioners have an adequate

understanding of what these concepts encompass so that they can differentiate between various reactions to trauma, deal with them effectively, and protect themselves from future experiences of VT (Sommer, 2008). As mentioned earlier, Newell and MacNeil (2010) discuss that VT can lead to cognitive changes such as a shift in one's beliefs, perception of self, perceptions of the world with regards to safety, trust and control, and changes in spirituality. All of these cognitive changes are the direct result of intensive therapeutic contact with trauma survivors (Pearlman, 1999 as cited in Newell & MacNeil, 2010). According to Baird and Kracen (2006), VT results in aversive changes in a counsellor's professional views of themselves, others and the world due to exposure to the traumatic experiences of their clients. It is thus important for trainee and practicing mental health professionals to be aware of the reality of VT and other related conditions and to understand their associated risk factors and symptoms in order to increase awareness of their vulnerability to experiencing these conditions so that they can implement protective interventions (Newell & MacNeil, 2010).

1.7 Psychology Students' Needs

As stated by Baker (2012), there is an urgent need for more research on the experiences of VT as well as how tertiary institutions can best prepare graduate students for potentially experiencing VT. It was further highlighted that, while there is an abundance of literature on mental health practitioners' experiences of VT, there are very few studies focusing on the attitudes, perceptions and experiences of graduate students enrolled in a masters or doctorate training programme (Baker, 2012). In the study conducted by Baker (2012), masters-level clinical psychologists were interviewed on their personal experience of VT. The results indicated that all of the students felt there was a need for a graduate-level course incorporated in to their training regarding VT. They felt it was essential in training to become a mental health practitioner (Baker, 2012). Students further felt that such a course would assist them in

recognizing VT and understand it as a normal response to doing trauma work. They also felt it would equip them with the necessary skills to engage in evidence-based psychotherapy with trauma survivors (Baker, 2012). Expanding on these benefits, students felt a course on VT would provide a space for them to share their experiences with each other, acting as a form of intervention/prevention (Baker, 2012). This is consistent with the work of Harrison and Westwood (2009), as mentioned previously, who indicate that education about VT could assist in its prevention. Further support for this literature is indicated by Adams and Riggs (2008), who suggested that minimal to no trauma-specific training is associated with a pattern of VT symptoms regardless of defense style.

1.10 Theoretical Framework

The present research is situated within a developmental and constructivist theory, drawing on the work of Skovholt with regard to therapist development, as well as the Constructivist Self-Development Theory. These will be discussed in more detail.

1.10.1 Skovholt's Phases of Therapist Development

In order to place this study within the context of trainee psychologists, one cannot ignore the work of Skovholt (2012), who highlights phases of therapist/counsellor development which mental health professionals have worked through and in which novice trainee therapists find themselves during their training programme. These phases go hand in hand with trainee anxiety, which to some degree can be hypothesized as a factor making trainees more vulnerable to vicarious trauma if their coping mechanisms are ineffective (Bischoff, 1997).

Although Skovholt highlights six phases of therapist/counsellor development (Goodyear et al. 2003; Jennings et al.2003), the focus will be on phases one through three as

these phases are important for understanding the personal and professional development of the trainee psychologist and how these are areas in which there may be a risk for experiencing VT due to the anxieties that trainees experience throughout the professional developmental process. Phase one is the pre-training phase which involves being untrained in psychotherapy yet engaged in the process of attempting to help someone work through emotional turmoil or interpersonal relationship difficulties (Skovholt, 2012). Trainee psychologists in this phase are considered lay helpers who use their own life experiences as a source for making suggestions and the decisions made are based on internal cognitive schemas of their own personal life experiences (Skovholt, 2012). Sympathy guides the pre-trainer in helping others but often they get too involved in the problems of the other or may even be too emotionally distant with those whom they are helping. This is what Skovholt (2012) terms the empathic balance, which an individual in the pre-training phase is lacking (Bischoff, 1997; Jennings et al. 2003; and Skovholt, 2012). This places trainee psychologists at the very beginning of their training at risk for compassion fatigue and burnout, which are elements of VT, if they are too engulfed in the emotions of those they are helping.

Phase two is the beginning student phase (Goodyear et al. 2003; Ronnestad & Skovholt, 2012). This involves a transition from the known role of a lay helper to that of a professional psychotherapist in training, which is both exciting and anxiety-inducing for the trainee (Ronnestad & Skovholt, 2012). The difficulty is making the transition from known role of lay helper to the unknown role of the professional which becomes an intense reality for trainees when they start to see clients (Goodyear et al. 2003; Jennings et al, 2003; Skovholt, 2012). A part of this difficult transition is the gap between theory and practice and the desperate need to find a model that fits the client's picture without the added complexity that most models of treatment offer (Ronnestad & Skovholt, 2012). Beginning students often model their behavior

after supervisors and other professionals because they question their ability to 'pull off' the professional role and as such they lack confidence in their pre-training ability cultivated during undergraduate and post-graduate studies as well as life experience (Goodyear et al. 2003; Ronnestad & Skovholt, 2012). This phase may place the trainee at risk for experiencing secondary consequences of the helping profession due to the intensity of their own emotional response to client details and the anxiety of adjusting to a new professional role that they desire to fulfill adequately.

Phase three is the advanced student phase (Ronnestad & Skovholt, 2012; Skovholt, 2012). This phase describes the end of training usually once students are placed in internships and field placements, which help the student psychologist to develop an ability to function at a basic professional level. Advanced students are often cautious, careful, conservative, and less formal and more individual in their style (Skovholt, 2012). During this phase, the advanced student uses acquisition, application and validation processes to select and reject models of treatment. Skovholt's study indicates that advanced students may employ a 'no conceptual attachment' style with treatment methods; they may have preference for a single therapy approach but remain flexible and open to others; they may use 'multiple serial attachments'; or they may be true believers firmly holding to one approach with a rejection of others (Bischoff, 1997; Goodyear et al. 2003; Jennings et al. 2003; Skovholt, 2012). The first and latter styles are less effective for professional practice as they indicate rigidity in treatment method (Skovholt, 2012), which prevents personal and professional growth and may ultimately lead to burnout, compassion fatigue and VT due to the monotony of work and the lack of self-reflexivity.

1.10.2 Skovholt's Novice Therapist Anxiety

In his book, Skovholt (2012) describes some of the issues novice therapists may encounter during training which could result in novice stress. The issues discussed include: 1) clients not returning for therapy, 2) feeling incompetent, 3) striving for a perfect balance between supporting and challenging clients, 4) defining success based on client progress and supervisor evaluation, 5) experiencing the client's pain and suffering, and 6) feeling helpless (Skovholt, 2012). These issues and concerns are somewhat interconnected and when combined, provide the base for novice anxiety overload. When a novice therapist receives their first practicum client, there is a mixture of excitement and anxiety around beginning practical work and being anxious about one's ability to handle the session (Williams, Judge, Hill & Hoffman, 1997; Skovholt, 2012). A significant portion of training involves anxiety around clients returning for therapy once a session has ended. To a certain degree, novice therapists measure their ability as a therapist according to whether clients return for therapy and should the client not return, the novice therapist may interpret this as an indication of their poor counselling ability and their failure. This goes hand in hand with the constant novice anxiety of feeling incompetent (Williams, Judge, Hill & Hoffman, 1997; Skovholt, 2012).

Skovholt (2012) further describes the tendency of novice therapists to define their success according to client progress and supervisor evaluation. Novice therapists depend on supervisors to make the ambiguous clear and to define the boundaries of therapy sessions for them so that there is clear direction for therapy work. However, supervisors provide a guidance role which often leaves the novice therapist feeling as if they are floundering in therapy and not doing the right thing which cultivates feelings of helplessness (Hill, Sullivan, Knox & Hoffman, 1997; Skovholt, 2012). Novice therapists also measure success based on client reactions and responses during therapy sessions. According to Hill, Sullivan, Knox and

Hoffman (1997) and Skovholt (2012), novice therapists embrace expressions of appreciation from clients and treasure indications of improvement in their client's presenting problem/s, for example improvements in depression and anxiety. However, when these expressions and so called improvements are not present, the novice therapist may begin to doubt their ability and success as a trainee therapist (Skovholt, 2012).

Gold (2005) and Skovholt (2012) discuss the significance of doing emotional work with clients as a novice therapist. Although this type of work is rewarding and gives meaning to the profession, novice therapists often express anxiety related to the emotional labour involved in the mental health field. The anxiety comes in to play because the novice therapist is now in the role of a professional occupying the professional space in the therapy room. The challenge is striking a balance between taking in too much or too little of the client's affect (Gold, 2005; Skovholt, 2012). Combined with this anxiety is that of feeling helpless, which can arise in situations where the novice therapist feels unsure of what to do, for example with suicidal clients or those who have experienced a trauma. Sometimes help is available when it is needed but at times it is not. This is what causes the novice therapist anxiety- the unpredictability of sessions and whether or not help will be available when the need arises (Gold, 2005; Skovholt, 2012).

1.10.3 Skovholt's Emphasis on Self-Care

Skovholt (2012) expands his argument on anxiety further by stating that coping with novice anxieties is an important element of self-care, which is essential while attempting to care for others. Skovholt (2012) argue that self-care facilitates an ability to continue making professional attachments regardless of the emotional intensity involved and to do so repeatedly while preventing burnout and developing resiliency. According to Skovholt (2012), "In the

caring professions…ourselves are our central professional instrument. We must preserve the self in order to use it for the other" (p115). Self-care serves as personal inoculation against secondary consequences of the helping profession, such as STS, counter transference (CF) and burnout (Shapiro, Brown & Biegel, 2007; Skovholt, 2012). Ronnestad and Skovholt (2012) and Skovholt (2012) outline that self-care is an essential feature in becoming a resilient mental health practitioner because of the intensity of emotional involvement in this profession. Novice therapists often struggle with the notion of self-care because they believe that a focus on self is selfish (Barnett, Baker, Elman & Schoener, 2007; Shapiro, Brown & Biegel, 2007). However, Skovholt (2012) indicates that other professions realize the need to care for their instruments- the woodcutter's axe, the opera singer's voice, and the eyes of the photographer- so why not us as mental health professionals? In order to become resilient practitioners, the novice therapist must learn to lose their innocence about the need for self-care (Barnett, Baker, Elman & Schoener, 2007; Shapiro, Brown & Biegel, 2007; Skovholt, 2012).

1.10.4 Constructivist Self-Development Theory

An important theoretical framework that complements Skovholt's development model and assists in the understanding of Vicarious Traumatization is the Constructivist Self-Development Theory (Collins & Long, 2003). If one has a sound understanding of CSDT then they may be better equipped to identify the symptoms and presentation of VT (Helm, 2010). According to Helm (2010), CSDT outlines how exposure to traumatic material impacts on the therapist's sense of self. It also emphasizes how people construct their realities through cognitive schemes and perceptions which help them to make sense of their surrounding world and experiences (Collings & Long, 2003). This theory can be understood as a combination of psychoanalytic and cognitive theories (Adams, Matto & Harrington, 2001; and Collins & Long, 2003). According to CSDT, a change in these cognitive schemes and perceptions is caused by

interactions between the clients' personal stories and the counsellor's personal characteristics (Saakvitne & Pearlman, 1996 as cited in Trippany, Kress & Wilcoxon, 2004). In the context of therapeutic work, a therapist attempts to cope with traumatic content based on their present circumstances and their early life experiences including intrapsychic, family, cultural, interpersonal, and social experiences (Saakvitne & Pearlman, 1996; Helm, 2010).

Through the lens of this theoretical framework, symptoms that result from exposure to traumatic cases are seen as adaptations to those events (Helm, 2010). When the therapist is exposed to an event- the trauma content of their client- that is incongruent with their perceptions of reality, they begin to adopt irrational beliefs to protect their meaning system from the harm caused by that indirect trauma experience (Helm, 2010). The symptoms of VT experienced by the therapist are thus adaptive responses to hearing the trauma content of their clients (Helm, 2010). Trippany, Cress and Wilcoxon (2004) and Helm (2010) further describe how the changes in the therapist's cognitive schemata are adaptive but are also pervasive and cumulative. They are pervasive because there is the potential for a ripple effect in to all aspects of the therapist's life, and they are cumulative because each therapeutic experience with trauma content can reinforce these beliefs and schemata (Helm, 2010).

CSDT theory further highlights how there are five components of the self: 1) frame of reference; 2) self-capacities; 3) ego resources; 4) psychological needs; and 5) cognitive schemes, memory and perception. These components all reflect areas in which the trainee and professional psychologist may experience distorted beliefs and where VT responses may occur (Pearlman & Saakvitne, 1995). CSDT states that any disruptions in one's frame of reference (the way an individual relates to the world and makes meaning) can be disorientating for the counsellor which has a reciprocal adverse effect on the therapeutic alliance. If counsellors

experience disruptions in their 'self-capacities' they often lose their identity, they have difficulties in their interpersonal relationships, and they find it difficult to control negative emotions, all of which has negative bearing on how the counsellor serves the traumatized client (Trippany, Kress & Wilcoxon, 2004). The third component of self that is outlined by the CSDT is ego resources which refers to personal resources that allow a person to perceive consequences, set boundaries and protect themselves. Disruptions to ego resources may lead to an inability to engage empathically when dealing with clients, especially in the case of traumatized clients (Trippany, Kress & Wilcoxon, 2004).

The fourth component (psychological needs) and the fifth component (cognitive schemes) address the different needs highlighted by Maslow's Hierarchy- a pyramid outlining different levels of physical, emotional, and psychological needs starting with basic needs for survival and progressing to higher order, more complex needs (Huitt, 2004). The first is 'safety needs' which is negatively impacted on when counsellors are experiencing VT as they will experience fearfulness, vulnerability and excessive concern for themselves and significant others (Pearlman, 1995 as cited in Trippany, Kress & Wilcoxon, 2004). Trust needs are the second set of psychological needs outlined by the CSDT. These needs, referring to an ability to trust oneself and others, place counsellors at a greater risk for experiencing VT because the counsellor begins to experience changes in their trust towards others and may be overly suspicious of particular groups. They may also lose confidence in their ability to accurately judge and intervene with their clients (Trippany, Kress & Wilcoxon, 2004), thus showing the interactive effect of VT on the professional and personal lives of mental health practitioners. Esteem needs and intimacy needs are also affected by a counsellor's experience of VT. With regards to esteem, the counsellor begins to feel inadequate and thus continuously questions their worth. When it comes to intimacy needs, a counsellor suffering from VT may withdraw

completely in their interpersonal relationships or they may take the other extreme whereby they become excessively dependent on others because they feel empty when alone (Pearlman, 1995 as cited in Trippany, Kress & Wilcoxon, 2004). Finally, control needs are related to self-management. When a counsellor suffers from VT, they feel as if they lack control which can either lead to helplessness or over control in other areas (Trippany, Kress & Wilcoxon, 2004). Another important element to consider is memory. As the client recounts their traumatic experience/s during therapy, it becomes fragmented in the counsellor's memory which may lead to the counsellor experiencing intrusive flashbacks of the client's descriptions of their traumatic memories (Trippany, Kress & Wilcoxon, 2004).

1.11 Conclusion

Much of the literature highlights what VT is, the effects it has on mental health professionals, and various means of prevention and/or intervention to cope with VT. According to Devilly, Wright and Varker (2009), VT can be understood as the "cumulative transformative effect upon the trauma therapist of working with survivors of traumatic life events" (p374). The literature has also highlighted the importance of educational programmes for postgraduate students who will be exposed to trauma work during their training and the various anxieties that the novice therapist may experience during their training. However, there seems to be a significant gap with regards to the attitudes and perceptions of trainee psychologists towards VT, STS, CF, and burnout. Research in to these attitudes and perceptions could potentially indicate whether trainee psychologists are aware of these phenomena and their effects, and whether or not they feel they are at risk for experiencing these phenomena. The above literature indicates the pressing need for more education of VT for trainee psychologists, and research in this area should incorporate an explorative component of student psychologists' attitudes, beliefs and perceptions that inform their experience of VT.

CHAPTER TWO

2 METHODOLOGY

2.1 Exploratory Research

Exploratory research is an inductive approach adopted when a phenomenon needs to be explored more because little is known about it or it may be a new area of research (Stebbins, 2001). This research is inductive in that it will attempt to develop a way of understanding the M1 psychology students' attitudes and perceptions of vicarious trauma. There is very little research that exists on trainees' attitudes and perceptions of vicarious trauma, hence this research is exploratory in nature. Furthermore, this research attempts to explore possible interventions for M1 psychology students, based on trainees' needs, which can be implemented at an educational level in order to protect them from potentially experiencing vicarious trauma. These needs include self-care, supervision, educational and practical workshops, and increased exposure during clinical work. Exploratory research aims to provide insight into a phenomenon, therefore it is flexible, open-ended and inductive (Stebbins, 2001).

2.2 Respondents

The target population for the research study were students involved in a professional Masters Psychology programme. A sample of clinical and counselling psychology Masters students from the University of KwaZulu-Natal (UKZN) were approached to participate in the research. This sample was representative of the target population as these trainees were registered with the Health Professions Council of South Africa (HPCSA, 2011) as student psychologists in a professional training programme. The students encountered clients in a therapeutic setting from at least March 2015, which is two months after starting their training. In order to successfully complete their training programme the student psychologists had to complete a minimum of

25 hours of clinical work during the year, they had to attend weekly practical placements in either a hospital or school/counselling setting, as well as attending the daily seminars and completing the academic work required. All of the students were in the same cohort. Collectively, the students who participated in the study encountered a number of therapeutic responsibilities and training workloads. This provided a space to account for novice anxiety and academic workload factors when interpreting the emergent themes from the interviews relating to attitudes/beliefs, perceptions and experiences of VT.

The study was specifically interested in the attitudes/beliefs and perceptions that trainee psychologists held of VT. Non-probability sampling was employed in the form of purposive and convenience sampling. The sample of this study comprised of six research participants. According to Crouch and McKenzie (2006), research based on interviews requires the researcher to be deeply involved within the field in order to establish close connections to the participants and to address the research problem in as much detail and depth as is possible. A small sample size thus allows the researcher to enhance the validity of in-depth inquiry (Crouch & McKenzie, 2006). Drawing on the work of Baker and Edwards (2012), they describe how qualitative research studies smaller samples for the purpose of in-depth exploration into the participants and their settings to gain a subjective understanding of how and why those participants "perceive, reflect, role-take, interpret, and interact" (p8). Both quantitative and qualitative research allows for generalizations and both research approaches are valuable (Baker & Edwards, 2012).

The sample was selected according to inclusion criteria rather than exclusion criteria. The inclusion criteria included:

- Registered M1 students at UKZN
- Clinical and/or counselling M1 students
- Registered as 'student psychologist' with the HPCSA

- Exposure to practical clinical/counselling work

Gender diversity of the sample was limited by the demographics of the students who were registered for the Masters programme. The M1 class comprised of only female students, resulting in a female-only sample. However, the sample was racially and ethnically diverse.

2.3 Demographics

A total of six participants were interviewed to explore their experience of the clinical/counselling psychology Masters programme at UKZN Howard College Campus with regard to preparation, awareness, and exposure to the secondary consequences involved with being a helping professional. The average age of the participants was 31 years, all of which were female. Three of the participants were white, two participants were black, and one participant was Indian. Three of the participants had majored in counselling psychology and the remaining three participants majored in clinical psychology. All six of the participants had completed their M1 studies at the time of the interviews. Four of the participants were interviewed during the vacation period prior to commencing their internship, whereas two of the participants were interviewed during the first month of their internship.

2.4 Table Summarizing Demographic Details of Participants

Respondent	Sex	Age	Race
1	Female	42	White
2	Female	35	White
3	Female	30	Black
4	Female	25	Black
5	Female	28	White
6	Female	32	Indian

2.5 Research Method

The research was conducted using a qualitative method and followed the approach of thematic analysis. Semi-structured interviews were conducted with a sample of trainee psychologists at the University of KwaZulu-Natal (UKZN) Howard College Campus. The thematic analysis (Braun & Clarke, 2006) approach was used to analyze the interviews. Trainee psychologists were therefore approached to participate in one 45-minute interview each in a clinical duty room located on the UKZN Howard College Campus.

The research study recognised that qualitative research is not an objective process (Morrow, 2005). It attempts to analyse themes that emerge from trainee psychologists' responses about VT. This approach does not seek to offer objective and factual accounts but rather offers an interpretation of the themes that emerge with regards to attitudes/beliefs, perceptions and experiences of trainee psychologists towards VT. The study further accounted for the researcher's role and influence in the process of interpreting results about trainees' attitudes/beliefs and perceptions of VT. This was done through a personal reflection section found in chapter six. The researcher upheld the responsibility to remain reflexive during the research process and to check interpretations with participants to ensure validity and accuracy (Morrow, 2005).

2.6 Semi-structured Interviews

The data was gathered through the use of semi-structured interviews. An open-ended interview guide was used during the interviews (See Appendix I). This interview guide had been developed in an open-ended manner in order to generate rich detail for analysis and interpretation.

Participants were fully informed of the research process in order for them to understand fully what procedures are involved, before the onset of data collection and were only interviewed once informed consent was obtained (See Appendix II). Participants were interviewed once and the interviews lasted approximately forty-five minutes. After data collection was completed, participants were contacted for further clarification and verification of the data during the thematic analysis phase as a part of member checking.

2.7 Procedure

Before ethical clearance could be obtained from the Research Ethics Committee of the University of KwaZulu-Natal, permission had to be granted by the registrar of the university to conduct the study. Permission also had to be obtained from the course co-ordinator to approach the masters' students and conduct the study within one of the counselling rooms. Once ethical clearance was granted, students were approached after their final M1 exams were completed so as not to interfere with their academic schedule.

For the process of data collection, requests for participation in the research study were sent out to registered M1 students. When students were approached, they were handed an informed consent letter (Appendix B). The informed consent letter indicated the purpose of the research study, the procedures involved, how long it would take to complete the interview, researcher contact information, and the means to ensure anonymity and confidentiality. After obtaining informed consent, interviews were then scheduled with participants and they were informed of when the interview would take place, whether it would be audio/video recorded, and that transcription would follow after data collection was complete. During the interviews they were asked to focus on their experiences thus far working as a trainee psychologist and to use this experience to assist them in drawing on their attitudes/beliefs and perceptions of VT.

2.8 Data Analytic Procedure

The thematic analysis approach that was adopted allowed for the researcher to identify, analyze and report themes (Braun & Clarke, 2006) related to trainee psychologists' attitudes/beliefs, perceptions and experiences of vicarious trauma across the participants. The analytic procedure identified key themes that emerged around awareness, attitudes/perceptions, perceived risk/susceptibility, and knowledge of intervention/management methods. Other findings using the analytic procedure included identifying the resources and coping mechanisms of trainee psychologists to assist them in managing and/or intervening in VT and their awareness of interventions and preventative methods to treat and/or protect themselves from the effects of VT.

The interview transcripts were analyzed and interpreted using Thematic Analysis as outlined by Braun and Clarke (2006). Thematic Analysis involved six phases: (1) Becoming familiar with the data; (2) Generating initial codes; (3) Searching for themes; (4) Reviewing themes; (5) Defining and naming themes; and (6) Producing the report (Braun & Clarke, 2006). Thematic Analysis has both benefits and limitations. The benefits of this analytic method are that it is suited to large data sets, it is good for team research, interpretation is supported by data, and it can be used to study topics other than individual experience. It has specific steps in order to establish and reinforce rigor of the results. A limitation of this approach is that it may miss some of the more nuanced data (Guest, MacQueen & Namey, 2011).

The researcher became familiar with the data during the interview transcription process which allowed the researcher to create codes and search for themes (Braun & Clarke, 2006). The researcher then reviewed the themes and employed a process of participant checking to ensure rigor and accuracy of the identified themes (Morrow, 2005). Once the themes were considered reliable and an accurate reflection of research participant's experiences, the themes were

compiled in to a report that sought to answer the research question of what attitudes/beliefs and perceptions trainee psychologists hold of VT. During this write-up, the transcripts were analyzed using the coded framework (See Appendix III) and once each transcript had been analyzed according to the framework, comparisons could then be made across the cases to look for similarities and differences in themes and participant responses.

2.9 Ethical Considerations

Regarding ethics, prior to commencing each interview, participants were presented with an informed consent form explaining the nature and purpose of the study and that participation was entirely voluntary. They were informed that their identity would not be disclosed, only their demographic information was required. Thus, anonymity was maintained. The interviews were audio recorded, thus only their first names were used in some recordings. Confidentiality was also maintained throughout the research process.

2.10 Issues of Validity and Trustworthiness

Validity in qualitative research speaks to the authenticity of the research and is upheld by giving truthful, undistorted accounts of the participants' opinions and responses. By consistently referring to the data during the analytic phase, validity was maintained (Neuman, 2006). Trustworthiness of the data was maintained through member checking and personal reflection, which was later included in a separate chapter within this dissertation (See chapter 5). Reliability in qualitative research refers to the accuracy of the research. Therefore, consistent and accurate data collection and an accurate transcription process is important (Neuman, 2006).

CHAPTER THREE: THEMES AND SUBTHEMES

Findings consisted of identifying four primary themes and various sub-themes across the six transcripts. When analysing the data, it became clear that there were patterns of similarity across the participants with regard to the attitudes and perceptions of vicarious trauma. These four key themes and sub-themes provided insight into the participants' understandings of vicarious trauma, its symptoms, the consequences thereof, and the importance of an intervention at an educational and training level. These themes also allowed the researcher to conceptualise vicarious trauma, from the trainee's point of view, as a 'mental illness' that is very real and requires much more attention than it currently receives. Each theme and sub-theme will be addressed individually.

3.1 Summary of themes and subthemes

A summary of the themes and subthemes arising from the data is presented in the diagram below. For a more detailed look at the coding framework, see Appendix III. Results are discussed under their major themes and subthemes.

Diagram showing the main themes with associated subthemes:

THEME 1: EXPERIENCE OF THE MASTERS PROFESSIONAL TRAINING

- Secondary consequences of the helping profession
- Emotional challenges
- Coping mechanisms
- Self-care workshop
- Trauma workshop

THEME 2: ATTITUDES AND PERCEPTIONS OF THE SECONDARY CONSEQUENCES OF THE HELPING PROFESSION

- Difficulties distinguishing VT from trainee anxiety
- Personal risk for experiencing VT
- Factors increasing risk for VT
- How to cope with the secondary effects of the helping profession
- Protective factors

THEME 3: KNOWLEDGE OF THE SECONDARY CONSEQUENCES OF THE HELPING PROFESSION

- Understanding/Definition of VT
- Symptoms of VT
- Consequences of VT
- How VT is a problem for the novice trainee

THEME 4: AWARENESS AND PREPARATION DURING TRAINING

- Exposure/Education on the potential risks when working in this field
- Concept of VT raised during studies
- Discussion during supervision
- Ideas to improve the exposure to/education of VT in training programmes

3.2 Theme 1: Experience of the Masters Professional Training

3.2.1 Subtheme 1: Secondary Consequences of the Helping Profession

Overall, the participants indicated that one of the prominent secondary consequences of the helping profession is feeling overwhelmed and anxious. This was a general perception of counselling work and working in the field of mental health, not specifically related to VT. One participant highlighted a positive consequence of the helping profession which she felt was an increase in knowledge. However, the general perception of the helping profession based on

participants' responses is that it can have negative consequences which some participants felt could impact on their ability to remain professional. One participant felt so overwhelmed by being a helping professional that she was unable to engage in effective coping mechanisms. The following quotes encapsulate the participants' description of the secondary consequences of the helping profession:

> *"So it was quite overwhelming and I really had to back off and process my own thoughts"* **(Respondent 1)**

> *"The positives are a lot of knowledge and practical work which is something that most of us lacked before. Um, and the negatives for me would be mostly fatigue as the year goes by. Um, early in the year you feel quite active and eager, you want to learn as much and engage as much as possible and then by the time the end of the year goes by, you are so tired and overwhelmed"* **(Respondent 3)**

3.2.2 Subtheme 2: Emotional Challenges

The participants' responses indicate that they faced significant emotional challenges during the M1 year, and those challenges were different for each respondent. For one participant, she found it particularly difficult to balance having a family with the amount of work in the Masters programme:

> *"Um, emotionally, I think for me it would have been a bit different because I have a family. So it was the added impact of seeing clients and then going home to see to the kids. So I think it was a different experience I had compared to everything else. So I think what happened is even the tiniest of things took on a*

different level emotionally….The whole year for me was the academic and family balance and getting stuff done on time" **(Respondent 6).**

For the other participants the emotional challenges included a lack of support, doubting their abilities, difficulties learning to separate from the content of therapy sessions, and making the transition from a student who is learning about theories to becoming a novice therapist practicing that knowledge.

"It's moving from a theoretical framework to a practical and experiential framework so it's juggling that with previous experience of having done debriefing but in a very different context and a different manner. So ya, it's about becoming a professional and taking all that on with the anxiety of becoming a trainee psychologist" **(Respondent 5).**

3.2.3 Subtheme 3: Coping Mechanisms

Based on the responses, many participants felt that an important coping mechanism is being able to compartmentalize and separate from the clinical setting in order to not become overwhelmed by the content of therapy sessions. The following quote emphasizes the importance of healthy distancing for the participants:

"For me it's a mind-set, it's a mind-set about I'm here to help them so I can't go down with them. I have to maintain a stable ground." **(Respondent 1)**

Supervision and discussion with fellow classmates assisted most participants in coping with the emotional challenges during the M1 year, as indicated by the following participants:

"…prepare for the next session as much as I could, by watching the video and making thorough notes, checking in the DSM, really brushing up on all the

things I thought were potentially diagnostic issues. Reading through the framework….So lots of preparation. And open discussion with my supervisor which was very helpful." **(Respondent 2)**

"...As well as, I used to speak a lot to my husband, to friends, to colleagues. My colleagues used to help me through it and one of my colleagues was a mom as well so I used to speak to her and we found shared emotions between us and she used to say "I know how you are feeling". And just that understanding and knowing we are going to get through this and we are going to do it". **(Respondent 6)**

Others made use of exercise, journaling, or social support as coping mechanisms.

*"I journal. I write. I pride myself in being a narrative (laughs). I keep a journal that I've had throughout the year and I do a little bit of writing on the side. I do poetry and I do, um, at the moment I'm currently writing a book for my baby so I do all that stuff to offload and channel those emotions that I can't offload with anyone else."***(Respondent 3)**

3.2.4 Subtheme 4: Self-Care Workshop

Respondents commonly reported that the self-care workshop provided in their training created an awareness for the importance of incorporating self-care in to one's novice therapist journey. For this participant in particular, it stood out as one of the most important aspects during the masters training because it is linked to making the correct choices for a healthy work-life balance and learning to discriminate priorities:

"I think that lecture stood out to me as the most important lecture from the entire year. And I was really stressed out by that point and just working flat out…I was on a path that was definitely going to lead to burnout. And that really made me aware of having a balance and having to make choices. Letting some of the things go that I would have liked to have done but didn't have the time to but choosing some pivotal things that were necessary to have a balance." **(Respondent 2)**

However, most of the participants felt that the workshop should not have been once off but rather an ongoing forum throughout the program, as expressed by the following quote:

"…well self-care is meant to be one of the biggest parts of the training that we should have. It shouldn't be once off; it shouldn't have been just in the beginning and that's it. And I thought it was poorly presented. I didn't feel like I got the skills and the tools to use throughout the year to maintain self-care. Of course it was emphasized that we need to take time off for ourselves throughout the year so we don't burn out. But strategies and techniques? There was none of that." **(Respondent 3)**

One of the participants expressed that, although the workshop was brief, it highlighted important aspects that helping professionals need to be aware of, especially when working with trauma. Self-care was easier for this participant during the Masters year, and has become more important to her since commencing the internship:

"We had a brief workshop on self-care which highlighted some of the aspects of secondary trauma, um, what to look out for and what to be cautious about…So from that workshop I must say that now having started my internship I found it more relevant than when I was in my M1. I find at an M1 level I had

a lot of time to myself so even if I wasn't focusing specifically on self-care it was there and I was able to do things that would fall under the domain of self-care." **(Respondent 5)**

3.2.5 Subtheme 5: Trauma Workshop

There were a range of responses from the participants regarding the trauma workshop, such as the impact that trauma work can have on helping professionals and how, to some extent, it is normal to be affected by trauma work; and the approaches one can take when working with trauma.

> *"I think (pauses) that you can be affected by it, and that certain reactions are normal. You aren't a block of ice…That it's ok to feel that way, and allow yourself to feel that way. Because there's a balance between feeling nothing and feeling something. Um, and from the workshop I kind of got that you will be affected."* **(Respondent 1)**

One participant described the benefits of the workshop that she gained, but how it was a brief discussion on a vast area that helping professionals are likely to experience and work with:

> *"It's not an area I was familiar with so it was really helpful to get some insight and learn that there are different approaches you can use. You can pick one and it has its own ways of dealing with trauma, which was very useful because I didn't even know that existed. And I think the practical role play that was done was really helpful to just show the extent that you can experience a client, or how a client can present… I would have liked more opportunity to do more stuff on it, maybe more role plays or to watch some dvds or something. It seemed like*

such a short snippet in a huge area and is something we are very likely to encounter." **(Respondent 2)**

The following quote captures how one respondent felt that the workshop left her feeling scared and anxious because of the awareness it created for the rawness of trauma. She describes feeling worried for the internship because the workshop and M1 are an overview, but she felt she still needed the 'know how' for working with trauma cases:

*"When we did the workshop it was a proper trauma scenario. And it was scary because it was so real in a way… It was very eye opening in the sense that people go through things which are real and heavy…I'm actually very worried about next year in general. I feel like M1 is an overview and there is no meat to anything. I'm very nervous for next year…Yes I did learn how to contain it in that scenario but where do I go from there? So I'm anxious for next year."***(Respondent 4)**

3.3 Theme 2: Attitudes/Perceptions of the Secondary Consequences of the Helping Profession

3.3.1 Subtheme 1: Difficulties Distinguishing VT from Trainee Anxiety

The majority of responses given by the participants encapsulate how they feel it is difficult to differentiate between VT and other forms of trainee anxiety due to 'blurred lines'. The following quote illustrates how a general feeling of being overwhelmed can get in the way of separating VT responses from novice trainee anxiety. The participant describes how a lack of 'know how' can cause anxiety, as well as difficulties separating academic and practical stress. She takes this argument further by describing how both forms of anxiety reinforce the other. These descriptions offered by the participant are useful in explaining why and how feeling overwhelmed is related to blurred lines- lacking knowledge and awareness of the secondary

responses to trauma material makes it difficult for trainees to draw a line between the forms of trainee stress and potential secondary responses, thus blurring the two together:

> *"Gosh I don't know, it's quite difficult to distinguish because this year has been very stressful. You are worried about performing academically, you're seeing clients, and you're trying to get your research organized so there's a lot of stress. And it's quite difficult to distinguish between that and the stress you are experiencing with your clients and I can only presume that the two would exacerbate each other… So I don't know, and I guess possibly the way of finding out would be through your own therapy or supervision and spending time unpacking it but not much time is given to unpacking it. I know I never unpacked it at all with my supervisor so I think that's a way that could help to identify it…Because sometimes you are on a steam roll where you are busy and stressed and think "this is my life, I'm doing it" but not actually thinking "Am I experiencing any trauma from my clients?""* **(Respondent 2)**

The next participant's response substantiates the previous response, as she reports a similar difficulty with differentiating the two concepts. Here however, she highlights the lack of knowledge of the two concepts as well as poor self-awareness which contributes to the difficulty with separating VT responses from trainee anxiety:

> *"Mmm, oh wow, that is definitely a challenge, especially with us starting off. Sometimes we aren't aware of our own blind spots and that can be an issue as well. So if you know what your anxiety is coming from, then you can identify your anxieties which will be different to burnout or fatigue or secondary trauma. So one is knowledge. Two is knowing ourselves and your blind spots. Knowing*

what you can take and how much of it you can take with trauma cases." **(Respondent 3)**

This is supported by the response of participant 5, who gives further mention to the blurred lines between VT and trainee anxiety:

> *"I think it's purely a lack of knowledge…I think we aren't trained well enough in it. I mean, you hear people speaking about it but so many people still don't know and it's something that affects everyone in the helping profession, nurses, doctors, not only psychologists…I do think at an M1 level, they are kind of blurred. You know, taking something home because you think you haven't done the right thing or taking it home because it's affected you. So I think there's a blurring of the lines in that respect."* **(Respondent 5)**

Similar observations were also made and linked to inexperience through this next quote offered by another participant:

> *"I think because trainee anxiety can be overwhelming as well and… it kind of overlaps so…you have already your trainee anxiety and then you have someone telling you what they've experienced. I think it's difficult. The lines become blurred…I think it would be difficult because you don't know if it's your own anxieties and your own inexperience as a helping professional or am I in a situation of vicarious trauma?"* **(Respondent 6)**

This section/subtheme thus reinforces the importance and value of more education, awareness and training on VT and other secondary responses so that trainees are better able to distinguish their novice anxieties from possible secondary responses.

3.3.2 Subtheme 2: Personal Risk for Experiencing VT

All of the responses provided by the six participants indicate that they felt it is a possibility to personally experience VT. The following respondent describes how she felt it is impossible not to experience some form of VT given the nature of crime in South Africa and the work load she will have to deal with when working as an intern:

> *"Number one- we are in South Africa. There is a lot of violence and crime here so we will be faced with it through our clients. We are in an environment where we may have to go see people who have just come out of a horrific situation. So I don't see how any of us can be immune to experiencing some kind of trauma and on top of that the work load… And you will have all this stuff that will go home with you and fester. So I feel like we will experience some kind of VT."*
>
> **(Respondent 4)**

For the third participant, she felt that a lack of awareness of VT increases the likelihood of one's personal experience of it. This particular participant expressed how she felt that the practical side of the internship will facilitate greater self-awareness and thus decrease the chances of her personally experiencing VT. This suggests that the academics in M1 might get in the way of protecting oneself from VT due to the lack of awareness and education during the programme:

> *"Um, I think we are if we are not aware of it. I think now we are going in to the practical side and with practical stuff you are more inclined to be able to identify it. Whereas here we are so busy with academics so we aren't sure whether it's the academics or the client I'm seeing…I think going in to practical stuff and exposure, we will be more aware of our feelings when working with certain clients and those kind of responses. So if we notice stuff like that then*

we are less likely to actually experience it but if you aren't aware of it then we can fall in to the trap of it." **(Respondent 3)**

Another participant's response was similar to the above, whereby she felt that having knowledge of VT does not entirely protect one from it, but this knowledge can increase awareness of the symptoms involved with VT and therefore make it possible to deal with it effectively.

"I think everyone has a risk of taking on VT. I don't think having knowledge of what it is protects you from suffering from it…I think there will be several cases that will lead to me experiencing some kind of VT. It might not be as severe as it could be but I think at least being aware of what it is will at least make you aware of what you are experiencing and the symptoms. It will make you that much more able to stopping and dealing with it instead of letting it go by because you don't know what it is." **(Respondent 5)**

3.3.3 Subtheme 3: Factors Increasing the Risk for VT

Across the responses, it is clear the participants felt that an unresolved personal trauma history (on the part of the therapist) was a significant risk factor for VT when working with trauma cases. This is could be due to the possibility of the client's trauma 're-igniting' trauma symptoms within the therapist. A second significant risk factor commonly emphasized by the participants was case load and the lack of social support. A third significant risk factor described by the participants was the lack of reflection regarding the effect of sessions. The following quotes encapsulate the significance of these risk factors for the participants:

"*Maybe case load, but in terms of getting the type of clients that have trauma histories. I know in clinical settings it has to go quite fast with answering certain questions and getting important information, which can sometimes lose the*

person and you can lose yourself in it because you don't have time to reflect on how you are feeling and how you are reacting to the client. So I'd say those would be risk factors. I'd say case load within the setting, lack of awareness, and maybe even space for you to reflect. Even if it's just 10 minutes to digest that client before you start with the next client. So not having that, I would say is a risk factor." **(Respondent 3)**

"If you haven't dealt with it (your personal trauma history)*, then I feel like it will impact you. But if you have dealt with it and you can notice when it* (personal trauma symptoms) *starts to come out in your responses, then you can deal with it. Then you will be fine. But there are a lot of people in South Africa who haven't dealt with their trauma and brush it off but don't work it through. And sometimes your trauma can affect how you perceive others with the same type of trauma so you might pass judgement on them. As a psychologist you need to deal with your trauma."* **(Respondent 4).**

The above quote in particular reflects how the participants felt that a personal trauma history does not necessarily equal a risk factor for VT responses. This participant was alluding to the idea that possessing a trauma history as a trainee or professional psychologist can be beneficial if it has been processed. However, if it has not been worked through, it may result in VT responses as a result of engaging with clients' trauma content.

Some of the participants felt that personal stressors, the stress and anxiety of M1, a lack of self-care, and lack of support were also risk factors that could contribute to the risk of experiencing VT, as indicated by the following quote by a participant describing the importance of self-care and a supportive system:

"…And I think some people who have less chances of self-care. That's a risk factor as well because it's important. So if you are already emotionally drained, you've come in to M1 and internship being emotionally drained, you are kind of vulnerable to then experiencing VT because you're in that situation where you're already at that point and something small can tip you over the edge and result in vicarious trauma. Um, ya, and a supportive system as well. You are seeing trauma cases every day and it's traumatic and if you don't have a supportive person or supportive environment, it's very possible you can experience vicarious trauma." **(Respondent 6).**

The following quote from a respondent reflects how she felt personal stressors, such as family difficulties or financial strain for example, can make a novice trainee therapist more vulnerable, and thus less able to cope with the nature of the work:

"…So there are lots of things that could cause you personal stress. You know, um, relationship difficulties, a death in the family, those things probably make you vulnerable emotionally which would make you less able to deal with the trauma in an effective way." **(Respondent 2)**

3.3.4 Subtheme 4: Coping with the Secondary Effects of the Helping Profession

All of the participants mentioned the value of personal therapy as a helpful means to cope with the effects of being a helping professional. Furthermore, the participants all described the use of debriefing in some way, whether it be through supervisors or work colleagues, in order to cope with the effects of the helping profession.

"So what I would do is debrief, speak to colleagues about the case. If it gets too much where I'm feeling very overwhelmed, um, and the other things aren't

helping then I would go further and speak to the supervisor and tell them that I'm feeling overwhelmed, the trauma cases are affecting me too much and my quality has dropped, I don't feel like I can connect anymore. And I would ask if I can just take a few cases a day until I get back." **(Respondent 6)**

"Definitely debrief. I think it's one of the most important things you can do and it all comes down to being able to process what you've heard, what you're coping with or not coping with, having that space where you can talk to someone whether it be formal supervision or informal debriefing with your colleagues. There's nothing more beneficial than that and for me personally it will be the way I deal with anything that I am struggling with… and also personal therapy for a more long-term plan. Debriefing is great on a daily basis but I think personal therapy may help as well and be a greater source of protection. Just so you can become more aware of yourself and anything that is a particular trigger for you. Then you can learn what may or may not set you off and what you may struggle with." **(Respondent 5)**

One respondent described using the therapeutic space as a means of debriefing and processing with the client so that both are learning to cope with their own responses to the client's trauma content:

"I'd say…hmmm…once you've recognized then either reflect on them yourself or reflect on them as you're feeling them through the session. I know we get taught that we don't burden our clients with our own issues but you don't have to do it in a way that burdens the client but when you are reflecting with the client on their issue and you are allowing yourself the space to reflect on yours

and understand yours as well, then it would also be a way of coping." **(Respondent 3)**

The same respondent proceeded to describe the possible value in focus groups as a means of formal peer support, especially during the M1 year:

"Share your anxieties with your colleagues. I was thinking of starting a group with interns and their working environments and doing routine focus groups where you meet and discuss your anxieties." **(Respondent 3)**

3.3.5 Subtheme 5: Protective Factors

The majority of participant responses expressed how previous experience and/or building up experience will serve as a protective factor against vicarious trauma. The following quote reflects this idea. The participant is describing how, with experience, it may become easier to learn to disconnect from work and leave it behind at the end of the day:

"Trauma is a very challenging thing to work with…There are a variety of different ways that you can take it on but…you need to be able to…separate yourself from those stories otherwise you can take them home and it can be something that sits with you and runs through your mind. It does interfere with your functioning. So it's an important skill to master and I think it comes with experience." **(Respondent 5)**

The following quote reflects that the respondent did not feel as overwhelmed as her colleagues because of her previous experience doing telephone counselling. This supports the idea reflected by the quote above- that experience may serve as a protective factor:

"For me personally I didn't find it as overwhelming as I thought I would because I have had experience before. And I've had face to face counselling and I've had, um, uh, counselling women who were abused in their past and the after effects of the abuse later so I've counselled them. So for me it wasn't so overwhelming." **(Respondent 6)**

Other protective factors that the participants described included personal therapy, self-care, debriefing/reflection, and drawing on support systems.

"I would suggest maybe seeing someone separately. It would be a good protective factor… and maybe even space for you to reflect." **(Respondent 3)**

"And also to just accept that you need someone to be your psychologist. We all need it." **(Respondent 4)**

One participant explains the role of a personal trauma history and how it can be a protective factor if it has been worked through and processed:

"Personal trauma history can be hugely beneficial if you've worked through it because you can then truly empathize with someone. You can really say that you've been there and know what they are feeling. It gives you a deeper way of connecting with that person. But if it isn't resolved there is a possibility that it might make cases difficult to deal with." **(Respondent 6)**

3.4 Theme 3: Knowledge of the Secondary Consequences of the Helping Profession

3.4.1 Subtheme 1: Understanding/Definition of Vicarious Trauma

When the participants were asked to define vicarious trauma, most of them had difficulty putting words to the definition without using the terms secondary trauma/traumatisation,

fatigue, and emotional burnout. This captured the difficulty most people may have conceptualising VT. The following quotes reflect specific difficulties with conceptualisation, such as associating VT with PTSD, struggling to find the words to describe VT without using other secondary responses as a description, and describing VT as a combination of other secondary responses:

> *"It's very difficult to differentiate. So VT is…It's trauma…So all the PTSD symptoms, um, but its secondary. It's not direct, it's not um, its being affected and having trauma symptoms but…through another person."* **(Respondent 1)**

> *"Um. Wow. I'm trying to think of a way to say it without using secondary trauma in the definition…I'm not sure how I'd define it but I think that constant fatigue. I actually don't have a definition…I'd say burnout to the point where, firstly you are constantly, um, re-traumatized. So constantly experiencing one event and eventually getting to a point where you have burned out and fatigued and are unaware of how that is affecting you."* **(Respondent 3)**

> *"I would define VT as being the effects of hearing other people's traumatic material and taking it on as your own. So not processing it but going home and having flashbacks, having thoughts running through your mind, experiencing symptoms of burnout, health related issues as well. Um, fatigue, so definitely the health side of it but again just hearing people's traumatic material and taking it on as your own. So almost secondary traumatisation. So not having experienced the trauma yourself but becoming traumatized through hearing other people's stuff."* **(Respondent 5)**

3.4.2 Subtheme 2: Symptoms of Vicarious Trauma

One respondent described how she would use reflection to help her understand how she is feeling about therapy sessions with particular clients, and how reflection would indicate whether or not she is starting to develop symptoms of VT. It would appear that the value of reflection lies in its relationship with self-awareness:

> *"I guess I'd have to reflect on the feeling I have before seeing that client. So if, knowing they were coming to see me, if I was trying to cancel the appointment or if I wasn't there on time or feeling really anxious about seeing them, those could be clues that maybe something is going on here."* **(Respondent 2)**

Another respondent described what would personally indicate possible onset of VT:

> *"For me, I think changes in vegetative functioning. There would be a lot of behavioural, social, occupational disturbances. And, there would be a lack of interest in what you're doing. You know when you feel like there's just something on your shoulders and it feels heavy?"* **(Respondent 4)**

Generally, the responses highlighted what participants felt are symptoms of VT, including flashbacks, intrusive thoughts, being over-cautious, isolation, decreased physical health, fatigue, irritability, and a lack of empathy/sensitivity towards clients. The following quotes highlight the symptoms mentioned across the participants:

> *"You feel the same things they are feeling. You're feeling traumatized now, avoiding certain places, having those strong feelings, for example towards men after dealing with a rape case. I did feel this in a sense with one case and thought "how could he do that?" So ya just feeling what the patient is feeling even though you haven't experienced that…Getting a bit irritated as well, maybe becoming isolated from others."* **(Respondent 6)**

"So if your behaviour starts changing, I think it's more behavioural. If you start being more cautious, thinking about what happened to that person and putting it in to your own life… Burnout for sure. Unbalanced thinking. Your cognitive thought processes are not quite logical and rational anymore; they're unbalanced. Um, which will impact on your relationships and your daily life." **(Respondent 1)**

"…Experiencing then the same symptoms that someone who has first-hand experience of trauma would experience. So any PTSD-like symptoms, anything like that I feel falls under it." **(Respondent 5)**

3.4.3 Subtheme 3: Consequences of Vicarious Trauma

Most of the participants described how vicarious trauma can negatively impact on the novice trainee's professional standard, as well as the ripple effect it may have within their personal lives, for example on their relationships or physical and emotional well-being. Burnout, irrational thought processes, social withdrawal, and changes to sleeping patterns were all described as probable consequences of VT:

"Burnout for sure. Unbalanced thinking. Your cognitive thought processes are not quite logical and rational anymore; they're unbalanced. Um, which will impact on your relationships and your daily life... I think the quality of your work won't be that good. The professional standard will decrease and your ability to engage properly with your client. Your empathy too." **(Respondent 1)**

"I think something like withdrawal has a significant impact on your social support system from your family members and your ability to work properly.

Um…If it affects your sleep and your eating that will have a knock on effect as well…And also one that really has the capacity to influence multiple areas of your life." **(Respondent 2)**

One response indicated how the participant felt VT can result in a loss of respect within the helping profession due to burnout, decreased professionalism, and losing one's desire to help others:

"Other than messing up your clients, I think personally in the field you would lose a lot of respect. You would have ten years max because you can't cope and deal with it. You would lose your desire to help which is why we are all here." **(Respondent 4)**

3.4.4 Subtheme 4: How Vicarious Trauma Can Be a Problem for the Novice Trainee

Generally, the participants felt that VT is a problem for trainees because it impacts negatively on professional service, and the lack of awareness about VT increases the risk for it to have a ripple effect in all areas of their lives. The following quote from a participant indicates how she felt VT is a problem for trainees because they are at the starting point of their careers. She also suggests that a strict selection criterion for the programme should be an ability to cope, otherwise VT may become a bigger problem for trainees:

"I think it's a problem because you are starting out. You should be chosen on the basis of your ability to cope so if you walk in and aren't able to cope then you are being set up for failure." **(Respondent 4)**

Two participants offered their understanding of why VT is a problem for the novice trainee- due to the lack of experience and knowledge, it could be difficult for trainees to identify VT

responses which could combine with novice anxiety and thus have a negative impact on the trainee:

> *"I guess the problem is that we are still trainees and not aware of it. So you may know the concept itself but not know the consequences of it if you've never been exposed to it, then we wouldn't know when it's VT or when it's the actual anxieties of being a new therapist and the lack of information. So yes, more the lack of experience is a problem because with more experience you would be able to identify it, knowing what it is. But as a trainee psychologist we are always nervous and trying to hold ourselves as therapists."* **(Respondent 3)**

This reflects the idea of 'trainee bravado' whereby trainees try to reflect the image of a good therapist. As a result, any trainee anxieties could be suppressed as far as is possible in order to portray this image. However, that could result in negative consequences such as the accumulation of anxiety to the point of experiencing VT or other related secondary responses.

> *"I think it could possibly have a negative impact on your level of enthusiasm and possibly, like, not even wanting to go in to practice once you are finished your qualifications which has huge effects for our country overall. So if someone has a negative experience and doesn't want to go in to the professional role, that's a wasted trained psychologist."* **(Respondent 2)**

The following quote reflects how the participant feels VT is a problem for novice trainees because it decreases professionalism and combines with the anxieties of being a novice trainee which can increase self-doubt:

> *"It would have the same effect, that not being able to be an efficient helping professional. In M1 it's just that much more profound because you are just starting out and finding your footing so you are dealing with the anxieties of*

being a novice therapist coupled with any trauma you may have taken on or not dealt with. But it's the same general effect…And then again if you are not trained in VT it adds to your anxiety because you may not understand or recognize why you are feeling this way or what you've done wrong because you're feeling this way and that adds to your anxiety because it should be recognized as a normal thing, it's not uncommon, but if you're not cognisant of it I think you may take it on as being a personal failure" **(Respondent 5)**

3.5 Theme 4: Awareness and Preparation During the Training Programme

3.5.1 Subtheme 1: Exposure and Education on the Potential Risks When Working in This Field

From the responses it is clear that the participants felt more could be done to create awareness on the potential risks to one's physical and mental health when working in this field. The participants described how the two workshops provided brief insight in to the potential negative effects of being a novice therapist, but it was insufficient to create the 'know how' in order to protect oneself and cope with the effects. The following two quotes capture this general perception:

"I think more can be done. There isn't enough on it. We had a workshop on self-care but it was more focused on daily care. I don't think it was in-depth enough. The flag was not raised high enough. It wasn't made real enough. We related it to the amount of work we are doing. It was related to looking after yourself during the Masters year; not looking after yourself as a professional psychologist. So I think that's where the gap is." **(Respondent 1)**

"I think they did touch on it with those two workshops. These things were mentioned and brought up but again I think it's a field that can be so easily neglected because people on the one hand think its common knowledge but on the other hand it's not. It's something that needs to be more focused on. I don't think it's a long thing, it doesn't have to be an in-depth or drawn out training experience but I do think it could have been done more. Although we did touch on it, I think it could have been explored a bit more." **(Respondent 5)**

3.5.2 Subtheme 2: Concept of Vicarious Trauma Raised During Studies

The responses from the participants indicate that they felt the term 'vicarious trauma' was not raised directly during their M1 year. Some described coming across the term academically due to their own research, or discussing the notion of VT indirectly through casual conversations with student colleagues. However, from the responses it is clear that the participants felt there was no direct focus on VT in lecturers or seminars. The following three quotes indicate this challenge raised by the participants:

"No. Maybe in passing but it's not "burnout is this and vicarious trauma is this" but you know, maybe, in supervision and interaction with others. We talk about it…So I know if someone had to ask "did you experience any secondary trauma or vicarious trauma?" we would probably react by saying "what the hell is that?" you know." **(Respondent 3)**

"I don't think it was directly discussed. I don't think with anybody. Maybe the symptoms were there, as that example I mentioned with the colleague feeling emotionally depleted. But not discussed directly like "I think I may be experiencing vicarious trauma". As I said we weren't taught the difference and

we weren't taught exactly what it is. We weren't told what we could experience working with a traumatized individual, these are the signs, and this is what you should do." **(Respondent 6)**

"I must say, and I could be wrong, but I don't recall ever hearing the phrase "vicarious trauma". We discussed it in other respects but I don't think it was ever sort of "this is VT". That term was never used. And I know from speaking to people about my research, very often the response is "what's VT?" And it's not just with them or us, it's with anyone like nurses and social workers. So I do think in principle the facts are discussed but not necessarily the term itself." **(Respondent 5)**

3.5.3 Subtheme 3: Discussion of Vicarious Trauma During Supervision

The participants described how their supervision sessions did not have a specific or direct focus on vicarious trauma. Most participants mentioned that they were offered the space to discuss their responses to cases but did not have specific discussions with their supervisors on what vicarious trauma is, what effects it can have, and how to cope with it.

INT: Did your supervisor ever speak about some of the consequences of VT and secondary stress to you?

Participant 3: No, no. It was more the sense of reflection on how I could be impacting the client. So not much for myself. And the fact that we aren't aware of it and how that can impact on the client as well. **(Respondent 3)**

The following quote reflects that the participant felt supervision sessions offered a supportive space to process the effects that clinical sessions had on her. However, she mentioned that supervision did not have a specific focus on VT which is congruent with the quote above:

> *INT: You mentioned that supervision is a good way to talk about cases and not just how you're working with them but also how they're working on you. So during supervision, did you and your supervisors ever have a discussion about the effects of being a trainee psychologist, the effects it could have on you?*
>
> *Participant 5: Ya we did discuss it. I think, again, maybe my cases which I dealt with reasonably well, I wasn't as affected but if there was a particularly difficult session then we did go a little deeper in to that. And it was nice to have support from a professional saying "this is normal". Um, "this is an expected reaction to this situation". But, um, it wasn't too sort of in depth or anything. I think I discussed it more with classmates but supervision was definitely a good place to get that stuff out and then have a professional chat to you and normalize your reaction.* **(Respondent 5)**

3.5.4 Subtheme 4: Ideas to Improve the Exposure to and Education of Vicarious Trauma in Training Programmes

To finish off the interview process, participants were asked what suggestions they had to improve the exposure to and education of VT during the Masters programme. The suggestions included seminars on VT, inviting guest speakers from the profession to share their experiences, group therapy sessions for debriefing, mentorship programs, more practical exposure by working with patients in hospital settings, and incorporating a discussion of VT in to supervision, as reflected through the following three quotes:

"I guess maybe a workshop where we share our own personal experiences which would be helpful because you would hear what others are going through and then don't feel so bad about it. So maybe have that spread throughout the year, maybe an hour session where we speak about our experiences." **(Respondent 2)**

"We almost need someone to come talk to us about what happened to them with burnout or maybe VT because of the trauma associated with the work to make it real. We underestimate it…I think somebody that's been through it. Somebody that has real stories and can tell the extent so that it kind of makes it real. They can explain what they've been through, how they coped with it, what the symptoms were like. Um, it just brings it home." **(Respondent 1)**

"And being offered by the psychology department, even if it's once a month that you get somebody in like a mentor or do groups, it's something for the emotional side for what we are going through as students and seeing clients." **(Respondent 6)**

This participant suggested having a more practical element in the Masters programme that would increase exposure to various cases and thus allow trainees to learn how to cope with the effects of client content:

"Different programs are run differently. I know that at U.J they see patients at the hospitals but we see them at the clinic so they have case load. You are already starting to get to know what happens and what is going on. I feel like that's a more practical teaching method because you are working with the actual victims. It's there. And you go back to your supervisor and work through it. And then in class you are learning about trauma models so you are getting it

from all angles and then can apply it. You can see it working. And that case load allows them to practice, which is something I don't feel like we've really had here." **(Respondent 4)**

The following quote was offered by a participant at the end of the interview. It summarizes the lingering question for most trainee psychologists, and for which the answer still remains to be found:

"That makes me wonder how people last so long. Was it the training or was it stuff they learned through working? What makes people last? How do they do it?" **(Respondent 4)**

3.6 Summary of Themes and Subthemes

The themes discussed in this chapter provide insight in to the difficulties that the M1 students faced during their masters training and their potential risk for experiencing VT at some stage during their career. The content elicited by the participants reflected how they felt the field of mental health is a difficult one to work in and thus requires significant efforts to ensure prevention of VT and a longer career life. Suggestions included self-care, debriefing, ongoing supervision, and personal therapy. Themes also explored M1 students' attitudes and perceptions of VT which revealed that there is a space for further awareness and education within the training programme. Lastly, the participants described suggestions aimed at improving the awareness and education of VT, for example seminars and greater exposure to trauma cases during training.

CHAPTER FOUR

4. INTERPRETATION OF FINDINGS

This chapter focuses on interpreting the findings of this study. Exploring the meaning of the findings as well as unexpected results will also be of focus in this chapter. The patterns of similarity and the differences across the participants' responses will be discussed in line with the literature. An underlying assumption throughout the data collection, analysis and interpretation phases has been the likelihood that trainee psychologists may experience vicarious trauma at the beginning stages of their career development because of the insufficient awareness created throughout education/training programmes. This assumption served as a base for the explorative nature of this research study, with the aim to explore if trainees held perceptions similar to this assumption. The above mentioned assumption will also be discussed in the later part of this chapter.

The core focus of this research project was to explore trainee psychologists' attitudes, perceptions, and possible experiences of vicarious trauma. The researcher was particularly interested in the symptoms of vicarious trauma that trainees described and their perceptions of the impact/consequences thereof, both professionally and personally. The researcher was also interested in how trainee psychologists' conceptualised/defined/understood vicarious trauma, and what they felt could be done in training programmes to create greater awareness of the phenomenon. These results will be discussed in line with the literature on symptomatology of and treatment/intervention for vicarious trauma.

In summary, with regard to the findings of this research, it was evident that M1's interviewed for this study found it difficult to explain and define vicarious trauma because of insufficient awareness of the concept and difficulties distinguishing vicarious trauma from other concepts such as compassion fatigue, burnout, and trainee anxiety. All the participants expressed various symptoms that they would identify as vicarious trauma and explained various means of coping

with the emotional challenges of being a mental health practitioner, as well as ways to cope with vicarious trauma if they started noticing the symptoms within themselves. Furthermore, this research reflects the various perceived risk and protective factors involved in the experience of vicarious trauma. It appears that this research highlights the need for more awareness of and education on vicarious trauma within the training and education programme offered at the University of KwaZulu-Natal Howard College Campus so that trainee psychologists feel they are better able to distinguish VT from other related concepts, and thus be better equipped to cope with the symptoms and consequences of VT. It is necessary to emphasize that participants did not report personal experiences of VT at the time of the research, although some did express features of VT, for example fatigue and overwhelm. However, they did not imagine these features to be an indication that VT was prominent and thus did not perceive that they were definitely experiencing 'full blown' vicarious trauma. The M1 students were exploring the concept with the researcher to gain insight in to their understanding of the concept and all it entails.

4.1 Experience of the Masters Professional Training

Research conducted on the secondary consequences of the helping profession indicates that secondary traumatic stress, compassion fatigue, burnout, and vicarious trauma all serve as examples of negative consequences involved within the field of helping (Jenkins & Baird, 2002; Trippany, Kress & Wilcoxon, 2004; Baird & Kracen, 2006; and Newell & MacNeil, 2010). Mental health professionals, whether trainee or experienced, work with vulnerable populations in South Africa and are thus likely to encounter patients with a trauma of some kind, either current/on-going or past (Doolan, Ehrlich & Myer, 2007; and Sommer, 2008). It is therefore more likely that mental health professionals, psychologists included, may experience

these secondary consequences, particularly vicarious trauma. Findings from this research identified how trainee psychologists experience emotional challenges when beginning their practical work as well as the combined effect of novice anxiety. Findings also showed that there are various coping mechanisms employed by student psychologists to manage the emotional challenges they faced and to help ease the impact of the secondary consequences of the helping profession.

Each sub-theme will be addressed with regard to interpretative relevance and importance. An exploration of the *secondary consequences of the helping profession* revealed how the participants often felt overwhelmed and anxious, creating a general perception that working within the helping profession can have negative consequences on emotional, physical, and mental well-being. Although the participants' responses created a negative perception of the impact of the helping profession on one's holistic well-being, this must be considered in the context of trainee anxiety. This can be linked to Skovholt's (2012) phases of therapist development that the respondents found themselves in at the time of the interviews. It is important to understand the personal and professional development of trainee psychologists and how these can be areas in which there may be a risk for experiencing vicarious trauma due to their already-existing high levels of professional developmental anxiety. Skovholt (2012) describes phase one as the pre-training phase (See 'Phases of Therapist Development in Literature Review), whereby the trainee has not yet entered the world of formal training and thus relies on their own life experiences and sympathy to make suggestions or give advice when helping others. The second phase highlighted is the beginning student phase, which is characterized by a transition to that of a professional therapist in training. At the beginning of the M1 year, and throughout most of its academic training, the respondents would have found themselves in a sort of transition space where they entered the M1 programme as lay helpers in the pre-training phase, and through their practical exposure, started to make the gradual

transition to the beginning student phase. This would understandably be characterised by anxiety and a sense of feeling overwhelmed, and as such, it may place the trainee at an increased risk to experience the secondary consequences of the helping profession (Skovholt, 2012).

At the time of the interviews, the participants were preparing to advance to phase three of their professional development. This refers to the advanced student who is preparing to commence the internship. Phase three is a tumultuous process of professional development and may explain why the responses offered by the participants reflected such a negative perception related to the consequences of the field of mental health work. All the participants described high anxiety levels throughout the M1 year, and this may have served as a defining world-view for these student therapists. However, an important point to make is that this anxiety may also be beneficial because the experience of anxiety during the M1 programme may provide significant insight in to the nature of work within the field of mental health. This in turn creates an awareness for the need to engage in effective coping mechanisms, for example self-care. From the findings it appears high levels of anxiety, as reported by most of the M1 participants, can pose as an increased risk for experiencing VT and other secondary responses (Baum, 2016; Cook, 2016), especially for the novice therapist who is embarking on their career development. None of the participants stated that they experienced VT. However, they made frequent mention of the anxiety and stress of the M1 year. It would appear that they did not perceive that their stress was an indication of VT, but that it was associated more with the transition from full time academic students to emerging therapists. Their perceived lack of VT could be further aggravated by a lack of knowledge of VT and poor coping methods to deal with trainee anxiety. The participants did not report that anxiety is necessary in order to fully understand the nature of the work within this field and the possible consequences. However, it is important to consider the benefit of experiencing trainee anxiety in terms of learning effective coping

methods at the beginning stages of their professional development, which may increase their resilience throughout their careers (Daniels & Larson, 2001).

Discussions with the participants regarding the *emotional challenges* reflected the significant emotional storm that trainee psychologists experienced during their M1 year. The types of challenges experienced were different for each participant but generally included a lack of social support, developing a work-life balance, self-doubt, striking a balance between theory and practice, and learning when to disconnect from the work done with patients. A large portion of the responses reflected how student psychologists found it difficult to separate from their practical work with patients and often had doubts about their abilities, training, education, and professionalism. This can be linked to the study conducted by Emery, McLean and Wade (2009) using the Therapist Belief Scale on clinical psychologists, and the study conducted by Theriault, Gazzola and Richardson (2009) exploring the consequences of feeling incompetent as a novice therapist. Although the population of the former study involved qualified and experienced professionals, the results of the latter study highlight how these are common anxieties experienced across the field of mental health professionals, including novice therapists (Adams et al., 2003; Trippany, Kress & Wilcoxon, 2004; Arnold et al, 2005; Theriault, Gazzola and Richardson, 2009; Williams, Helm & Clemens, 2012).

These studies explored therapist beliefs and burnout, aiming to identify unhealthy and ineffective beliefs that may increase the risk for burnout in the field. Further, the results can be linked to the emotional challenges experienced by the participants. The participants in this study described the challenge of translating theory in to practice which can be linked to an inflexibility of therapeutic approach and the struggle with insecurities and self-doubt (Emery, McLean and Wade, 2009; Stoltenburg, 2005; Theriault, Gazzola and Richardson, 2009). This reflects a rigidness of the novice therapist's practical work that involves the mentality of 'sticking to what I know'. In addition, many of the participants described doubting their

abilities once they began practical work. Most M1 participants mentioned how there is a need as a novice therapist to see results within therapy sessions, which is perceived as an indicator of the therapeutic progress made by the patient. Such progress may also be perceived as an indication of therapeutic skill. Hence there exists an internalised responsibility for the progress of patients and therapy sessions, which is congruent with the literature (Emery, McLean & Wade, 2009). From the results there appeared to be the assumption that if therapeutic progress was not noticeable to the student psychologists, then they believed they were failing as novice therapists.

The aforementioned challenges can further be related to the transition between the pre-training phase and the beginning student phase outlined by Skovholt (2012). This offers a possible explanation for the high levels of trainee anxiety. Due to feelings of anxiety and being overwhelmed, and the ambiguity of the therapeutic space, it is understandable that the novice trainee would have a high need for control in therapy settings (Emery, McLean & Wade, 2009). This sense of control over the therapeutic space and the progress made by the patient may directly foster a sense of professional security for the trainees, creating the impression that they are performing adequately. Therefore, a lack of control over the therapeutic context and an intolerance for ambiguity may cause self-doubt about one's professional ability. This was reflected in the results of the present study whereby the participants described their personal feelings of being overwhelmed, which was associated with patient distress. This low tolerance for distress, also emphasized by Emery, McLean and Wade (2009), thus created more anxiety within the student psychologists. The maladaptive beliefs highlighted by Emery, McLean and Wade (2009) and further reflected in this research study are associated with younger, less experienced psychologists- which is the position that novice student therapists find themselves in- and are also associated with higher levels of burnout, compassion fatigue, and ultimately VT (Emery, McLean & Wade, 2009).

Questions about the participants' *coping mechanisms* were asked with the aim to explore the types of coping strategies employed by student psychologists. An interesting perspective is that the participants described coping mechanisms that they would normally adopt, or described coping styles that they would ideally like to adopt in the future. Thus most of the participants described how they lacked the coping styles they described or wished to use them more prominently. The common coping methods employed included drawing on peer support and supervision, and the ideals that the participants are striving towards include learning to compartmentalise and disconnect from practical work. The general sense from the responses indicates that student psychologists may feel unprepared for the potential consequences of being a mental health professional in training, which goes hand in hand with the lack or insufficient use of effective coping mechanisms. This is an important finding with regard to training programmes, and may indicate an area of need within training programmes that focuses on building coping skills. One can further hypothesise about the relationship between effective coping skills and trainee anxiety, which is likely to decrease or have less of an influence on a trainee's professional development if they employ effective coping mechanisms. Furthermore, it could have an indirect link to vicarious trauma experiences amongst trainees once they enter the field in their internship year and onwards. It is crucial for student psychologists to learn effective coping skills during their training so that they can cope with the emotional challenges and secondary consequences of the helping profession as they arise, thus reducing their risk of experiencing vicarious trauma at the early stages of their career development.

An exploration of the *self-care workshop* reflected the value that this workshop held for the participants and the insights they gained from it. From the responses, it is clear that the participants valued the workshop which they felt created a very real awareness for the importance of self-care. Interestingly the participants described the realisation that their self-

care was either non-existent or poor, and that it had to become a number one priority throughout their professional development in order to make it within the field. This contradiction between the importance of self-care but the lack of application could be linked to the 'know how' of self-care, which the participants described as lacking. Expanding on this, participants expressed an on-going need for self-care education rather than once-off education. This can be linked to the work of Skovholt (2012) where he describes the importance of self-care for coping with novice trainee anxieties. Self-care according to Skovholt (2012) facilitates an ability to continue making professional attachments to one's patients regardless of the nature of their distress, and serves as a protection against the secondary consequences of the helping profession, including burnout, secondary traumatic stress, compassion fatigue, and vicarious trauma (Skovholt, 2012).

The importance of self-care cannot be over-emphasised, especially with trainee psychologists who are already experiencing anxieties and emotional challenges due to their new journey within the career of mental health. The fact that the responses reflect the participants' need for more emphasis on self-care, including education on the 'know how' of self-care, creates a niche within training programmes to incorporate self-care education in to the training in an on-going manner. After all, as Skovholt (2012) reiterates "in the caring professions…ourselves are our central professional instrument. We must preserve the self in order to use it for others" (p115). In relation to vicarious trauma, self-care has been emphasised in the literature as a buffer and protection against the risk of being vicariously traumatised. It can also be thought of as a coping method to heal oneself in the case where the mental health professional finds him- or herself to be vicariously traumatised (Shapiro, Brown & Biegel, 2007; Skovholt, 2012). Based on current research (Barnett, Baker, Elman & Schoener, 2007; Shapiro, Brown & Biegel, 2007; Skovholt, 2012, Ronnestad and Skovholt, 2012), the importance of self-care for trainee psychologists needs to be emphasised continuously in order to build a resiliency/immunity

against vicarious trauma at best, or effective internal and external resources to cope with vicarious trauma at worst. Self-care is likely to slip down the list of priorities due to the heightened anxiety around academic performance and professional development. In keeping with this, student psychologists may experience more difficulty with implementing and maintaining self-care because their focus is on doing well, and there is a lingering fear that if one is not coping then it will be noticed and counted against their professional readiness. Related to this idea is the work of Skovholt (2012), more specifically regarding phase two of therapist development and the trainee anxiety it encompasses due to performance with practical work. This suggests that self-care needs to be emphasised continuously throughout the training stages so that it becomes second nature for trainees. Doing so may also prevent academic anxiety from getting in the way of protecting themselves from VT or other secondary responses.

The information obtained regarding the *trauma workshop* reflected a sense of fear within the participants surrounding cases with a traumatic history. This fear is not related to engaging with trauma cases per se, but has more to do with self-doubt and feeling ill-prepared to work effectively with victims of trauma. This can be related back to the literature which outlines the importance of trauma-related classes and more practical training in order to build competency for engaging with trauma cases (Adams & Riggs, 2008; Parker & Henfield, 2012). For most of the participants, there was a sense of appreciation for the workshop due to its practical nature, but it left the M1 students wondering how they would attempt to intervene with someone who is presenting with trauma. Furthermore, the participants' fear can also be associated with their thoughts on how a trauma case could impact on them cognitively, emotionally, and behaviourally. Most participants were able to acknowledge the impact that lingered following the practical role play conducted during the workshop, which could have increased their anxieties about working with trauma cases.

As Somer (2008) describes, many mental health practitioners work in diverse environments such as family or personal therapy as well as crisis support. However, there is an increasing likelihood of encountering clients who have experienced trauma and are still trying to work through their trauma-related issues. Mental health professionals encounter traumatised clients on a daily basis, therefore it is important to adequately prepare and train these professionals in order to reduce their risk of experiencing VT. This particularly applies to countries with high crime and violence rates, for example South Africa (Doolan, Ehrlich & Myer, 2007). Many participants expressed that South Africa has a high crime and violence rate which may result in a high likelihood of working with traumatised clients. Given the nature of crime within South Africa, as indicated by the literature (Seedat et al., 2009), it is understandable that the participants expressed anxiety and fear regarding working with trauma cases. The concerns reflected through their responses can perhaps therefore be related to knowledge of high levels of trauma in South African society and the likelihood of encountering traumatised clients (Kadambi & Truscott, 2004; Sommer, 2008). Further, the high chance that the nature of the trauma will be severe may also exacerbate anxiety. These factors can potentially combine with other variables related to their training. For example, trainee anxiety and self-doubt, a lack of exposure to trauma cases, and a lack of 'know-how' when it comes to working with traumatised clients could all potentially impact on the trainees' competency when working with trauma cases. Education is thus important in order for student psychologists to become aware of the reality of trauma within the populations that they are likely to work with (Munroe, 1999, as cited in Sommer, 2008). Education will also build their awareness and knowledge of how trauma may present, how it affects both the client and the professional, how to intervene effectively and appropriately, and lastly how to look after themselves when working with these vulnerable populations. Self-care can therefore be considered an essential and integrated

element of trauma related work, which has emphasized by the literature (Ronnestad & Skovholt, 2012; Skovholt, 2012).

4.2 Attitudes/Perceptions of the Secondary Consequences of the Helping Profession

The first point discussed under this main theme was the *difficulties distinguishing vicarious trauma from trainee anxiety*. This is similar to a sub-theme that occurs later within the discussion which looks at the understanding and definition of vicarious trauma offered by the trainees. The transcripts indicated that the most significant factor which makes it difficult to differentiate between vicarious trauma and trainee anxiety is a lack of knowledge of vicarious trauma (and other related concepts). In addition to the literature (Williams, Judge, Hill & Hoffman, 1997Gold, 2005; Skovholt, 2012), the participants indicated that the levels of stress experienced during the M1 year were high which resulted in the focus being more on trainee anxiety than vicarious trauma. Reflecting on this, it is understandable that trainees would assume their feelings are associated with trainee anxiety and the stress of the M1 training. Given their ideas, in addition, they didn't expect to experience VT at such an early stage of professional development. The danger with this is that there is no attention paid to the possibility that the anxiety may be progressing or accumulating, which could then develop in to vicarious trauma at a later stage. Supported by the literature (Trippany, Kress & Wilcoxon, 2004; Arnold, Calhoun, Tedeschi & Cann, 2005; Williams, Helm & Clemens, 2012), anxiety could deplete a trainee's ability to cope effectively with the challenges involved in the helping profession, thus increasing their risk for vicarious trauma. This highlights an important educational space to be filled by training programmes- attention to both trainee anxiety and vicarious trauma, so that trainee psychologists are able to tell the difference and then seek appropriate interventions and coping methods.

Furthermore, the student psychologists within this study described how it is difficult to differentiate between vicarious trauma and trainee anxiety because they do not know where to draw the line between their own anxieties related to being a novice therapist and concerns and difficulties related to vicarious trauma. Given that knowledge, attitudes and perceptions are largely shaped through training programmes, this also appears to require attention. This would need to include an understanding of VT and the ability to distinguish it from other related concepts such as compassion fatigue, burnout and counter transference.

Regarding the *personal risk for experiencing vicarious trauma*, it was evident from the transcripts that all participants felt they were at some risk for experiencing vicarious trauma. This shared belief among the student psychologists within this study was not related to experiencing vicarious trauma as a novice therapist specifically, but to experiencing vicarious trauma at some point in their career lifespan. Exploring this further, the shared belief amongst the participants regarding the likelihood of experiencing vicarious trauma can be related to discussions around previous sub-themes, such as the nature of trauma cases due to crime and violence in South Africa, and the lack of awareness of vicarious trauma. These can be seen as factors that may influence student psychologists' beliefs about the likelihood of a personal experience of vicarious trauma.

From the results it appears that trainees perceived that the lack of knowledge increased their personal risk for experiencing vicarious trauma. Further, the trainees did not perceive knowledge of VT as a preventative measure or a protective factor. However, given their responses, it was evident that they perceived how knowledge of VT would allow them to identify VT and its symptoms, which in turn allows them to intervene rather than mislabelling it as something else, such as burnout or trainee anxiety. The findings further support the literature which speaks of the need to include graduate-level courses on vicarious trauma, as highlighted by Baker (2012). These descriptions offered by the participants reflect the

complexity of factors contributing to the experience of vicarious trauma, and more specifically the factors that each individual believes would contribute to their risk of experiencing vicarious trauma.

This leads to the *factors increasing the risk for vicarious trauma*. There were a variety of factors suggested by the participants which could serve as risk factors for vicarious trauma such as case load, lack of supportive systems, lack of self-care, M1 anxieties and stress, and an unresolved personal trauma history. This last risk factor described by most of the participants was an interesting finding of this research. It was assumed that participants would describe a history of trauma to be a risk factor for vicarious trauma in terms of triggering memories and emotions/cognitions/behaviours associated with that traumatic event, which would then impair one's professionalism. However, this was not the case as indicated by their responses. Interestingly, participants described how a trauma history can serve as both a risk and protective factor, depending on whether the individual has processed and worked through that trauma. Thus a trauma history that has been resolved is more likely to serve as a protective factor when working with traumatized clients, and as participants described, it will make empathic engagement that much easier. However, if trauma history has not been worked through and its effects are still lingering, then it may be a risk factor that increases the likelihood of experiencing vicarious trauma (Jenkins & Baird, 2002; Kassam-Adams, 1995; Pearlman & MacIan, 1995; Wall, 2001).

An interesting argument that can be generated from the findings around this sub-theme involves the notion of self-care. In addition to the literature (Shapiro, Brown & Biegel, 2007; Skovholt, 2012), the participants previously described how self-care is important and should be a priority regardless of the stage of professional development. They also emphasized in their responses how a lack of self-care can result in vicarious trauma (Barnett, Baker, Elman & Schoener, 2007; Shapiro, Brown & Biegel, 2007; Skovholt, 2012). However, one has to consider whether a lack

of self-care is a cause of vicarious trauma, or whether it can be viewed as a symptom/consequence of vicarious trauma. One can imagine that if self-care was lacking prior to any other vicarious trauma symptoms then it could be classified as a factor which contributed to the risk of vicarious trauma. Therefore, if a lack of self-care is present in conjunction with other symptoms of vicarious trauma, then it can be considered a symptom/consequence of vicarious trauma. This argument was not offered by the participants, nevertheless it is important to note in this discussion and may indicate the need for future research on the role and value of self-care as a protective factor and whether the lack of self-care results in VT or if a lack of self-care is an indicator of VT.

To build on the discussion, it was important to explore how student psychologists *cope with the secondary effects of the helping profession*. Prominent coping methods included personal therapy, debriefing, supervision, and peer support. It is interesting to note that, although the participants described the value of self-care, they did not describe it specifically as a coping mechanism. Their responses reflected the perception that self-care is an on-going process more than a coping mechanism when VT or other secondary responses develop. This could imply that if one is implementing self-care as a coping method then it is almost too late. Further to this was the perception that personal therapy served more as a preventative/coping measure than acts of self-care. It was mentioned by most of the participants as one of the most significant means of coping, despite most of the participants not engaging in personal therapy due to the cost. However, they acknowledged the importance of personal therapy as an on-going coping method throughout their careers and was something that they planned to prioritize.

The perception of personal therapy as a valuable coping method can be linked to the therapist beliefs that student psychologists may hold. If student psychologists experience difficulty tolerating the distress of the patient, and assume responsibility for the outcome of therapy, as outlined by Emery, McLean and Wade (2009), then it is likely that personal therapy would be

utilized more than self-care for the purpose of debriefing. Personal therapy may also cater for their own emotional containment, especially due to the high levels of anxiety during the M1 year. To develop this argument further, student psychologists are deeply invested in their professional development during the M1 year which is time-consuming as indicated by the responses. Thus applying acts of self-care requires more of an on-going effort than personal therapy sessions. Given their responses, it is clear that time is limited during the M1 training programme. Acts of self-care are generally perceived to take more time than personal therapy, which serves as a possible explanation for greater motivation to utilize personal therapy as a coping mechanism rather than engaging in acts of self-care. The value of personal therapy as a coping method above self-care is supported by the literature (Hesse, 2002; Pearlman & Saakvitne, 1995; Sexton, 1999; Yassen, 1995).

The use of personal therapy as a coping method can be viewed as an effective means of dealing with the consequences of the helping profession, not only because it is a form of self-care for the student psychologist, but it also serves as a processing space which maintains professional accountability and standards. Regarding supervision and peer support, the participants described making use of these systems of support within the academic and/or workspace which is important for them to maintain their quality of service. The combination of personal therapy and work support systems could facilitate a holistic approach to helping the helper by incorporating both the personal and professional elements of self, which can be thought of as the ideal way to cope with the secondary consequences of the helping profession. From the transcripts it is clear that the participants value support as an important means of coping, whether it be personal support from family and friends, or professional support from colleagues and supervisors. This is supported by the literature (Ortlepp & Friedman, 2002).

Protective factors were explored in order to understand what the participants believed could act as buffers against vicarious trauma. Supported by the literature (Adams et al., 2001; Parker

& Henfield, 2012), it is evident from the transcripts that previous experience or gaining experience will serve as a protective factor. Placing the participants in the context of trainee anxiety and early professional development, which is in line with the work of Skovholt (2012), it is easy to understand why they emphasized experience as a protective factor. Half of the participants did not have any previous experience prior to their M1 year, and it was these participants who invested hope in the idea that increased experience will foster more effective coping skills and resilience within the field. Relating this to the work of Skovholt's (2012) phases of therapist development, these concerns and perceptions regarding the role of experience as a protective factor can be thought of as characteristics of the second phase. The other half of the participants had some previous experience through crisis team work or telephone counselling, and they described how they felt their previous experience had created an awareness for the very real impact that being a mental health professional can have on one's personal and professional life. For these participants, previous experience reminded them that they have coped with difficult cases before and therefore have the abilities to cope with them in future. These participants could be placed on the border between phases two and three because they possess some qualities characteristic of both. They expressed the same concerns regarding overwhelm and anxiety which are features of phase two, however their previous experience may have assisted them to make the transition between theory and practice, which are features of phase three (Skovholt, 2012). One can hypothesize that this would likely decrease self-doubt and trainee anxiety, and ultimately their risk for experiencing vicarious trauma.

For those who lacked previous experience, there was a clear belief that experience builds resilience and it is through experience that one will learn how to compartmentalize and disconnect from therapy work- one of the major factors highlighted by participants under the first theme of this discussion. Those who had previous experience shared the belief that it has

aided them to cope better with cases. These beliefs appear linked to professional confidence. There may be a chance that students without previous experience will have higher levels of self-doubt, and thus feel anxious and overwhelmed. This could differ from those with some form of previous experience who may experience less self-doubt and may be better able to cope with the demands of cases.

Perhaps the debate about experience needs to be explored further. The literature often describes how a lack of experience or being new to a field places greater risk on the professional in terms of experiencing vicarious trauma (Pearlman & MacIan, 1995; VanDeusen & Way, 2006; and Parker & Henfield, 2012). Based on observations from the results, it is evident that the M1 students in this study hold the same perception, because most of the participants discussed the importance of experience as a protective factor. However, one cannot ignore the opposite side of the coin that looks at the vulnerability to experiencing VT amongst the 'aged professional'. Does a lifetime of involvement and accumulated experience in the field create an immunity to vicarious trauma, or does this lifelong professionalism increase the risk for burnout? This needs to be explored further. One would need to specifically explore the coping methods adopted by older professionals in the field. Furthermore, the relationship between coping skills, years of service, and VT/secondary responses would also need to be explored. This could then be compared with the present results reflecting how the M1 students perceived experience as a protective factor rather than a risk factor. This may account for the different perceptions of the role of experience as an influencing factor in one's experience of VT.

4.3 Knowledge of the Secondary Consequences of the Helping Profession

The discussion of this theme began by exploring trainee psychologists' *understanding/definition of vicarious trauma*. From the transcripts it is evident that the majority

of the participants experienced difficulty during the interview process in terms of defining vicarious trauma. Those who were able to define it had more knowledge of the concept because of their own research but were able to acknowledge how it would be difficult for other students to understand and to differentiate from other concepts, such as burnout and compassion fatigue. These responses are congruent with the literature offered by Parker and Henfield (2012). Their study highlighted how school counsellors found it difficult to conceptualize vicarious trauma because half of the participants thought of vicarious trauma as a concept synonymous with burnout, transference, and secondary trauma (Parker & Henfield, 2012). In both this study and that of Parker and Henfield (2012), we can see two groups of mental health professionals- trainees and school counsellors- experiencing difficulty with the conceptualisation of VT. This indicates a significant need for more education on vicarious trauma during training and education. Such a need is substantiated by the literature and the results of this study indicating how mental health professionals, regardless of their career stage, may have misperceptions of VT.

The research offered by Parker and Henfield (2012) and the findings of this study reflect another significant issue: the notion of 'blurred lines' amongst the various concepts. Most of the definitions that the participants offered incorporated elements of PTSD, secondary trauma, and emotional and physical fatigue. However, an interesting finding is that, although the participants struggled to define vicarious trauma and separate the various concepts, they were able to recognize that vicarious trauma involves "*trauma symptoms but through another person*" (Respondent 1). The participants were able to describe how vicarious trauma may occur indirectly by listening to and empathically engaging with clients' trauma content and experiences. This was further reflected through the M1 students' perception that VT entails an adoption of the client's trauma, thus taking it on as their own. This reflects a basic understanding of the nature of vicarious trauma and how it develops. Although this basic

understanding is present, as indicated by this research, there is still a pressing need for specific M1 education and training to unpack the various concepts that embody the secondary consequences of the helping profession. This is congruent with the work of Sommer (2008) and Baker (2012) who discussed the importance of preparing graduate students for the potential risk of VT. More specifically, the results of Baker's (2012) study emphasized the need to incorporate a VT course in to graduate programmes. The response of participants in this study are supported by the work of Baker (2012) and reflect the same idea- the need for seminars on VT. If the M1 training programme specific to this study is able to fulfil this need, one can envisage an ideal scenario where student psychologists are asked to define the various concepts and are able to do so with ease rather than confusion and difficulty.

The participants were asked to describe and unpack *vicarious trauma symptoms*, which presented with interesting aspects. The participants discussed a range of symptoms in their responses which included both PTSD and non-PTSD symptoms. In general, their responses outlined the following symptoms: flashbacks, intrusive thoughts, hypervigilance and hyperarousal, isolation, decreased physical health, fatigue, irritability, lack of empathy/sensitivity, vegetative shifts, anxiety, avoiding certain clients or sessions, and a decrease in social and occupational functioning. These results are supported by the literature (Saakvitne and Pearlman,1995; and Williams, Helm & Clemens, 2012) describing symptoms of vicarious trauma that include loss of energy, interpersonal difficulties, hopelessness and despair, intrusive thoughts, increased emotionality or a lack of emotion, changes in cognitive schemas, and the possibility of depersonalization and dissociation in severe cases. While not all of these symptoms were addressed by the participants, there appears to be a significant overlap between what the symptoms outlined by the literature and what the symptoms described by the participants. This is both interesting and significant because the student psychologists in this study were able to imagine and describe the symptoms they would notice

in themselves and/or colleagues in the case of vicarious trauma onset and progression. What makes this an interesting observation is that such an understanding of the symptoms of VT exists despite the challenges associated with defining/conceptualizing vicarious trauma. The students were able to name most of the symptoms despite difficulties differentiating between VT and other secondary responses.

As indicated by their responses, the M1 students held the perception that the symptoms of vicarious trauma could manifest as emotional, cognitive, and/or behaviour symptomatology, which is supported by the literature (Way et al, 2004). An important consideration that needs to be re-highlighted in the discussion of this sub-theme is whether or not these cognitive, emotional, and behavioural symptoms of vicarious trauma should be considered symptoms or consequences of vicarious trauma. For example, is hopelessness a symptom of vicarious trauma (a symptom meaning something that indicates the presence of a phenomenon) or is hopelessness the result or consequence of vicarious trauma (a consequence being something that results from a phenomenon)?

The symptom-consequence debate has important implications for the severity of vicarious trauma. Furthermore, this debate influences which coping methods or interventions need to be utilized. Symptoms usually imply the beginning stages of a phenomenon whereas consequences indicate the cumulative effect thereof, thus suggesting that consequences are more severe than symptoms. This debate was not discussed by any of the participants within this study but it is worth mentioning due to the implications for intervention. Student psychologists described having difficulty adopting effective coping methods which they feel they need to learn in order to prevent burnout, compassion fatigue, secondary traumatic stress, and vicarious trauma. Perhaps coping methods and the severity of symptoms/consequences are interrelated, however this needs to be explored through further research to be confirmed or disputed. If one is able to identify the symptoms early and utilize effective coping methods,

then the severity of the consequences will be lower. However, if student psychologists were able to identify the symptoms but did not know how to cope with them, then there could be a greater risk for a cumulative effect of VT symptoms. This may have more severe consequences, such as losing one's desire to help others as expressed by one participant. The argument of symptoms-consequences re-iterates how education and training programmes need to focus on the symptomatic profile of vicarious trauma and the various coping methods that should be used before the symptoms develop a cumulated effect across the cognitive, behavioural and emotional domains (Way et al, 2004).

The interviews progressed to an exploration of the *consequences of vicarious trauma*. The aim was to understand what student psychologists believe to be the impact of vicarious trauma and their understanding of the severity of its consequences. From the transcripts, it is evident that the participants believed vicarious trauma can have profound consequences on their personal and professional lives, thus highlighting a ripple-effect nature of the consequences of vicarious trauma. Newell and MacNeil (2010) described how vicarious trauma can result in changes to one's perceptions of self, others, and the world. These can be thought of as the cognitive consequences of vicarious trauma. The participants all described various cognitive changes that may result from vicarious trauma such as irrational and illogical thought processes, and unbalanced thinking. Their responses are thus in line with the literature offered by Newell and MacNeil (2010), and reflect an awareness of how severe vicarious trauma can be if it is able to produce cognitive changes. Trippany, Kress and Wilcoxon (2004) further support the responses offered by the participants, as they describe how vicarious trauma can significantly disrupt counsellor identity, values, beliefs, perceptions, and memory- most of which were reported by the M1 students in this study.

The participant responses can be further linked to the CSDT described in the literature review (Pearlman and Saakvitne, 1995; Collins & Long, 2003; Helm, 2010). More specifically, the

responses offered by the participants can be linked to the five components of the self, which all serve as areas where a trainee or professional psychologist can experience VT symptoms/consequences (Trippany, Kress & Wilcoxon, 2004; Helm, 2010). Although none of the participants described personal experiences of VT during their M1 year, their perceptions of VT were accurate and they could identify some of these symptoms within themselves. Further, all of the student psychologists within the study described feeling overwhelmed and anxious. According to the literature (Pearlman and Saakvitne, 1995; Collins & Long, 2003; Helm, 2010), a trainee psychologist who is already experiencing novice anxiety could potentially experience disruptions to those five components outlined by CSDT. Vicarious trauma can cause disturbances in their thought processes and reasoning, perceptions, memory, and internal resources for coping, as emphasized by the participants and is supported by the literature (Lerias & Byrne, 2003; Newell & MacNeil, 2010; Williams, Helm & Clemens, 2012). Further, it has the potential to cause a defragmented sense of self (professional and personal) which can have a ripple effect in to other areas of life. This has been emphasized at a basic level by the participants who described how the cognitive changes can have a 'knock on effect' for other domains of life including relationships, social support, professionalism and quality of work. Due to the research from this study and the literature, it is understandable why Sommer (2008) expressed how education and training programmes have an ethical obligation to inform trainee psychologists of the risks and consequences associated with working as a mental health professional, further emphasizing the need for vicarious trauma courses within this specific education/training programme.

The final point for discussion in this section aimed to explore *how vicarious trauma can be a problem for the novice trainee*. As expected, the participants were able to make links between the consequences of vicarious trauma and how it could be a problem for the novice trainee. Interestingly, the participants described how vicarious trauma is a problem for the trainee

because they are at the starting point of their career and professional development. This could be linked to Skovholt's (2012) stages of therapist development emphasized previously in this discussion- the M1 participants were nearing the end of the beginning student phase and preparing to enter the advanced student phase at the time of the interviews. One can see how their explanations reflect concerns for their career lifespan and how they have identified with the anxieties surrounding their professional ability to survive in this field. Adding to this dilemma is the lack of awareness of VT. Participants described this as more of a problem because it results in an inability to identify vicarious trauma in themselves in terms of the symptoms and consequences.

There is the sense of a snowball effect that emerged from this sub-theme. The participants described how vicarious trauma is a problem for a number of reasons. Firstly, they are at the start of their careers, which involves its own anxieties. Secondly, there is a general lack of awareness of vicarious trauma which makes it difficult to identify/recognize. Lastly, there is the fear that VT can result in a decreased professional standard, a negative impact on clients, and the ripple effect in to other spheres of their lives. This is supported by the literature (McCann & Pearlman, 1990; Courtois, 2002; Cunningham, 2004; Newell & McNeil, 2010; Trippany et al, 2004; as cited in Williams, Helm & Clemens, 2012). Thus vicarious trauma is perceived as a real threat to the novice trainee therapist who is conscious of their professional performance and preoccupied with the need to establish themselves in the field and build a career. From this discussion it is evident that vicarious trauma threatens all of the above for multiple reasons. For example, VT is a threat either due to the lack of knowledge or due to the likelihood of it occurring at the starting point of their careers. It can also be a threat due to the negative impact it has within the professional sphere, or a combination of all of the above. It is important to note that, although the participants did not describe personally experiencing VT during their M1 year, their responses reflected the perception that a trainee psychologist may

be at risk for experiencing VT due to multiple reasons, for example the lack of knowledge of VT and the lack of previous experience.

4.4 Awareness and Preparation during the Training Programme

The research findings under this theme will be discussed in terms of the amount of exposure and/or education that the participants received on the risks involved with being a mental health professional. It will also explore the education of vicarious trauma during their lectures and supervision. In addition, this section will unpack their suggestions to increase the awareness of vicarious trauma within the education setting in order to improve resilience in the field and better equip trainee psychologists to prevent or cope with vicarious trauma.

From the transcripts it is evident the participants felt there was a need within their education and training programme to increase *exposure and education on the potential risks when working within this field*. Sommer (2008) and Baker (2012) discussed the same idea highlighted by the participants of this study- that education and training programmes need to incorporate a more specific focus on VT. This need could be geared more towards a practical knowledge of how to identify and cope with vicarious trauma responses, rather than an in-depth theoretical knowledge. As is evident from the previous sections in this discussion, the participants have a general understanding of vicarious trauma, its symptoms, and its consequences/impact. The difficulty lies in conceptualisation, thus highlighting a starting point for education programmes. One can further hypothesize that if there are difficulties with conceptualization, then it is likely that there will be challenges with regard to the implementation of effective coping methods and interventions, which the research findings of this study indicate were a challenge for the M1 students.

One must acknowledge that the participants were not describing their Masters programme as inefficient, as is evident through their appreciation of the two workshops on self-care and trauma for example. However, they were voicing a very real need for ongoing awareness strategies within this specific programme. This resonates with the literature of Newell and MacNeil (2010) who described how training in both the professional and educational spheres of mental health were important to adequately prepare mental health practitioners, especially those in training, for the negative psychological effects of trauma work and the potential risk of VT. What is interesting to highlight is that the participants felt the brief education they did receive on self-care was related more to looking after themselves during the Masters year, but not as a professional psychologist. The participants further indicated that self-care was not a priority during their M1 year and that they were nervous to utilize academic support due to the fear of evaluation. This could be linked to the idea of 'trainee bravado' where the main goal is to make it to the end of the Masters year. However, this singular goal needs to be expanded to the broader picture of their internship, community service, and professional practice thereafter by looking at ways to cope effectively throughout the professional journey (Somer, 2008; Newell & MacNeil, 2010).

In order to further the understanding of awareness and preparation, this research explored if the *concept of vicarious trauma was raised during their studies*. Before this question was asked during the interview process, it was assumed that the participants would express how vicarious trauma was not focused on specifically at any point during their training programme. The responses offered by the participants in this research reflect this assumption because most of them described how vicarious trauma was not discussed directly through lectures or seminars, but rather indirectly through casual conversations with peers or due to their own research. The self-care workshop provided valuable insight regarding its importance, however the participants expressed that it was not specifically related to VT. These observations are

congruent with the literature outlined by Adams and Riggs (2008) and Parker and Henfield (2012). The casual discussions that were had amongst the participants focused more on how they were coping and what they were struggling with. The term 'vicarious trauma' was not spoken of directly but the ideas and notions of the concept lingered in their conversations.

This is an interesting finding because it implies that, although there were no direct courses on vicarious trauma within this specific training programme, there was a subconscious awareness of what vicarious trauma entails, for example its symptoms and consequences. This reinforces the idea that student psychologists' cognitions and perspectives are largely shaped and geared throughout their studies towards an understanding of the potential risks and consequences involved in the field of mental health. In addition to the literature (Baker, 2012; Parker & Henfield, 2012), and as reported by the participants, it would seem that the need they were highlighting was more for the 'know how' regarding prevention and coping with vicarious trauma. Furthermore, as student psychologists juggling between professional development and managing trainee anxiety, it is understandable that they expressed such a need for more awareness within the Masters programme.

Building on the main theme, the research explored whether the participants experienced *discussions of vicarious trauma during supervision*, which is interconnected with the above sub-theme. The aim of this particular question in the interview process was to explore if the participants had been offered either an educational or supportive space during supervision to explore vicarious trauma. It is important to emphasize how the participants valued supervision for its academic support, which is in line with the literature (Hill, Sullivan, Knox & Hoffman, 1997; Skovholt, 2012). Their responses merely highlight the space for more attention to vicarious trauma within a supervision setting and the room for emotional support. From the responses, there is a general perception that supervision focused on how the M1 students were working with their cases and their understanding of those cases. However, based on their

reports, it is clear that they would have appreciated more emotional support during supervision and a specific focus on vicarious trauma.

Reflecting on this, it is possible that the participants describe a need for extra emotional support because of their heightened trainee anxiety. Furthermore, trainees were anxious about the ongoing evaluation process, and would therefore be less likely to utilize the emotional support out of fear that it may impact on the evaluation process. This idea offers a possible explanation of the need for more focus on vicarious trauma in supervision/lectures and more emotional support. The support may have been present but the fear of being evaluated negatively overruled their use of those supportive spaces. Education and training programmes therefore need to consider how evaluation is conducted and find a space to include more support. Further, these programmes need to create a culture of acceptance when utilizing support during the training phase so that M1 students do not carry the perception that use of support equates with poor coping skills and thus negative evaluation. Supervision is an invaluable domain during training programmes, as indicated in both the literature (Goodyear et al. 2003; Somer, 2008; Ronnestad & Skovholt, 2012) and the results of this study. The challenge for the novice therapist appears to revolve around adequate utilization of supervision. The two sub-themes discussed indicate the importance of including vicarious trauma in education/training programmes through lectures and supervision. This may allow student psychologists to feel they are learning both the knowledge and the 'know-how' of vicarious trauma, rather than suppressing their trainee anxieties and not utilizing supportive systems due to the fear of evaluation.

Finally, the student psychologists of this study were asked to express their *ideas to improve the exposure to and education on vicarious trauma in training programmes.* Baker (2012) emphasized how tertiary institutions need to best prepare student psychologists for the potential risk of vicarious trauma and how to deal with it effectively. Further, Baker's (2012) study

revealed that student psychologists felt a course on vicarious trauma would equip them with the necessary skills to engage in effective psychotherapy with trauma survivors. The suggestions offered by the participants, such as seminars and guest speakers, are consistent with the literature outlined by Sommer (2008) and Baker (2012). In addition, both the literature and the participants' responses reflect the belief that courses on VT and an incorporation of active preventative measures during education and training would be helpful in creating more awareness of vicarious trauma and increase their ability to cope with it.

Another important suggestion offered by the participants was increasing the practical exposure offered by the training programme. Most participants expressed how that the exposure to cases during training is protected and filtered so that their cases are manageable. However, it was evident that the M1 students would have preferred greater exposure, either in the university clinic or through their hospital placements. This would deepen their practical knowledge and experience regarding trauma work. Further, it would assist them with learning how to cope with VT and its consequences. None of the participants worked with trauma cases during their M1 year, hence a possible explanation for suggesting more exposure during training. There appears to be an assumption rooted within this suggestion- that increased exposure will result in increased practical knowledge and efficiency when working with trauma cases. Furthermore, the assumption also suggests that increased exposure will improve their coping and self-care abilities.

The aforementioned assumption is in agreement with the work of Parker and Henfield (2012). The participants in their study described how a lack of experience (professionally and within training programmes) may be a risk factor for VT. The observations from the participant responses of this study are therefore congruent with the literature. Half of the participants in the study conducted by Parker and Henfield (2012) mentioned how they did not engage with any trauma-related cases during their training, which resonates with the participants of this

study. The similarities between the literature and the present research reflect the value of practical work and the need for increased exposure during training. There is great potential for education and training programmes to make important changes and additions that would benefit trainees invaluably.

CHAPTER FIVE

5. PERSONAL REFLECTION

Given the research method used, a reflection chapter is included to acknowledge bias and make evident to the reader how I attempted to limit such bias overly affecting the research process. This section will allow myself as the researcher to reflect on the research process from a unique angle- as both the researcher and an M1 student/trainee psychologist. It is important to acknowledge that this was, in a sense, a dual role. The process of personal reflection thus allowed for any researcher bias to be accounted for in an attempt to increase the trustworthiness of the data.

My interest in vicarious trauma research began in my honours year through a systematic review. My research supervisor had a general interest in vicarious trauma and allowed her students to structure their specific topics based on that underlying theme. Hence the focus of my study at the time emerged, which aimed to develop a sound conceptual understanding of vicarious trauma and identify interventions required to cope with it. The end goal was to suggest an intervention programme for the university, however this did not materialize because I felt there was more to be done, and more to be researched, before one could attempt to suggest an intervention for vicarious trauma. There was a gap within my existing literature regarding student psychologists' attitudes, perceptions, and experiences of vicarious trauma. This gap thus created the starting point and focus for my Masters dissertation.

I decided to build on the research I had conducted during my honours year, this time with a renewed focus on the understanding that student psychologists have of vicarious trauma. This was spurred by my own realization of how real vicarious trauma is and the severe impact it could have on the helper's professional development. This was a lingering fear in the back of my mind: "Will I experience vicarious trauma? How long will I last as a mental health

professional?" This thought process snowballed to the point of wondering what student psychologists need to know about vicarious trauma in order to be best equipped to identify and cope with it so that they can thrive within the field of mental health. Before I could answer that question, I had to explore how student psychologists conceptualized vicarious trauma.

When constructing the interview questions, I had to make careful efforts not to create leading questions. This was done with the help of my research supervisor who assisted in revising the interview questions. When the time arrived for the data collection process to begin I had to mentally prepare to manage both the interview process and my own cognitive and emotional presence as I did not want to influence the participants' responses. It was certainly very easy to get swept up and consumed by the discussions during the interviews, but I held to the mental reminder of my role within this process. Although I wanted to be drawn in to the discussion as if I was also a participant, I had to suspend that perspective and experience, and remain the researcher.

I did not disconnect from my own experiences and perspectives as a student psychologist while engaging in the data collection process. That would have been impossible. However, I used those perspectives, attitudes, emotions, and experiences to better relate to the participants which assisted further in obtaining rich detail from the interview process. As a researcher I was also able to resonate with the fears, anxieties, and attitudes of the participants which added a personal element to the data collection. I believe this was invaluable to the whole research process.

As a trainee psychologist who had just completed the M1 year and was preparing to enter an internship, I found myself in a similar position as the participants and I could recognise the same anxieties within myself that the participants described. It felt comforting to know that, even though we had all completed our M1 studies, I was not the only trainee who feared the

unknown of the internship and doubted my personal and professional readiness for it. The research process therefore offered some relief and comfort knowing that I was in a similar space of professional development as the participants.

Although I knew about vicarious trauma and what it entails, I held similar concerns as the participants- will we experience it as early as our internship year? How will we cope with it? Can more be done at an educational level to prepare us for the type of work we will be doing and the potential consequences thereof? I found myself wondering if I had received enough exposure in my M1 year in that would equip me to cope with my internship and onwards. These thoughts continued to linger in the months that passed until my research continued.

A few months passed before I resumed with my dissertation which was due to the general struggle of adapting to the working life of an intern clinical psychologist. After resuming with the results process, I reawakened the same concerns and anxieties I had at the end of the M1 year, and found myself agreeing with the participants while listening to the recordings. These thoughts reignited my energy for this dissertation so that the voices of student psychologists can be heard. However, in order to not impose my own views, I engaged in ongoing reflection and maintained communication with my supervisor. Hopefully, education and training programs introduce some changes or additions to their programmes so that our fears and anxieties as student psychologists can be transformed in to skills, knowledge, and know-how for the future.

Being a few months shy of completing my internship and awaiting information about community service, I am able to reflect on the research process and feel thankful. Yes, it has been difficult jumping from M1 into an internship. It is difficult working a full day and balancing time for this dissertation without sacrificing my own self-care and thus burning out so early in the game. And it certainly is anxiety-provoking to think about community service

where there is no supervision and support like that which exists for an intern. I do feel there needs to be more of a focus on vicarious trauma within education programs and greater exposure to working with trauma cases so that novice therapists understand the line of duty they have entered in to rather than developing 'superman fantasies' of saving everyone, which can result in disappointment and unrealistic expectations for the job. Yes, we are here to help, but we cannot do that effectively if we, our own personal tool, are not doing all that we can to ensure we thrive professionally and personally. Through it all this research process has helped me understand how valuable we are as mental health professionals and that we cannot take ourselves for granted when working within this field, regardless of whether we are just starting out or preparing to wrap up our history of service.

CHAPTER SIX

6. CONCLUSION

6.1 Reflection on Research Questions/Objectives

As a result of the findings and discussion of this study, it appears that due to the nature of the work involved in the field of mental health, mental health professionals are at an increased risk of experiencing vicarious trauma. Regarding the specific focus of this study, it would seem that trainee psychologists have the perception that they may be at a greater risk for experiencing vicarious trauma due to a number of factors.

The stages of therapist development highlighted by Skovholt (2012) describe how the journey through professional development is one characterised by ambiguity, uncertainty, and novice anxiety. This places student psychologists in a vulnerable position due to the already existing emotional challenges encountered during the training year. Coupled with an insufficient knowledge of vicarious trauma, these factors can be considered a recipe for increased risk. Furthermore, student psychologists may be so engrossed in performing well academically in their Masters year that the potential signs or symptoms of vicarious trauma may go unnoticed.

Another factor increasing risk for vicarious trauma experiences within student psychologists is a lack of experience, as emphasized by the participants in Parker and Henfield's (2012) study. This was also emphasised by the respondents of this study who believed that lacking experience may increase their risk for vicarious trauma. Thus there is the perception of a direct relationship between experience and risk for vicarious trauma. One cannot ignore the variables that the trainees perceived as influential in this causal relationship, such as coping mechanisms and knowledge of vicarious trauma. From the research it appeared that trainees perceived VT to be complicated in nature, with different factors contributing to its development and severity. The

complexity of this relationship between the risk factors and VT further creates a need within education and training programmes to increase the knowledge of vicarious trauma.

One of the core aims of this research was to explore if there is a need within psychology education and training programmes to include more of a focus on vicarious trauma. The process for attempting to achieve this aim was to explore the participants' experiences of the training program with regard to the exposure and education of vicarious trauma, and what the participants felt could be done within the training domain to increase their knowledge and ability to cope with vicarious trauma. The suggestions offered included seminars throughout their training on vicarious trauma, how to recognize it, and how to cope with it, as well as greater exposure during their training so that student psychologists can develop practical knowledge and know-how and increase their experience level, rather than simply focusing on 'easy' cases and theory. These suggestions were spurred by the respondents' anxiety that they had not engaged with trauma cases and thus doubted their abilities to cope with such cases during their internship and onwards. This can be related to the literature offered by Baker (2012) and Parker and Henfield (2012) who described the need for more graduate-level course on vicarious trauma to be incorporated in to training programmes. It can therefore be concluded that this aim was achieved.

6.2 Limitations

As previously mentioned, all of the participants were females. The disadvantage to this is that there is no representation for the perspectives, experiences, and attitudes of male trainee psychologists in this study. There has not been any literature indicating which gender, if any, is more likely to experience vicarious trauma, but it is realistic to assume that men and women within this field have different perspectives, and may experience similar or different emotional challenges during the training programme. It would have been interesting to draw comparisons

between male and female trainees' coping methods for trainee anxiety and vicarious trauma, and to compare or contrast their experiences of the training programme and suggested improvements to note if there are any notable differences between the perceptions, attitudes and experiences of male and female trainees within the field of mental health. This is an important consideration for future research.

6.3 Future Considerations

This research study was exploratory in nature and focused on convenience sampling, hence the focus on student psychologists. Future research should attempt to include samples from various mental health professionals, such as psychiatric nurses and social workers, in order to compare perspectives, attitudes, and experiences of vicarious trauma across the field of mental health rather than a single focus on the field of psychology. Furthermore, future research could also focus on sampling Masters Psychology students from various tertiary institutions which would allow for the comparison of education and training programs across South Africa. This would allow more accurate suggestions to be proposed to tertiary institutions to increase awareness and education of vicarious trauma. Both of the above suggestions would allow for generalizations across tertiary institutions in South Africa, as well as a greater understanding of how different mental health professionals perceive, experience and cope with vicarious trauma.

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APPENDICES

Appendix I: Interview Schedule

A Qualitative Study of Trainee Psychologists' Attitudes/Beliefs and Perceptions of Vicarious Trauma

Participant Number: _____

Contact Number for Participant Checking: _____

Biographical Information (to be filled out by participant):

Age _____ Gender _____ Race _____

What is the duration of your counselling experience (example: 1 year Masters training)?

_____

Do you have any additional work experience related to the field of psychology?

_____

Section 1: Experience of the Masters Professional Training

1) What have you noticed in your experience as a novice therapist with regard to the secondary consequences of the helping profession?
    a) What are some of the emotional challenges you face as a student psychologist?
    b) What are you currently doing to manage or cope with the anxieties and demands of being a novice therapist?
    c) In the beginning of the Masters programme you did a workshop on self-care. How important is the idea of self-care after that workshop? What does self-care mean for you?
    d) You also participated in a two-day workshop on trauma. How did this impact you? What insight have you gained with regard to trauma work?

Section 2: Attitudes/Perceptions of the secondary consequences of the helping profession

1) What are some of the difficulties distinguishing VT from general training anxieties?
2) Do you think you are likely to experience VT?

Probe: If yes, why do you think you are susceptible?

Probe: If no, why do you think you are not susceptible?

3) What are some of the factors you believe could increase the risk of experiencing VT (for example experience, case load, personal trauma history) and why?
4) In your opinion, what would you do to cope with/manage the secondary effects of the helping profession?

Section 3: Knowledge of the secondary consequences of the helping profession (In particular, VT)

1) What is your understanding of VT? How would you define VT?
2) How would you know if you are suffering from VT? In other words, what are the symptoms that would indicate VT?
3) Are you aware of the repercussions/consequences of VT?
4) In what way/s is VT a problem for the novice training therapist?

Section 4: The Needs of Novice Therapists with regard to Awareness and Preparation during Training Programmes

1) Briefly describe your training experience with regard to exposure and/or education on the potential risks to psychological, physical and professional health when working in this field.
2) Has the concept of Vicarious Traumatization ever been raised during your studies (education, training, supervision)?
3) During supervision, has there been a discussion of the secondary consequences of the helping profession?

   Probing question: Which consequences were discussed?
4) What can be done to improve exposure and education on the secondary effects of the helping profession in training programmes?

(Approx. 45 minutes per interview)

Appendix II: Informed Consent Form

A Qualitative Study of Trainee Psychologists' Attitudes/Beliefs and Perceptions of Vicarious Trauma

My name is JENNA-LEE LOEVE. I am a Clinical Psychology Masters candidate studying at the University of KwaZulu-Natal, Howard College Campus, South Africa.

I am interested in learning about trainee psychologists' attitudes/beliefs and perceptions of Vicarious Trauma (VT). The study seeks to understand what trainees know about VT, the attitudes they may hold of VT, and their perceptions of what may make them more or less vulnerable to experiencing VT during their training years and in future practice. The study will explore this qualitatively through the use of semi-structured interviews and thematic analysis.

Research participants are students enrolled in the Counselling and Clinical Psychology Masters Programme at UKZN Howard College. The participant's age, race, gender and experience level are not the focus for this study. Participants will be asked to participate in semi-structured interviews reflecting on their attitudes/beliefs, perceptions and experiences of VT. The interview will take approximately 45 minutes.

Research Participants will be asked to give their contact number and/or email address for the purpose of follow-up conversation during the data analysis phase. As part of a participant checking phase, the research findings and interpretations will be shared with the participants and they will be asked to comment and share feedback on whether the interpretations made are an accurate and comprehensible reflection of their attitudes/beliefs, and perceptions.

Interviews will be conducted on the Howard College campus outside of lecture/academic/practical times to avoid disruptions to students' training me schedule. Participants consent to the interviews being recorded using an audiotape device. Participation in this study is voluntary. Participants are free to withdraw at any time and their decision to participate will in no way affect their coursework or evaluation as M1 students.

To ensure confidentiality and anonymity, only the researcher will have access to personal details of participants. Participants will then be assigned a number which will be used for

reference purposes only by the researcher and the research supervisor. Findings will be published in a thesis, presentation, and/or conference.

Please note that:

- Your confidentiality is guaranteed as your inputs will not be attributed to you in person, but reported only as a population member opinion.
- The interview may last for about 45 minutes.
- Any information given by you cannot be used against you, and the collected data will be used for purposes of this research only.
- Data will be stored in secure storage and destroyed after 5 years.
- You have a choice to participate, not participate or stop participating in the research. You will not be penalized for taking such an action.
- Your involvement is purely for academic purposes only, and there are no financial benefits involved.
- If you are willing to be interviewed, please indicate (by ticking as applicable) whether or not you are willing to allow the interview to be recorded by the following equipment:

	Willing	Not willing
Audio equipment		
Video equipment		

If there are any areas of concern or questions regarding the study's aim and purpose and one's role as a participant, the researcher will provide this information. A copy of the final report will be made available to all participants on request.

I can be contacted at:
Email: jennloeve@gmail.com
Cell: 0833756109
My supervisor is Professor Duncan James Cartwright who is located at the Centre for Applied Psychology clinic on the Howard College Campus. He can be contacted via email at cartwrightd@ukzn.ac.za.

You may also contact the Research Office through:

P. Mohum

HSSREC Research Office

031 260 4557 or mohunp@ukzn.ac.za

Thank you for your contribution to this research.

By signing this consent form, you agree to participate in the research study explained and indicate that you fully understand the study, its aims and purpose, as well as your role as a participant.

I, _____ , am participating freely and understand that I can withdraw at any point should I choose to no longer continue and that this decision will not affect me negatively. I understand that this research project will not benefit or harm me personally, and I understand my participation will remain private and confidential.

Email Address _____

Signature of Participant _____

Date:

Appendix III: Coding Matrix

INDEX	THEME	P1	P2	P3	P4	P5	P6	SUMMARY
1	DEMOGRAPHICS							
1.1	AGE	38	36	30	24	28	32	Average age is 31 years
1.2	GENDER	FEMALE	FEMALE	FEMALE	FEMALE	FEMALE	FEMALE	All female
1.3	RACE	WHITE	WHITE	BLACK	BLACK	WHITE	INDIAN	3 white, 2 black, 1 indian
1.4	QUALIFICATION	M1 COUNSELLING	M1 COUNSELLING	M1 COUNSELLING	M1 CLINICAL	M1 CLINICAL	M1 CLINICAL	3 clinical, 3 counselling
2	EXPERIENCE OF MASTERS PROFESSIONAL TRAINING							
2.1	Secondary Consequences of the Helping Profession	This participant felt that the helping profession challenges her regarding maintaining boundaries which can lead to a decrease in professional quality if she is not able to separate herself from the content of the patient.	She felt overwhelmed and anxious due to the content the patient was bringing.	Highlighted how the positive consequence is an increase in knowledge but the negatives are fatigue and feeling overwhelmed. She also mentioned the impact that trauma work can have on a novice therapist, leading to burnout and decreased professionalism.	She found it very difficult and felt it was worsened by the lack of emotional support. The participant also noticed her anxiety and how she sacrificed her coping mechanisms due to the stress of the M1 year.	This participant reports not experiencing the secondary consequences of the helping profession to such an extent that it was unmanageable or overwhelming but reflected on how she feels she could potentially experience those consequences during the internship. She also felt that trauma is challenging to work with and can impair one's functioning.	This participant found it challenging in the beginning of the M1 year where she felt overwhelmed to an extent when she began seeing patients.	Overwhelmed and anxious; difficulties with boundaries; lack of emotional support; fatigue.
2.2	Emotional Challenges	Self-doubt and wondering if she has done the right thing. The participant also describes feeling unfulfilled and unfinished.	She felt ill-equipped to know where to begin when working with patients. The participant also found it emotionally challenging to wait a week for supervision to discuss her thoughts and concerns after a session. The student-professional balance was difficult.	The lack of support was an emotional challenge for this participant, as well as learning to detach from the therapy setting once sessions are over.	She felt the lack of support was an emotional challenge as well as conflict amongst the M1 students due to the emotional difficulties they were all facing.	This participant felt that a significant emotional challenge was the transition between being a student using theory and being a novice therapist that is having to practice what has been learned, and the novice trainee anxiety that accompanies that transition.	She did not feel as overwhelmed as she was expecting to feel due to her past experience of counselling work but she did reflect on how the content of patients can leave a sense of hopelessness and helplessness for her. A significant emotional struggle for this participant was striking a balance between family life and Masters work.	Self-doubt; the transition from student to an emerging professional; balancing work and family; learning to disconnect from therapy sessions
2.3	Coping Mechanisms	Setting boundaries and having that mind set of being a helper so she can't "*go down with them*". This participant also felt that the use of knowledge/theory that had been taught previously was a coping mechanism for her. Being aware of her priorities at home and using the travel time to debrief and destress served as coping mechanisms. Exercise is also a coping mechanism.	Preparing for the next session and having open discussions during supervision served as coping mechanisms for this participant. She also highlighted the importance of maintaining a professional distance as a coping mechanism to avoid getting lost in the client's content.	This participant made use of journaling to process and offload the emotions involved in being a helping professional.	Supervision served as a means of coping for this participant. However, she felt that her normal coping mechanisms went "*out the window*" during her M1 year due to the stress. She felt that if she could go back, she would take some time to focus on her own well-being, for example going for a walk. Another coping technique was talking to fellow students and engaging in her own personal therapy.	Supervision and talking with classmates served as coping methods. She also mentioned accepting and working with the anxiety so that it becomes a normal part of the experience. This helped her to cope with the anxiety.	This participant felt it was difficult to make use of effective coping mechanisms, however compartmentalizing is a key coping mechanism and protection against feeling overwhelmed. She also took the time during the weekends to spend with her family and have that break from M1 work. Talking with classmates was another means of coping for this participant.	Exercise, journaling, time management, supervision, peer support, personal therapy.
2.4	Self-Care Workshop	This participant expressed how it is important to be reminded about self-care because she feels no one does enough of it within this field. It was an added challenge for her due to being a mother but she mentioned how it is something she continues to strive for.	The self-care workshop was considered to be the most important lecture from the entire year for this participant. However, according to this respondent there is more room for a continued focus on self-care rather than once-off.	For this participant, self-care should have been one of the biggest components of the program. She felt it should not have been once off and that she did not learn the skills, tools and techniques for how to go about doing self-care. This participant further mentioned how self-care is important when working with traumatic cases.	Self-care is very important for this participant as she feels it should be the first priority. However, she does admit that her self-care was very poor during the Masters programme.	This respondent expressed how the self-care workshop was brief but highlighted aspects of trauma work that practitioners need to be cautious of. For this participant, self-care was easier as she felt she had a lot of time to herself but has expressed how it seems more relevant now that she has begun her internship.	The self-care workshop made this participant aware of the importance of self-care and how little of it she was doing.	Self-care is important and is something that most participants feel they need to do more of. Should be emphasized more during the programme.
2.5	Trauma Workshop	This participant mentioned the insight she gained from the trauma workshop- that it can affect helping professionals, especially novice therapists, and that it is normal to have these feelings and reactions.	For this participant, the trauma workshop was helpful in terms of learning what approaches can be used when working with trauma cases. The role play involved helped the participant understand how a traumatized client can present but she felt it was a short look in to a big area and would have liked more practical opportunities.	The trauma workshop provided insight in to the impact that trauma work can have on a therapist and how therapists can possibly re-enact those trauma experiences, ultimately leading to secondary traumatization.	The trauma workshop was scary for this participant because of how real the practical example felt for her. She felt the workshop was eye opening with regard to the effect trauma can have on clients but is nervous for her internship because she feels it was just an overview.	For this participant, the trauma workshop provided insight in to how challenging it can be to work with trauma, especially if one has a personal trauma history. However, this participant has previous experience in trauma work and she feels experience helps in terms of learning how to compartmentalize after working with trauma cases. The trauma workshop served as a reminder of the nature of trauma work.	The trauma workshop showed this participant the immediate impact of trauma. It made her feel overwhelmed as a helping professional after the role play. The workshop further made her realize the importance of self-care so that, as a helping professional, you do not meet with the next client carrying the trauma of the previous client.	Provided valuable insight but should be on-going so that more skills and practical knowledge can be learned.

3	ATTITUDES/PERCEPTIONS OF THE SECONDARY CONSEQUENCES OF THE HELPING PROFESSION	P1	P2	P3	P4	P5	P6	SUMMARY
3.1	Difficulties distinguishing VT from trainee anxiety	She describes how VT would manifest as PTSD symptoms but how it could be difficult to see VT in oneself as a helping professional due to the nature of the work.	For this participant, she describes how it is difficult to separate trainee anxiety from VT due to how busy the M1 year is and the stress involved. She suggests that unpacking it further with a supervisor and in personal therapy may help to identify VT for the novice therapist.	This respondent expressed how it is also a challenge to differentiate between VT and trainee anxiety, especially due to blind spots regarding triggers for anxiety. She further mentions that if a novice therapist is aware of where their anxiety comes from, they will be better able to identify it and thus tell the difference between VT and trainee anxiety.	For this participant, the line is blurred between VT and personal anxieties. She describes how helpers have their own anxieties and traumas to deal with but may forget that, which then makes it difficult to differentiate between the VT associated with the work being done or personal anxieties that need to be processed.	She describes how it's difficult to tell the difference between VT and trainee anxiety due to a lack of knowledge. Furthermore, she expressed that during M1, trainees blur the lines between academic anxiety and trauma effects, which thus makes it a challenge to tell the difference between VT and trainee anxiety.	This participant also describes how it is difficult to tell the difference between VT and trainee anxiety because the lines are blurred. She mentions how the M1 year is filled with anxiety which makes it difficult to differentiate between personal anxiety due to professional development or the early signs of VT.	Difficult to differentiate because of the stress involved in M1 and due to blind spots about triggers for stress/anxiety. Lack of knowledge leads to blurred lines between concepts.
3.2	Personal risk for experiencing VT	This participant expressed how she feels she does have a personal risk for experiencing VT, particularly because she is a parent so she has strong emotional responses when working with children.	She described how she feels it is a possibility to experience VT due to the nature of the work mental health professionals engage with and the high possibility of working with trauma cases due to the crime rate in SA.	This participant feels there is a risk to experience VT if there is no awareness of it and also due to the transition from M1 to internship where there is more engagement with cases.	She described how it is a possibility to experience VT due to the nature of crime in SA as well as the work load involved. She mentioned the importance of debriefing but how it will still be likely that most young psychologist's will experience some form of VT.	This participant expressed how she feels everyone involved in this field has a risk of experiencing VT and that awareness of it does not mean protection against it. She further mentioned how the nature of cases can also influence if she and others experience VT.	For this participant it is likely that she will experience VT because she mentions how it is one thing to learn about self-care and detaching from work content, but she needs to learn how to implement systems of doing just that otherwise she will experience VT.	All felt there was a risk for experiencing VT due to lack of knowledge, the nature of crime in SA resulting in high case load, and minimal exposure during training.
3.3	Factors increasing the risk for VT	Personal trauma history, case load, and being a parent are factors that this participant felt could increase her risk of experiencing VT.	Personal trauma history, day-to-day stress when running a private practice, and personal stressors such as relationship or family conflict.	The stress of M1, case load and the nature of the cases, and lack of debriefing space, and a personal trauma history that has not yet been processed and worked through.	Families who do not understand the nature of the work and/or may be unsupportive, unprocessed personal trauma history, personal blind spots, physical health,	Case load, lack of experience, and an unresolved personal trauma history.	Case load, personal trauma history, lack of self-care, and lack of social support.	Personal trauma history, case load, inexperience, lack of support, and lack of self-care.
3.4	How to cope with or manage the secondary effects of the helping profession	Write about it, reflect on it, own personal therapy, taking a time out/debriefing.	Personal therapy, peer support, supervision, debriefing space.	Self-care, knowing your blind spots, group therapy, individual therapy, reflecting on your emotional response to a patient's trauma.	Accessing work support, personal therapy, taking a break when it becomes too much to cope with, self-awareness, faith.	Self-care, debriefing, personal therapy	Self-care, debriefing, work support from colleagues, social support, personal therapy.	Personal therapy, support, debriefing, supervision, self-care.
3.5	Protective Factors	Experience, professional boundaries, self-awareness, personal therapy, and support all serve as protective factors.	Experience, the ability to remain contained during a moment of crisis, and support are considered protective factors by this respondent.	Mentoring, self-care, experience, a space to debrief/reflect, personal trauma history if it has been worked through, and personal therapy.	Peer support, supervision, personal therapy, and her religion serve as protective factors.	Experience, self-care, and personal trauma history.	Experience, maintaining personal and professional health, and support.	Experience, boundaries, self-care, support, personal therapy.

4	KNOWLEDGE OF THE SECONDARY CONSEQUENCES OF THE HELPING PROFESSION	P1	P2	P3	P4	P5	P6	SUMMARY
4.1	Understanding/Definition of VT	Similar to PTSD; adopting certain habits based on what is happening in your environment with your clients; having trauma symptoms but no direct trauma.	The personal reaction and effects of working with clients who have trauma- depression, anxiety, trauma symptoms.	It includes burnout and fatigue. Feeling re-traumatized by the client's content to the point of being burnt out and fatigued.	Feeling overworked, behavioural changes, others noticing a change from who you normally are and asking if you are okay.	The effects of hearing the trauma of others and taking it on as your own. Not directly experiencing the trauma itself but becoming traumatized by hearing other people's stuff.	Listening to the trauma of others, not having your own direct threat to life or other trauma, yet feeling the same things that they are feeling.	Personal reaction to hearing the trauma of others, fatigue, and behaviour changes. Taking another's trauma on as if it were your own.
4.2	Symptoms of VT	Physical responses, flashbacks, being over-cautious, the typical trauma symptoms, lack of empathy and energy when engaging with clients. The symptoms are cumulative and include cognitive and behavioural elements.	Noticing how you are feeling about sessions and clients, especially those with trauma content, and your behavioural response to that- cancelling sessions, arriving late, feeling anxious- those would be clues that VT is beginning.	Fatigue, being neglectful, irritability, responding to events in unusual ways (outside of your normal response), and a lack of sensitivity.	Vegetative shifts; occupational, social, and behavioural disturbances; depression; lack of interest in doing the work.	PTSD-like symptoms: flash backs, intrusive thoughts, fatigue etc	Irritability, isolation, intrusive thoughts (behavioural and cognitive changes).	Fatigue, irritability, vegetative shifts, social changes, behavioural changes, PTSD symptoms.
4.3	Consequences of VT	Burnout, less logical and rational thought processes, the impact on daily relationships, quality of work will decrease, and hypervigilance may result in overreactions to events/triggers.	Withdrawal from support systems; it will impact on your sleeping and eating patterns which has its own knock-on effects. The effects have the capacity to influence multiple areas of one's life.	Creates disconnect between therapist and client, and a lack of sensitivity.	Losing one's desire to help, burning out, and the negative impact on relationships.	Less efficient psychologist with decreased professionalism, and unable to give one's all to each client.	It will affect professionalism, and negatively impact on personal relationships.	Burnout, negative impact on relationships, decreased professionalism, withdrawal.
4.4	How VT is a problem for the novice trainee	The impact on professional service/standards.	May impact on level of enthusiasm and might make the trainee not want to enter in to practice once qualified.	The problem lies in the lack of awareness/knowledge and the lack of experience - more experience will better equip trainees to identify it.	VT is a problem for novice trainees because they are just starting out so this participant feels that if trainees aren't able to cope, then it could be a set up for failure.	VT is a problem for novice trainees because they are just starting out so they are dealing with those anxieties coupled with possible VT symptoms. Lack of awareness/knowledge then means they won't be able to recognize and deal with VT.	VT is a problem because trainees do not know how it can have a ripple effect in all areas of one's life beyond just their personal experience of it.	The impact on professional service; the impact on career development; the ripple effect in all areas of life.

5	AWARENESS AND PREPARATION DURING THE TRAINING PROGRAM	P1	P2	P3	P4	P5	P6	SUMMARY
5.1	Exposure/education on potential risks when working in this field	More can be done to raise awareness. The focus was on coping during the Masters year but there is a gap when it comes to learning about the potential risks and how to cope when one becomes a professional.	Not covered directly through lectures or modules. There was mention of getting legal protection which created more anxiety for this participant. The "how" of caring for oneself once you're a professional was sparse.	Described picking up on the possible risks involved with being a mental health professional through the practical work with clients. The participant also felt the orientation programme assisted with this awareness but she still feels that they need more assistance in understanding the possible risks.	Feels there was insufficient exposure during the program and that more time needs to be spent on this awareness. She further described how it must expand beyond just teaching about the possible risks involved.	It was mentioned/highlighted through the two workshops but not as in-depth as it could have and should have been. The potential risks need to be focused on a bit more for this participant.	Feels there was some education through the workshops but she feels it was insufficient. She feels the exposure was not enough to equip her to deal with the possible experience of VT symptoms during her internship. More practical engagement is necessary.	More can be done to raise awareness of VT. No direct focus on it but the workshops provided some key insight which can be expanded on.
5.2	Concept of VT raised during studies	Came across it academically but not through practical exposure or lectures.	Not raised specifically and not with the exact term 'vicarious trauma'. The idea of VT was spoken about more through casual conversation than direct lectures/seminars.	Concept was raised in passing through casual conversations but not directly.	It was raised briefly during her honours programme by the traumatology lecturer but there was no discussion on the consequences of VT.	Participant describes not hearing the direct phrase 'vicarious trauma'. The facts are discussed but not the term itself and as a result, most people do not know what it is.	It was not discussed directly.	Not discussed directly and not with the term ‘vicarious trauma’. Often spoken about indirectly with peers.
5.3	Discussion during supervision	This participant describes having a supportive supervisor during her practical placement at a counselling centre. The supervisor offered debriefing but they did not discuss VT directly nor the cumulative effects.	Concept of VT was not raised or discussed during supervision.	Her supervisor did not specifically discuss VT and how to cope with its consequences but some discussion was had on her response to cases.	Not raised or discussed during supervision.	It was discussed indirectly in supervision. The participant discussed with her supervisor her reactions to sessions and was given that supportive space. But it was not a direct discussion on VT.	Discussion during supervision was not specific. It was linked more with her responses to sessions with clients.	No direct focus in supervision, however some participants did have the space within supervision to talk about the impact of their cases.
5.4	Ideas to improve the exposure to/education of VT in training programs	Guest speakers sharing their experiences with burnout, fatigue, vicarious trauma etc. so that trainees understand how real it is and can hear what others did to cope with it.	Workshops where trainees get to share their personal experiences and responses to cases so that lecturers can normalize these responses and offer support.	A workshop on VT, possibly a mentorship programme, and a reflection space in supervision dedicated to learning about VT.	Possibly seeing patients in a hospital setting rather than through the clinic in order to increase exposure.	Workshops and training experiences with more exposure which will increase knowledge of VT. Possibly integrate in to supervision a discussion of VT. Hearing personal stories from other professionals.	More emotional support rather than just the academic support. Access to free sessions with a psychologist. Group sessions with fellow class mates or a mentoring programme.	Seminars and workshops, guest speakers sharing their experience of VT, more exposure during practical work, group mentoring.