

CHAPTER 2: LITERATURE REVIEW

2.1. Introduction

Caregivers are expected to put their personal feelings aside and objectively assess their clients and render appropriate treatments according to the practice guidelines. On the other hand they cannot avoid being compassionate and empathetic to their patients as these are the tools needed in human service. The concept of caregivers is generally used for individuals who look after or take care of children's well being. These may include parents of children and those who reside with them. However there are other types of caregivers who are in helping professions. It is the latter that this study focuses on. Thus the concept of caregivers in this study refers to helping professionals such as nurses, teachers, social workers, psychologist and counselors.

Compassion Fatigue, like any other kind of fatigue, decreases the caregiver's ability to bear their patient's suffering (Figley, 2002). Joslyn (2002) points out that individuals who perform emotionally intense work can be susceptible to compassion fatigue. She further argued that caregivers that work with traumatized children are considered at high risk. Helping professionals who listen to stories of fear, pain and suffering of others may feel similar pain and suffering because they care (Talbot, Manton & Dunn, 1991; Thompson, 2003). These caregivers are vulnerable to compassion fatigue, especially caregivers working in an environment of continuous traumatic stress such as Soweto.

Sexual abuse seems to be on the rise in South Africa. Child abuse and violence in our society continues to escalate especially in townships like Soweto. Most South African townships are marred by violence of various kinds. These townships were created during the apartheid era as urban reserves for cheap labour, by forcefully putting people who were not necessarily from the same communities together. There is gross overcrowding in these townships (Mwanda, 1999). Violent crime such as car-hijacking, armed robberies, burglaries, rape and domestic violence have been common features of this society and have been engaged in by the perpetrators, many of whom claim that their actions are a means to escape poverty and unemployment (Mwanda, 1999; Fako, 1997).

Amongst these crimes sexual abuse of children has also been rife in South Africa in the recent years. Although there have been increased reports about sexual abuse recently, the Johannesburg Child Welfare's Child Abuse Treatment and Training Services reported that they deal with these types of cases regularly (Gifford, 2002). Robertson (1989) indicates that medical practitioners in South Africa first noticed incidents of sexual abuse in the 1980's, hence the formation of the Child Protection Unit during this period. In 1992 it was reported to UNICEF and the National Children's Rights Committee that 1,139 cases of sexual abuse were reported to the Child Protection Unit of South Africa (Fako, 1997). Then in 2002, child sexual abuse gained increased publicity as the nation was shocked by the increasing news reports of infants and children who have been molested. Mwanda (1999) conducted a study on the profiles of sexual abuse in Soweto for a period of nine months at a childhood abuse center in Zola Clinic. These children were cases, which were referred from surrounding clinics in Soweto which included

Dobsonville, Tladi, Chiawelo, Mofolo and Orlando clinics. Her findings over the nine-month period indicated that 357 children were sexually abused in this area. Bearing these findings in mind the main aim of this study is to look at the psychological effects of working with sexually abused children in Soweto. While there have been extensive studies on sexual abuse, limited studies have been conducted to investigate levels of compassion fatigue on caregivers working with sexually abused children in a township and how their sense of coherence is affected as a result of working in such an environment.

Helping professionals are often called upon to assist survivors of violent crime, natural disasters and childhood abuse. These helping professions such as psychologists, social workers, nursing staff and teachers, often experience emotional reactions when they particularly have to deal with childhood trauma. Listening to traumatic accounts may be overwhelming and may cause caregivers to experience strong affects such as fear, pain which are similar to those of their patients. They may also experience trauma symptoms such as intrusive thoughts, nightmares and avoidance, alterations in their relationships with their community, colleagues and families (McCann & Pearlman, 1990). These experiences may lead to profound psychological effects on caregivers and may be disruptive and painful. They may persist for months or years after working with traumatized individuals especially working with children, as they have to deal with the psychological effects of childhood trauma. Figley (1995, p.1.) affirms this as he articulated that “there is a cost to caring. Professionals who, listen to clients’ stories of fear, pain and suffering may feel similar pain and suffering because they care.”

It has been noted by other researchers that caregivers with unresolved trauma, their trauma can be re-experienced when listening to traumatic accounts of their patients (Espery, 1996; Emery, Emery, Shama, Omiara & Jassani, 1991).

Stamm (1995) argues that caregivers can be traumatized without actually being physically harmed or threatened and can be traumatized by learning about the traumatic event. Caregiver's response to this type of trauma is observed when they manifest a compassion fatigue response and disruption in their sense of coherence, which will be discussed below.

2.2. Defining Compassion Fatigue

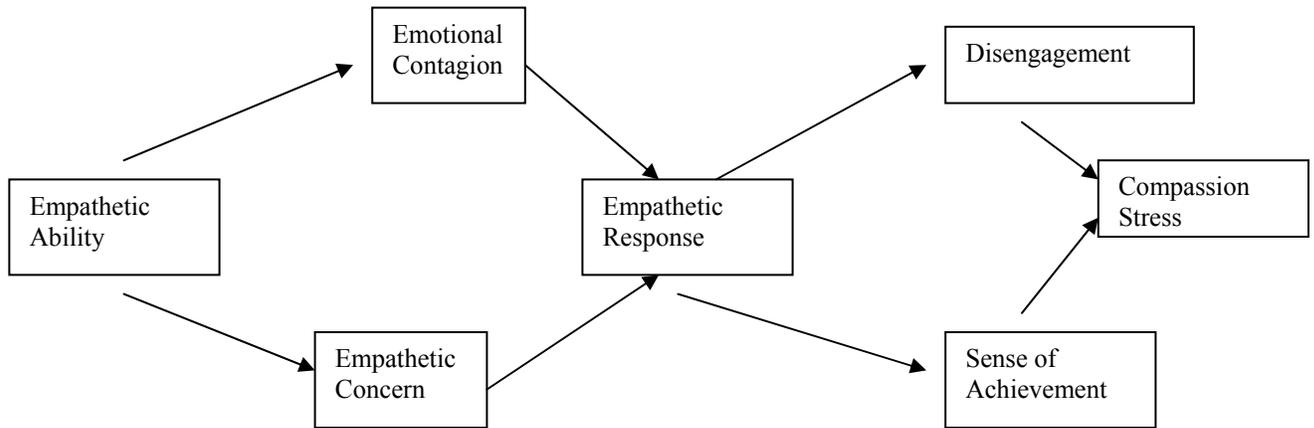
Compassion fatigue is the consequence of caring both about and for traumatized people. This entails preoccupation and tension with the individual or cumulative trauma of patients manifested in ways such as re-experiencing the traumatic event, avoidance or numbing of the reminders of the event, and persistent arousal. Thompson (2003) advocates that compassion fatigue is a one-way street in which caregivers give a great deal of energy and compassion to their patients over a long period of time and in turn are unable to reassure that the world is a hopeful place.

Constant giving of compassion over time and caring may result in high levels of compassion fatigue. Compassion fatigue is elicited by care giving and expending emotional and physical energy on a daily basis. It develops over time that is taking weeks and at times years to surface. Over time the ability to feel and care for others becomes

eroded through the exhaustion of skills expressing compassion. Caregivers may manifest emotional blunting reacting to situations differently than others would normally expect. Caregivers become emotionally drained from hearing about or being exposed to pain and trauma of people they are helping (Figley, 2002; Thompson, 2003).

Compassion fatigue is a consequence of working with people who have experienced extremely stressful events (Baranowsky, Gentry & Dunning, 1997; Beaton & Murphy 1995). Figley (1995) described Compassion fatigue as a state of exhaustion and biological, psychological and social dysfunction due to prolonged exposure to the traumatic experience of another. He further asserts that Compassion Fatigue is initiated by an individual's empathetic ability, where the individual manifests empathetic contagion, which is experiencing the feeling of the victim, as well as empathetic concern (that is the motivation to assist the victim). This will result in an empathetic response where the helper would either disengage or have a sense of achievement, depending on the nature and outcome of their intervention (Jay, 1995; Figley, 2002; Beaton & Murphy, 1995; Collins & Longa, 2003). This process involves an interaction of six variables illustrated in Fig. 1 (see page 11) - (i) empathetic ability (this refers to the caregiver's skill to notice the pain in others), (ii) emotional contagion (defined as the experiencing the feelings of a sufferer as a function of exposure to the sufferer), (iii) empathetic concern (refers to the individual's motivation to act), (iv) empathetic response (measures to help ameliorate the suffering), (v) sense of achievement (is the effort to relieve suffering) and (vi) disengagement(the extent to which the caregiver can distance him/herself from the continuous misery of the sufferer).

Figure 1 Trauma Transmission: A model of compassion stress (Figley, 1995)



Figley (1995) further illustrates that secondary traumatic stress (Compassion stress) in conjunction with prolonged exposure as well as traumatic recollection can lead to Compassion Fatigue. This Compassion Fatigue is dependant on the degree of one’s life disruptions. This is demonstrated by fig. 2

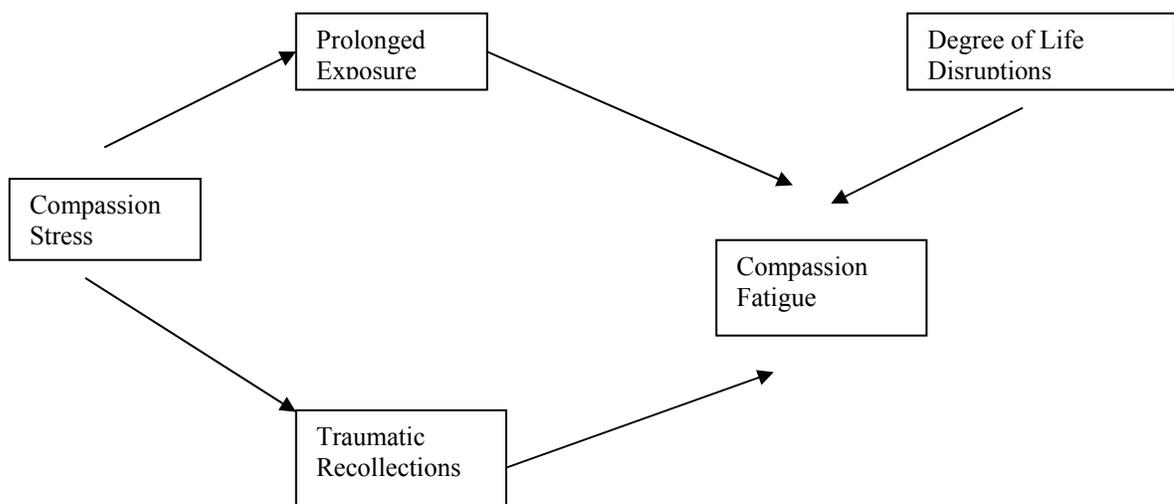


Fig 2. Trauma Transmission: A model of Compassion Fatigue (Figley, 1995)

2.3. Related Concepts

Compassion fatigue is associated with a number of related concepts such as vicarious traumatization, secondary traumatic stress and burnout. Compassion fatigue can be described by these concepts (Figley, 2002). The next section elaborates on these concepts in relation to the caregivers working with sexually abused patients. It has to be noted that vast literature utilizes vicarious traumatization interchangeably with compassion fatigue.

2.3.1. Burnout

Burnout is described as being related to a situation whereby a caregiver or therapist experiences high stress levels with low rewards or with minimal goals. Burnout does not encompass the interaction of the situation with the affected person instead it only focuses on the stressful situation. Rotter (1954) describes burnout as the state which an individual's minimal goals are too high and not changed in response to feedback. Depression, cynicism, boredom, loss of compassion and discouragement are some of the symptoms associated with burnout in caregivers.

Rice (1999) advocates that job burnout is manifested by firstly, emotional exhaustion where the individual feels that they cannot give much and that they have been emotionally used up. Secondly depersonalization takes place when patients are treated with disengagement and calculating detachment. Thirdly, burnout entails the feelings of

reduced personal accomplishments and ability, where the caregivers view themselves as incompetent and inadequate.

McCann and Pearlman (1990) identified the following circumstances as some of the symptoms that may cause burnout in individuals who work with trauma survivors.

Firstly, trauma survivors may present with chronic, in-depth symptoms, which are often difficult to treat, or may need long term therapy. Secondly, the patient may not focus on the trauma memories and lastly caregivers who perceive victimization as a reflection of social and political problems may manifest feelings of hopelessness about the impact psychotherapy may have on the root cause of crime and violence. This may be true for caregivers working in a continuous stress environment like Soweto.

Compassion fatigue, like burnout, can affect the caregiver's ability to render services effectively and maintain personal and professional relationships; compassion fatigue is sudden and acute, while burnout is gradual wearing down of workers who feel overwhelmed by their work and incapable of effective positive change. Weiner (1989), Stamm (1995), Pearlman & Saakvitne (1995), all affirm that burnout may be a significant factor or precursor to compassion fatigue.

2.4. Compassion fatigue and Childhood Sexual Abuse

Compassion fatigue focuses on the caregiver as a whole, that is, observable symptoms are placed on a larger context of human adaptation and meaning. Whereas Secondary

Traumatic Stress is based on a diagnostic conceptualization of posttraumatic stress disorder (PTSD). That is it looks at observable symptoms and focuses less on the context and etiology of the caregiver's response. It is the former that this study focuses on.

Compassion fatigue is defined as “the transformation in the therapist's inner experience resulting from empathetic engagement with client' trauma material” (McCann & Pearlman, 1990, pg 151). Meaning that exposure to the patient's account of their sexual abuse experiences and trauma reenactments in the therapeutic alliance, the caregiver becomes susceptible through his or her empathetic openness to emotional effects of compassion fatigue. This impact is seen in the caregiver's professional and personal life.

It is reported that the effects of compassion fatigue on an individual are identical to those of traumatic exposure. These include imperative disruptions in the individual's sense of meaning, rapport, identity and world view, psychological needs, beliefs about self and other, interpersonal relationships and sensory memory (McCann & Pearlman, 1990; Janoff-Bullman, 1985; Stamm, 1997, Collins & Longa, 2003).

There are two factors which lead to compassion fatigue in caregivers: firstly, the context of therapy and its characteristics, which is the characteristics of the patient, the nature of the work, political, social and cultural context within both the traumatic events and therapy take place. Caregivers working in Soweto can be influenced by these factors since this township is marred by violent crimes and has been influenced by a history of political oppression. Making these caregivers susceptible to compassion fatigue as they

work in a continuous traumatic environment. Secondly, vulnerabilities and the traits of the caregiver as well as how he or she works. These include the caregiver's personal experience of childhood sexual abuse, rescue phantasies, altruism, and insufficient supervision (Mwanda, 1999; Fako, 1997; Figley, 2002; Kopel & Friedman, 1997; Straker & Moosa, 1994).

2.5. Working with Sexually Abuse Children

Caregivers working with sexually abuse children are often faced with the following dilemmas: the incest taboo, that is a wish to deny incest, the caregivers need to see parents and caretakers of the child as benevolent, grief about the innocence of childhood, shock and outrage that children are cruelly victimized, the meaning of doing work that suggests being voyeuristic, erotic transference, sexually stimulating material (Figley, 1995; Pearlman & Saakvitine, 1995; Stamm 1997). These experiences seem more pronounced when working in a continuous traumatic stress environment and may lead to caregivers experiencing compassion fatigue. Kopel and Friendman (1997) posits that little is known about the psychological process involved as a result of continuous exposure to violence. They further point out that child abuse has a high risk of retraumatization of survivors and caregivers who listen to accounts of the abuse. Straker and Moosa (1994) advocate that caregivers in a context of civil conflict and political repression may be at risk of being directly traumatized. This may impinge on the caregiver's state of mind and influence their reactions to trauma work. Working in a continuous traumatic stress environment may pose ethical and moral dilemmas for

caregivers. Caregivers working with children who are sexually abused may be more affected, as this experience may be overwhelming for the child as well as devastating. Thus escalating compassion fatigue levels of the caregiver. Caregivers living in Soweto may be left feeling devastated as they have no control on the children's environment and often have to send these abused children back to their abusive environment. These children have to live in this abusive environment and try to survive it. The psychological effects of childhood trauma and the environment they live in are elaborated on below.

2.5.1. Psychological Effects of Childhood Sexual Abuse

Putman (2003) describes childhood sexual abuse as a complex life experience. He advocates that a variety of behaviour and conduct problems can be associated to child abuse. He further reiterated that sexualized behaviour is the most commonly linked to sexual abuse. Vast literature on childhood sexual abuse has documented long term-effects of childhood sexual abuse include the following: depression guilt, negative self perception, shattered assumptions about their environment, sexual difficulties and self destructive behaviours such as drug and alcohol abuse, relationship problems and a tendency to re-victimization (Janoff-Bullman, 1985; Terr, 1991; Russel, 1986; Browne & Finkelhor, 1986)

It is reported that children who have been sexually abused manifest symptoms of Post Traumatic Stress Disorder; these include anxiety, sexual problems, and difficulty in social interactions, depressions and low self-esteem. Lewis (1997) advocates that a

child's response to a traumatic experience is parallel to their developmental phase in which they are in and symptomology presentation varies according to age. The abused child environment plays a significant role in the child's worldview. The child's experience of an abusive environment is elaborated in the next session.

2.5.2. The Sexual Abuse Environment

Herman (1992) asserts that trauma in children has an impact on their personality and a child who is exposed to an abusive environment has to face challenging tasks of adaptation. The child has to trust people, who are untrustworthy, look for safety in a place which they experience as unsafe, try to find control in a situations that is unpredictable and seek power in an environment where they feel helpless.

It is reported that chronic child abuse often occurs in an environment that is filled with terror where caretaking relationships have perversely malfunctioned. This environment is described as having totalitarian control that is enforced by violence and death threats. This may include threats about the death of a family member if the child discloses the abuse, extreme enforcement of petty rules, and destruction of external relationships through isolation, secrecy and betrayal. These children also develop pathological attachments to those who abuse them (Herman, 1992; Robertson, 1989).

Children in this abusive environment will acquire a state of constant alertness and develop the ability to predict the warning signs for an attack. For instance sexually

abused children can pick up subtle signs of sexual arousal (Herman, 1992). Caregivers are then faced with the difficulty of undoing these shattered assumptions the abused child perceive about their environment.

2.6. Effects of Compassion fatigue on Caregivers

Depression, despair and cynicism, alienation from friends, colleagues and family, professional impairment and both physical and psychological symptoms experienced by trauma survivors are some of the effects that caregivers experience due to compassion fatigue. The re-traumatization of the patient can also occur when the caregivers has unacknowledged compassion fatigue. This may result in countertransference where the caregivers may disturb the therapeutic frame as well as the therapeutic alliance.

Countertransference, a more psychodynamically orientated construct, implies that the helper experiences painful feelings, images and thoughts when working with traumatized survivors. There is evidence that the themes following reactions of working with survivors include guilt, rage, grief and mourning. Shame and the use of defenses such as numbing, denial and avoidance are prominent features / reactions manifested by caregivers (McCann & Pearlman, 1990)

Moosa's (1992) research on countertransference experiences of South African caregivers suggests that individuals who had direct or indirect exposure to personal trauma are more likely to experience contertransferential feelings toward trauma survivors. She further explains that the caregiver may manifest complementary contertranference where he or

she may relive the emotions that the child has evoked in family members who are close to them. Moosa (1992) asserts that this type of countertransference reaction can facilitate the therapy process by enabling the caregiver to have an understanding of how significant others in the child's life react to their situation.

Herman (1981) suggests that working with the incest survivor's population the caregivers can experience gender related countertransference feelings. The female therapist may overidentify with the patient and experience feelings of rage toward the perpetrator.

While on the other hand a male caregiver may experience overidentification with the aggressor. Stamm (1997) further posits that countertransference occurs when the patient affects the caregiver's work while compassion fatigue, secondary traumatic stress and vicarious traumatization is about how a patient affects the caregivers' lives, relationships with themselves, social networks and work.

The caregiver may exhibit demoralization about their work as well as disillusionment about the patient due to compassion fatigue. This behaviour exhibited by the caregiver may feed into the insecurities of the sexually abused child. The child may in turn experience therapy as insecure, or relate to the caregiver as they would relate with their perpetrator.

Compassion fatigue may be evident even in the supervision of caregivers. A supervisor who experiences compassion fatigue may show little interest in their supervisees' work and he or she may display inadequate personal and professional self-care and may also

violates bonfires in both supervision and therapeutic relationships. Leaving the caregiver with feelings of inadequacy and isolation.

2.7. Compassion Fatigue and Post Traumatic Stress Disorder

Figley (1995) reiterated that Secondary Traumatic Stress Disorder is equivalent to Posttraumatic Disorder in much of its presentation on caregivers would also experience Post Traumatic Stress Disorder (PTSD) symptoms when they have treated a traumatized person, for example a sexually abused child. The job of caregivers requires concern, compassion, dedication and commitment and they are inclined towards easing the distress of others and these feelings are more intense when the victim is innocent or unable to protect him or herself. Caregivers use different mechanisms to cope with demanding work, but their natural defenses may breakdown more particularly when working with children (Collins & Longa, 2003, Dyregrov & Mitchell, 1992; Joslyn, 2002).

2.7.1. Definition of Trauma

Herman (1992) a key trauma expert, offers a definition that “trauma is a feeling of intense fear, helplessness, loss of control and threat of annihilation.” (p.33). She further documents that traumatic events cause pervasive changes in the individual’s physiological arousal, emotion, cognition and memory.

Figley (1985), a further theorist in the traumatic stress field, defines a traumatic event as an event that is sudden, overwhelming and is often dangerous to oneself or significant other. However it is advocated that one person's perception of trauma can be another person's difficult experience. Figley (1985) argues further that traumatic response is an emotional state of discomfort and stress resulting from memories of a catastrophic experience, which shatters the individual's sense of safety. Thus the term 'trauma' is used both to describe the event and the response to the event. It is the latter, that is, the impact of the event, that this study is concerned with. Compassion fatigue may manifest signs of post traumatic stress disorder (PTSD). The evolution and description of the PTSD concept is explored below.

2.7.2. Posttraumatic Stress Disorder (PTSD)

The end of the 19th century marked great interest in conceptualizing the relationship between psychological trauma and psychopathology. Janet (1889, in van der Kolk; Brown & van der Hart, 1989), a pioneer in conceptualizing this relationship, postulated that when a person experiences emotions which overwhelm his or her capacity to take appropriate action, the memory of this traumatic experience can not be properly digested. He further advocated that this memory can be split off from consciousness and dissociated only to later return as fragmented imagery of the trauma including a change in emotional conditions, somatic states, visual images or behavioural reenactments. Janet (1889, in Van der Kolk et al, 1989) initiated the identification of dissociation as the cardinal symptom of post traumatic stress.

Janet (1889, in Van der Kolk et al, 1989) suggested that traumatization was a consequence of an individual's inability or failure to take effective action against a potential threat. Thus he or she becomes helpless which is due to overwhelming emotions that disrupt the proper memory storage. At times the traumatized person may develop post traumatic amnesia and hyperamnesia due to their failure to transform traumatic experiences into less frightening information. Caregivers that experience compassion fatigue may manifest feelings of helplessness when listening to traumatic accounts of abused children.

Freud (1920) further notes that traumatic material that does not have verbal presentation leads to anxiety which the victim may defend against it using defenses such as suppression, avoidance and flight. He also mentioned that conscious memories and feelings related to trauma that are forgotten by the sufferer, may return as intrusive recollections, feelings states and behavioural reenactments. Van der Kolk et al. (1989) argue that stress causes people to regress to earlier modes of memory processing that is, trauma leaves them in a state of unspoken terror because the traumatic experience does not fit into their existing conceptual schemata. Other trauma researchers have noted the occurrence of specific memory disturbances (McCann & Pearlman, 1990). Janet (1889, in Van der Kolk et al, 1989) further postulated that the initial emotional reaction to the traumatic event determines the intensity of the post-traumatic reaction. He divided trauma response into three stages- firstly, a mixture of dissociative reactions, obsessional ruminations and generalized agitation precipitated by a traumatic event. Secondly, a

delayed post traumatic symptomatology is composed of a blend of hysterical, obsession, and anxiety symptoms with poorly recognizable traumatic etiology. Lastly, post-traumatic decline which includes somatization disorder, depersonalization and melancholia, ending in apathy and social withdrawal (van der Kolk et al, 1989).

The increased interest in PTSD by medical and behavioural scientists' lead to developments in the conceptualization of Posttraumatic Stress Disorder. The American Psychiatric Association (APA) published and documented the concept of Post Traumatic Stress Disorder in four different versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Seven years after the publication of the DSM III-R the APA published it's forth edition of the DSM. The DSMIV (1994) states that an individual who has experienced or been exposed to the trauma stimuli may develop Post Traumatic Stress Disorder (PTSD) if:

“The person experienced, witnessed, or was confronted with an event that involved actual or threatened death or a serious injury, or threat to physical integrity of self or other. The person's responses involved intense fear, helplessness or horror” (p.424).

(Courtesy of APA, DSM IV)

The following symptoms should be present for at least one month:

Recurrent, intrusive recollections of the traumatic event accompanied can be affective distress, avoidance of stimuli associated with trauma and increased arousal.

Figley (2003) argues that the term PTSD addresses people who are directly traumatized by one or more types of traumatic events but excludes those who were indirectly or secondarily traumatized.

2.8. The Sense of Coherence (SOC)

Adverse health effects from an individual's biological limitations and life stress may be mitigated by coping resources and social support available to the individual. Coping resources are compromised or lessened when a traumatic event occurs (Flannery & Flannery, 1990). The constructive Self Development Theory and Sense of Coherence (SOC) construct look at how the caregiver's perception of self and the world become compromised when working with sexually abused children. If a caregiver's cognition is disrupted due to working with traumatized children their Sense of Coherence (SOC) is likely to be compromised as Antonvosky (1979) argues that low SOC is associated with perceiving stressful situations as threatening and anxiety provoking.

The Sense of Coherence (SOC) is a generalized, long lasting way of perceiving the world and one's life and it consists of both cognitive and affective components. Antonvosky (1979) advocates that a specific situation, failure or detailed success can have an impact or minor shift in the individual's sense of coherence. SOC is shaped and tested, reinforced and modified not only in childhood but also throughout one's life. Rupture in one's structural situation, that is marital status, occupation, place of residence, can lead to a significant modification in the individual's sense of coherence. Antonvosky (1979) further posit that a person's sense of coherence (strong or weak) plays an imperative role in determining one's choice of changing one's structural situation.

Antonvosky (1979) further defined the Sense of Coherence (SOC) as an individual's ability to consider which coping strategy is the best intervention in addressing any specific problem. He reiterated that this strategy is dependant on three components:

Firstly, *comprehensibility* which referred to the individual's sense that their internal or external environments are structured and predictable. The individual perceives stimuli as making cognitive sense and information is structured and consistent.

Secondly, an individual's belief that they have the means to meet the demands of the environment, which Antonvosky (1979) called *manageability*. This entails one's perception that resources are at their disposal and are sufficient to meet the demands posed by overwhelming stimuli. Thus the individual is not intimidated by unpredictable events or feel treated unfairly.

Lastly, *Meaningfulness*, which refers to the individual's sense that these environmental demands are challenging and worthy of personal investment. That is the extent that life makes sense emotionally and that problems and demands encountered in their lives are worthy to be invested on as well as worthy to be committed to and engaged with rather than being seen as burdens that one would do without.

2.8.1. The Development of SOC

Life experiences are imperative in shaping one's sense of coherence (SOC). Antonovsky (1979) posits that from birth an individual constantly goes through situations of challenge and response, stress, tension and resolution. The world then becomes coherent and predictable as these experiences become consistent and an under load or overload balance of stimuli is experienced. When an individual's experiences all become predictable one will then experience unpredictable experiences as unpleasant surprises and would not be able to handle them and thus their SOC becomes weakened. Paradoxically unpredictable experiences are essential for the development of a strong SOC. The individual then learns some defense mechanisms to deal with the unexpected.

Antonovsky (1997) estimated that SOC is fully developed once people reached the age of thirty as individuals at this developmental stage have more coherent ways of looking at the world. Particular social structural and cultural historical situations are likely to provide the developmental and reinforcing experiences that result in a strong SOC. A study done by Antonovsky and Sagy (1986) indicated that the development of SOC is dependent on the individual's relationship with their parents as well as having a stable community. Their findings pointed out that a stable community enables individuals to perceive their world as predictable and manageable. In this study caregivers work in an area that has a long history of continuous traumatic stress, thus one would anticipate that caregivers may have lower levels of SOC. However, there should be variation in levels of SOC across the sample enabling correlations to be calculated.

2.8.2. The Strength of SOC in Relation to Stress

Antonvosky (1979) posits that the strength of SOC has direct physiological consequences and may affect an individual's health status. There is negative correlation between SOC and symptomatic psychological or physical responses to stress. Antonvosky (1987) argues that the individual with a strong SOC will be able to mobilize resources to confront a stressor, whereas a person with a low SOC is more likely to give up before taking action when facing a stressful situation. Traumatic experiences cause rupture to the self, the frame of reference that is identity, worldview and spirituality are disrupted (Pearlman and Saakvinte, 1990). The individual's ability to tolerate affect, maintain a sense of self and inner sense of connection with others is compromised. Also impaired is the individual's ego resources and their sense of memory. These are some of the features which may be experienced by caregivers working in a continues traumatic stress environment (Jannoff-Bullman, 1985; Straker& Moosa, 1994; Collins & Longa, 2003).

Antonvosky (1987) further reiterated that a strong SOC involves a perception that one's environments is predictable and comprehensible. When a caregiver experiences compassion fatigue he or she is likely to have a low SOC and their world view affected by trauma work. Janoff –Bullman (1985) advocates that traumatic life events impact on three basic assumptions about the self and the world. That is, the belief in personal vulnerability, the view of oneself in a positive light and the belief in a meaningful orderly world. A shift in these assumptions has been observed in most caregivers working with sexually abused children.

The strength of one's sense of coherence plays a significant role in determining the individual's choice of remaining in or changing one's structural situation. A person with a weaker SOC will anticipate that things are likely to go wrong, that is, their needs will not be met as there is a disturbance in their understanding that the world is predictable. While a person with a stronger SOC is able to see reality, to judge the likelihood of desirable outcomes in view of the countervailing forces operative in their life. Therefore SOC is related to how the individual assess and cope with stressful situations. The SOC construct assists in assessing the individual's resiliency to stress (McSherry & Holm, 1994).

Disruptions in needs, beliefs and relationships are observed when a caregiver experiences compassion fatigue and displays low SOC. The constructive self development theory suggests that traumatic experiences may change psychological needs like safety, trust, self esteem, control and intimacy. Once the individual feels that these basic needs cannot be fulfilled as a result of trauma, these beliefs will impact on the individual's relationships, identity and feelings such as hope or despair. Thus the caregiver can experience his or her beliefs about self and others affected by their trauma work. McCann and Pearlman (1990) further suggest that given the nature of the trauma work, the caregiver may feel stigmatized just like trauma survivors and this may estrange the caregiver from their intimate relationships as well as have a sense of separateness from family, friends and colleagues. Pearlman and Saakvitne (1995b) advocate that the significant indicators of disrupted needs and schemata are an increased sense of personal

vulnerability or capacity to do harm (safety), a decreased sense of trust in one's perceptions or judgments in others (trust) and devaluing of oneself or others (esteem) an increased need for control or a low sense of control over self and others (control) and a decline sense of connection with self or others (intimacy). Caregivers' schema's on safety are disrupted when they perceive harm to innocent people and threats to their patient's safety. Caregivers working with rape or sexual abuse survivors may take extra precautions against such violations (McCann & Pearlman, 1990a).

Antonvosky (1979) further reiterated that SOC is influence by three aspects. That is the individual's General Resistance Resources (GRRs) which include: one's material available, knowledge, or intelligence, ego identity, coping strategies (rational, flexible, farsighted), social support, cultural stability, magic, religion, philosophy, art and preventative orientation. Secondly he or she draws on their specific resistance resources, and thirdly use their strong sense of coherence which becomes a protective trait from some stressors. This enables the individual to define stimuli which may be perceived as stressors. Antonvosky (1979) also advocates that a person with a strong sense of coherence draws on his or her GRRs when confronted with a stressful situation and this enables them to manage a stressful situation well. It is anticipated that that caregivers' with low SOC may manifest poor interpersonal relationships due to compassion fatigue. Important signs that compassion fatigue affects a caregiver's relationship include social withdrawal, inability to tolerate different feelings required to maintain intimate relationships, feeling alienated from intimate friends and sexual partners due to the nature of your work, and an inability to enjoy common entertainment with your partner or

friends. Also affected by compassion fatigue are the caregiver's ego resources. Trauma work may disrupt the caregiver's abilities to meet psychological needs and relating to others (ego resources). For instance judgment can be impaired by their disrupted beliefs which hinder them from foreseeing consequences accurately boundary maintenance may be compromised, self protective judgement can also be affected.

Memory disruption is a key aspect of the consequences of trauma (Schiraldi, 2000, McCann & Pearlman, 1990). Caregivers working and listening to accounts of victimization may internalize the memories of their patients and their memory may be temporally or permanently altered. These memory disruptions may impact on the caregivers psychological and interpersonal functioning.

Caregivers may experience the intrusion of their patient's traumatic imagery that can be disturbing if the intrusive images are sexual and emerge during sexual activities. This difficulty may impact on the caregiver's relationship as he or she may experience difficulties discussing this problem with his or her partner. (McCann & Saakvinte, 1995).

McCann and Pearlman (1990) further suggest that imagery that is most painful for the caregivers is usually related to the schemas of the caregiver's salient need. For instance if the salient need is safety. The caregiver will be preoccupied with the threat. The alteration in the imagery systems of memory is linked to the individual's affective states (Paivio, 1986). Emotions that are commonly reported by caregivers include sadness, anxiety and anger. These feelings may be conscious or repressed in the unconscious state

of the caregiver. Helpers who experience difficulties with processing their emotional reactions may manifest denial and emotional numbing. This occurs when the caregiver is exposed to a traumatic imagery that is too overwhelming both emotionally or cognitively for him or her to integrate. This too can be related to the caregivers inadequate ability to self-soothe or regulate his or her affect as well as the nature of the traumatic experience which may be too different from the helper's world view or schemas (McCann & Pearlman, 1990).

McSherry and Holm (1994) conducted a study on individuals to assess their psychological and physical responses when experiencing stressful situations. Findings in this study indicated that individuals with low SOC reported being more stressed or anxious and angry, while those with high SOC managed the challenges of a stressful situation. In view of these findings one can assume that compassion fatigue may have a negative correlation with SOC.

SOC has been fairly extensively researched in the field of posttraumatic stress (Flannery & Flannery, 1990). This research has largely focused on whether SOC plays an ameliorating role in the context of extreme stress and it has been investigated as both a predisposition as well as a possible mediating variable. SOC can be transformed or modified due to a stressor which has a great impact on the individual's personal life or environment. This unpredictable experience may result in a significant weakening of one's sense of coherence. Thus causing disruptions in the caregiver's capacities.

Pearlman and Saakvitne (1995) attribute the self-capabilities as intrapersonal; abilities

that enables the caregiver to have a positive sense of self and have affect tolerance. This aspect has three categories (a) maintenance of the positive sense of self (b) ability to modulate strong affect and (c) the capacity to have inner sense of forming therapeutic alliance with others. When the self capabilities are ruptured the caregivers may overextend oneself, overindulge to manage affect, this includes overeating or substance abuse amongst other things, constant self criticism, and hypersensitivity to emotionally charged stimuli and a sense of isolation and disconnection from their environment. To cope with these symptoms caregivers may use defenses such as numbing or intellectualizing to cover up their painful experience or compassion fatigue.

2.9. Treatment of Compassion Fatigue and Enhancement of the Sense of Coherence

Pearlman and Saakvitne (1995) posits that using personal, professional and organizational strategies can ameliorate compassion fatigue. These strategies may also assist in enhancing the caregiver's sense of coherence.

Personal Strategies: this includes the caregiver identifying their disruptive schemas these may include five salient needs such as safety, trust, esteem, intimacy and control. Once the caregiver has insight to his or her disruptive schemas. They are able to explore the theme within the trauma stories that stand out for them. Thus making the difficult imagery less intrusive for the caregiver.

Maintaining a personal life that is fulfilling is another aspect that caregivers can use to ameliorate compassion fatigue. Hence caregivers have to be able to balance their work and sufficient rest to be able to function well. Personal psychotherapy is also recommended for caregivers working with trauma as this provides an opportunity for the caregiver to focus on himself or herself and their needs. Personal therapy enhances the caregiver's ability to reclaim their emotional lives. Thus strengthening their SOC (Thompson, 2003; Joslyn, 2002).

Professional Strategies: regular supervision with an experienced trauma therapy supervisor can play a role in addressing compassion fatigue and low sense of coherence in caregivers as trauma work can be demanding to do without constant professional consultation. This also becomes a space a caregiver can use to discuss cases and their transferential and countertransferential responses to the work without shame. Caregivers can also develop professional connection this can be achieved by their attendance of workshops meeting with colleagues to share coping strategies as trauma work can be overwhelming when a caregiver works on their own. Pearlman and Saakvitne (1995) maintain that remaining connected to the community of trauma therapists assists the caregiver to affirm their commitment.

Organizational Strategies: when caregivers are experiencing psychological difficulties that are work related, the organisation they work for may also have detrimental effects of this problem due to compassion fatigue. The effectiveness and quality of the organization may be disrupted. NGO's, schools and clinics in Soweto may experience this problem as

they are situated in a continuous traumatic stress environment. Caregivers who do not acknowledge and adequately deal with their compassion fatigue may affect the therapeutic environment. Resignation of staff members due to compassion fatigue may result in high staff turnover. Commitment and optimism among staff members may decline due to compassion fatigue (Sexton, 1999).

Compassion fatigue in organizations results in caregivers being ineffective team members. They may not participate in tasks such as case conferences that may benefit the patients. Caregivers may portray cynicism and be excessively critical and judgmental when consulted by their colleagues. This negative behaviour may lead to mismanagement of the confidentiality of the patients as well as erratic billing and scheduling.

Caregivers working with sexually abused children come from a variety of settings. The organization should be able to attend to the physical setting that is safe and private. There should be regular supervision and case discussions for care givers. However this may seem idealistic for some caregivers in Soweto, as they have to improvise due to lack of resources. Skills development of caregivers should be encouraged. The organisation can assist in developing adjunctive services that is creating rapport with other agencies that work with childhood traumas. This would enable caregivers to develop professional connection and combat a sense of isolation that could be experienced by caregivers working with childhood sexual abuse (Sexton, 1999; Thompson, 2003; Joslyn, 2002).

2.10. Conclusion

Working with sexually abused children places caregivers at a vulnerable position for secondary traumatic stress. Since sexual abuse can be perceived as taboo and may evoke strong emotions in caregiver. This may become a difficult experience for them to remain neutral in such situations. Dyregrov and Mitchell (1992) posit that caregivers working with children experience psychological effects which may include feelings of helplessness and hopelessness, cynicism towards perpetrators and blaming of parents for not being able to protect their children.

Compassion fatigue is often apparent as caregivers work with traumatized children. Figley (1995) asserts that due to the empathetic nature of working with trauma survivors, this may lead to caregiver's coping skills being impaired and them experiencing compassion fatigue. Thus the caregiver's inner experiences become altered when working with sexually abused children and this influences their reactions to trauma work. Not only their relationship with their families and colleagues become affected but their work as a whole becomes affected. This is evident in the caregiver's transference and countertransference reaction to the child and their work. Which may impair the therapeutic alliance including the caregiver's judgment ability (Moosa, 1992). McCann and Pearlman (1990) affirm that there is a drastic change in the caregiver's sense of self frame and identity. While Janoff-Bullman (1985) advocates that the caregiver's beliefs in personal vulnerability and the existence of a benign, ordered world become shattered.

The literature suggests that there are buffers for the treatment of compassion fatigue. These include personal insight about their perception and insight into what evokes strong emotions in the helping professional's work. This enables the caregiver to separate themselves from over identification with the aggressor or the victim and place this knowledge in its appropriate context (Raphael, 1986, Straker & Moosa, 1994). Secondly, professional consultation enables caregivers to interact with individuals that work with trauma work. Thus ameliorating the sense of isolation from their families and colleagues, and perception of their work as worthless and hopeless especially when working in a context of continuous traumatic stress like Soweto. Lastly, organizational involvement can also assist in overcoming vulnerability to compassion fatigue and low sense of coherence.

Literature state that the South African political and social context is affected by violence and trauma and this is part of daily life (Mwanda, 1999; Fako, 1997; Esprey, 1996). It is inevitable that helping professionals in this environment will experience compassion fatigue. This hypothesis has been confirmed by studies conducted by Durrant (1999) where she found Physiotherapy and Occupational therapy students were at high risk to experience compassion fatigue as they worked in a continuous stress context. Nkosi's (2002) findings on the level of compassion fatigue on trauma nurses also support the vulnerability of these caregivers to compassion fatigue and also indicate that these caregivers' coping skills become compromised due to working in a continuous traumatic stress environment

The literature also suggests that an individual's SOC may be affected due to traumatic stress. However Antonvosky (1979) advocates that an individual with a strong SOC may be able to handle traumatic stress. While those with a low SOC may experience difficulties in managing traumatic stress. The sense of coherence concept is based on how caregivers' coping strategies are compromised when working in a continuous traumatic stress environment. Different aspects of their lives get severely affected when working with traumatized patients especially vulnerable children.

This study aims to investigate whether there is a significant correlation between SOC and compassion fatigue amongst a group of caretakers working in a context of ongoing stress with a particularly vulnerable population of trauma survivors, that is, sexually abused children.