INDIRECT EXPOSURE TO TRAUMATIC MATERIALS: EXPERIENCES OF CLAIMS WORKERS IN THE SHORT-TERM INSURANCE INDUSTRY

Marné Ludick (Student, Psychology Department, the University of Witwatersrand)

Dr Daleen Alexander (Research Supervisor, Psychology Department, the University of Witwatersrand)

A research report submitted to the Faculty of Humanities, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master of Arts in Psychology by Coursework and Research Report.

Johannesburg, 2006

DECLARATION

I declare that this research report is my own unaided work. It is submitted for the degree of Master of Arts in Psychology by Coursework and Research Report in the University of Witwatersrand, Johannesburg. It has not been submitted before for any other degree in any other university.

_____

Marné Ludick

_____ day of _____, 2007

ABSTRACT

The study focused on claims workers in the short-term insurance industry and on whether their working conditions, such as dealing with traumatised clients and traumatic materials, are affecting them adversely. Equivalent attention fell on underwriting clerks, the comparison group, to ascertain whether they differ significantly from claims workers along the dimensions of compassion satisfaction, burnout, secondary traumatic stress as well as self-esteem and optimism/pessimism. These constructs were measured by the ProQOL-RIII - , the Mehrabian MSE – and MOP Scales, after which the scores were analysed. These scores were then compared across the two groups and also in terms of mode of interaction, using parametric statistical procedures. Although no significant differences were found between the two study groups, interesting interaction effects and other findings were nevertheless revealed that shed valuable light on these groups of workers.

CONTENTS

LIST OF TABLES AND FIGURES

1 INTRODUCTION

Each year, myriads of people are exposed to some kind of traumatic event. These range from accidents, encounters with criminals, violence, natural disasters, abuse and neglect. None of us are completely immune to the effects of trauma. It can often result in serious, persistent and chronic emotional and behavioural problems (Perry, 2003). There are also those individuals who offer help to the victims of trauma that are affected. Police and rescue workers often arrive at the scene first, health - and mental health professionals treat the traumatised and injured, and legal practitioners often represent the victims of trauma. The family and friends of loved ones affected by trauma frequently have to deal with the effects on an ongoing basis. These professionals and caregivers are also often impacted upon by a person's trauma, referred to as "*vicarious traumatisation*", a phenomenon at the core of this study (McCann & Pearlman, 1990, p. 133).

Although inspirational, life changing and positive results are often reported by those who care for the traumatised, they are nonetheless constantly at risk of being affected by direct and indirect traumatic materials (Anderson, 2004). Extensive literature on vicarious trauma acknowledges the seriousness of this phenomenon (e.g. Annschuetz, 1999; Hesse, 2002; Sabin-Farrell & Turpin, 2003; Sexton, 1999). It also identifies and recognises many potentially damaging effects associated with helping professions and familial care-giving. These are often referred to as "*the cost of caring*" (Annschuetz, 1999, p. 17; Figley, 2001, para. 15; Perry, 2003, p. 1).

There are, however, many other less obvious populations that might be at risk that have largely been overlooked in the conceptual anthology of vicarious reactions. One such a population that is at the central focus of this study, is that of claims workers who operate within the short-term insurance industry. Often traumatic events are accompanied by the loss of property or possessions such as vehicles that are written off, belongings that are stolen and vandalised by criminals, as well as housing and personal effects that are destroyed by natural disasters. Those who are fortunate enough to have short-term insurance to compensate for their material losses, begin the process of lodging claims and negotiating settlement shortly after the traumatic event.

The claims workers' constant exposure to the trauma and traumatic materials of their clients is what brought them to the central focus of this study. Although the claims workers form the main study group, throughout the study their experiences are continuously compared to those of underwriting clerks, who are mainly technicians trained in policy administration. This was done in order to ascertain if there were any significant differences between the two groups, their typical work-related contexts and the traumas that typically emanate from their respective positions. These constant comparisons brought about that a considerable amount of the information yielded by the study was devoted to the comparison group of underwriting clerks. The claims workers nevertheless remain at the core of the study, seeing that all of the traumatising phenomena dealt with occur within this group of workers. In the case of the comparison group of underwriting clerks, only

some of the identified traumatising phenomena are applicable, which reduced their role in the present study considerably.

Now that the study has been broadly contextualised, a review of important related literature and the theoretical framework of the study will be traced next.

1.1 Demarcating the literature

Numerous studies on vicarious trauma have been carried out which show how it manifests across a wide spectrum of professions. These range from different emergency and rescue service workers, rape victim advocates and funeral directors, to journalists (Levin & Greisberg, 2003; Linley & Joseph, 2004a; Stamm, 1997). Those living with a traumatised person such as the husbands of breast cancer survivors or those living with holocaust survivors, have also been at the core of several studies (Lev-Wiesel & Amir, 2001; Linley & Joseph, 2004a). The largest portion of these studies, however, focuses on health - and mental health workers (Annschuetz, 1999; Hesse, 2002; Sabin-Farrell & Turpin, 2003; Sexton, 1999; Steed & Downing, 1998). The majority of the available literature on vicarious trauma is therefore also applicable to these workers.

However, as stated previously, the population of claims workers in the short-term insurance industry, who are central to this study, have largely been overlooked. There is a clear lack of research evidence and statistics on this group regarding trauma and vicarious trauma. Similarly, very little information is available on the comparison group of underwriting clerks and how they might differ from the study

group along these dimensions. After an ongoing and extensive search, no literature could be found on trauma, or more specifically vicarious trauma, related to insurance workers. This posed a slight problem as they do not have much in common with health - and mental health workers. Insurance workers are neither trained professionals in counselling, nor do they work as intimately with clients as health - or mental health professionals. They are also not exposed as directly and continuously to the same levels of physical and mental trauma as is the case with health - and mental health workers. The fact remains, however, that claims workers particularly are constantly and inadvertently exposed to traumatised clients and traumatic materials, in the line of their work-related duties.

After careful consideration, it was decided that the groups that seemed to closest resemble claims workers would be journalists, legal representatives, jurors and even researchers. They all have somewhat more in common with one another and with the population of claims workers. Although we do not have a jury system in South Africa, it was postulated that literature on this group would still offer some insight into the dynamics of vicarious traumatisation. They are, as is the case with claims workers, often confronted with graphic details and traumatising materials in order to reach a work-related goal. Jurors are often exposed to such traumatising materials during the course of reaching a verdict. Claims workers, on the other hand, are exposed to traumatised clients and traumatic materials during the course of reaching a claims settlement. It is safe to say that claims workers would also be confronted by the same troubling materials in order to get to the facts of the case and compile their reports, as would jurors, researchers and legal representatives.

Throughout the study there is still, however, considerable focus on literature related to health - and mental health workers, as much of the illumination of and theories on vicarious traumatisation emerged from these research efforts. Furthermore, the foremost focus of the study predominantly fell on the group of claims workers, but almost equal attention was also afforded to the group of underwriting clerks, as they continuously acted as a comparison group along the dimensions of each of the study variables. This somewhat dual focus ensured insight into both groups of workers in search of significant differences between them. Before embarking on an exploration of vicarious trauma per se, some focus on trauma and related concepts are warranted to serve as the backdrop against which vicarious trauma and this study in particular will be discussed.

1.2 Trauma and related concepts

Trauma has been the focus of many research studies over the past decade (Allen, 1998; Damousi, 2001; Dohrenwend, 2000; Van der Kolk, McFarlane & Weisaeth, 1996; Van Dijk, Schoutrop & Spinhoven, 2003; Van Emmerik, Kamphuis, Hulsbosch & Emmelkamp, 2002). Both physiological and psychological experiences and changes following a traumatic event, have been recorded and investigated on an ongoing basis (Barlow & Durand, 2001; Dohrenwend, 2000; Gil, Calev, Greenberg, Kugelmass & Lerer, 1990; McFarlane, Atchison, Rafalowicz & Papay, 1994; McNally, 2003; Sue, Sue & Sue, 1994). The term "*trauma*" was originally derived from the Greek word for "*wound*", but is also widely applied when referring to psychological injury caused by some emotional assault (Reber, 1985). Although this definition was formulated twenty years ago, it still holds today. The dual meaning

makes provision for injury on a physical as well as a psychological level, and also reflects the notion of an external event leading to an inner subjective response (Becker, Daley, Gadpaille & Green, 2003).

A wide array of different events can lead to emotional trauma, of which the most impressive is sometimes believed to be the aftermath of war (Barlow & Durand, 2001). Events such as severe accidents, natural disasters, the loss of a loved one, physical assaults or human actions such as rape, child abuse or torture, are also believed to be causes of traumatic stress (Barlow & Durand, 2001; Becker *et al*., 2003). A study undertaken by the Centre for Healthy Ageing (2005), indicated that emotional trauma can even result from far lesser occurrences, such as the break-up of a significant relationship, a humiliating or deeply disappointing experience, the discovery of a life-threatening illness or disabling condition, and many other more common situations.

Since the mid 90's, there has been emergent research evidence that indicates that a traumatic event does not necessarily have to be experienced directly for traumatisation to occur (Annschuetz, 1999; Hesse, 2002; Lev-Wiesel & Amir, 2001; Linley & Joseph, 2004a; Pieper, 1999; Sabin-Farrell & Turpin, 2003; Sexton, 1999; Stamm, 1997; Stamm, Varra, Pearlman & Giller, 2002; Steed & Downing, 1998; Varner, 2004). This brings us to vicarious traumatisation, a variable that has direct bearing on this study.

1.3 Vicarious traumatisation

When an individual experiences trauma without direct exposure, it is referred to as *vicarious trauma, indirect traumatisation or secondary traumatisation.* Various authors agree that these different terms all refer to the effects that someone else's trauma can have on persons dealing with traumatised individuals, in the line of their different duties (Annschuetz, 1999; Hesse, 2002; Sabin-Farrell & Turpin, 2003; Sexton, 1999; Stamm, Steed & Downing, 1998).

Vicarious traumatisation is more clearly described as a cumulative process of continued exposure to traumatic materials or images (Linley & Joseph, 2004a). It eventually leads to fairly lasting cognitive changes, whereby inner experiences such as thoughts, perceptions and interpretations are negatively transformed (McCann and Pearlman, 1990). This definition is seated in the Cognitive Constructivist Development Theory postulated by McCann and Pearlman (1990). Verbal exposure to traumatic material theoretically has the ability to change cognitive schemas as well as memory systems (Rae Jenkins & Baird, 2002).

As can be seen, this entire definition and description of vicarious trauma is focused more on cognitive processes, from which meaning and adaptation to our world emerge, rather than on the emergent symptoms. By definition, claims workers in particular could be at risk due to their constant exposure to and dealings with traumatised clients, and their schemas and memory systems might very well be affected in a similar way. Underwriting clerks are not expected to be affected by the

same token as they are mostly spared the necessity of having to deal with traumatised clients.

In addition to these altered cognitive processes, various other psychological symptoms associated with vicarious trauma are also cited by different authors (Annschuetz, 1999; Hesse, 2002; Lev-Wiesel & Amir, 2001; Pieper, 1999; Sabin-Farrell & Turpin, 2003; Stamm *et al*., 2002; Steed & Downing, 1998; Varner, 2004). The first set of reactions often reported is similar to that of direct traumatisation, being the initial feelings of horror, intense fear, helplessness, shock and disbelief. The resultant set of symptoms are believed to be similar to those of posttraumatic stress disorder or PTSD (such as sleep disturbances, feelings of hopelessness, helplessness, flashbacks, anxiety, depression, hypersensitivity, apathy, anger, feelings of being trapped and emotional numbness). The phenomenon of PTSD and how it relates to the study will be returned to again later in this chapter when the direct diagnosis of PTSD is discussed in more detail under the DSM-IV diagnostic system section.

In conclusion, Hesse (2002) explains that vicarious trauma can seriously impact on one's personal and occupational life. Professionals who constantly listen to reports of extreme loss, trauma, horrific events and testimony of human cruelty, may even start experiencing symptoms parallel to those of their clients (Lev-Wiesel & Amir, 2001). Claims workers are confronted by such reports whilst documenting each claim, which is largely not the case with underwriting clerks. It was therefore

interesting to determine whether these duties befalling claims workers, would have any significant effects on them compared to the underwriting sample.

Looking at past studies involving researchers, journalists and legal representatives, some interesting findings are reported that clearly imply the possibility of vicarious trauma. Newman and Kaloupek (2004), for instance, conducted research to establish the risks and benefits from doing trauma-focused research. The greater focus of the study was on research participants, but they also reported that researchers and research institutions often reported vicarious traumatisation as one of the more salient risks to research staff. This was found to be the case across many different types of studies where researchers were exposed to the traumatic materials of participants.

Goldenberg (2002) performed a more comprehensive study of the effects of trauma research on a group of eighteen researchers who interviewed Holocaust survivors. Although this study indicated that researchers reported more positive than negative effects, vicarious traumatisation and compassion fatigue were the most prominent negative effects that were identified. There were, for example, reports of insomnia, anxiety and instances of minor depression after each interview and again when having to present the findings. There were also several reports of sadness and difficulty that was experienced in listening to the narratives, due to their sheer disturbing nature (Goldenberg, 2002). Especially in cases where survivors' recollections were accompanied by crying, researchers reported the most difficulty and the most noteworthy emotional effects. Some of the researchers also reported

increased feelings of fear and vulnerability (Goldenberg, 2002). Claims workers might be experiencing similar feelings, as some clients often talk about equally disturbing events during claims negotiations. It is also not impossible that these clients might also express equally intense emotions such as crying.

Studies that have focused more on the experiences of jurors have reported similar effects during trials. The National Center for State Courts in the USA (1998), reported that significant sources of stress in jurors, amongst others, are the descriptions of traumatic events and the introduction of troubling evidence and testimonies. In a study performed by this group, they reported that jurors ranked descriptions of grisly cases quite high as a source of stress. Jurors, however, have the added stress and responsibility of reaching a fair verdict. A group of non death-penalty jurors also consistently ranked the description of the event, testimonies and troubling evidence as each being one of the ten highest sources of stress and distress to them (National Center for State Courts, 1998).

An equally interesting study involving a group of professional newspaper journalists also revealed some interesting results. It was found that continuous exposure to events involving trauma demonstrated change in their cognitive schemas that are so often associated with vicarious trauma. Their major beliefs regarding personal invulnerability, meaning, self-worth and overall benevolence of the world, were considerably impacted on (Pyevich, Newman & Daleiden, 2003). These schemas were found to become increasingly negative, were hindering the development of adaptive schemas and were instead promoting maladaptive schemas.

Yet another study indicated that the staff of a Holocaust Memorial Museum showed significant and somewhat lasting emotional distress (Stamm, 1997). It was their duty to prepare Holocaust artefacts for display. Consequently, they were constantly exposed to disturbing personal belongings of Holocaust victims and other reminders of the Holocaust, which affected them quite adversely (Stamm, 1997).

Finally, Levin and Greisberg (2003) studied vicarious trauma responses in attorneys and made some startling reports. Compared to a control group of professional mental health workers, attorneys consistently exhibited higher levels of vicarious trauma due to less support, higher case loads and lack of supervision around trauma and its effects (Levin & Greisberg, 2003). More than half of the attorneys surveyed, encountered an amount of 21 or more trauma clients during a period of a year compared to 70% of the mental health professionals from the control group who averaged 20 or less clients in the same time period.

The results further indicated that attorneys experienced more symptoms of vicarious trauma compared to the comparison group and consistently scored higher on each of the vicarious trauma subscales. When translating these scores into symptoms, the attorneys displayed higher levels of intrusive recollection of trauma material, avoidance of reminders of such material and reduced pleasure and interest in activities (Levin & Greisberg, 2003). Sleep disturbances, irritability, and diminished concentration, were also found to be equally prevalent. This situation was further exacerbated by a lack of preparation in understanding the clients and also a lack of regular opportunities to discuss and ventilate their personal feelings (Levin

& Greisberg, 2003). When looking at claims workers, they might not deal with traumatised clients as often as the group of attorneys, for instance, but they also largely lack supervision surrounding trauma and its effects and similarly have very few opportunities to ventilate their feelings.

1.3.1 Positive effects of vicarious traumatisation

Although the literature on vicarious trauma in groups other than mental health professionals are quite scant, the studies that were highlighted here all have one thing in common. They report on the effects of exposure to client's trauma and clearly validate the existence of vicarious trauma, although in varying degrees. Having said this, it is also very important to mention that not all studies on vicarious trauma have indicated a purely negative outcome. Some of the literature that is now only beginning to emerge, clearly distinguishes between certain negative as well as several positive outcomes (Joseph, Williams & Yule, 1993; Linley & Joseph, 2004a; 2004b; Newman & Kaloupek, 2004; Waysman, Schwarzwald & Solomon, 2001). Linley and Joseph (2004a, p. 2) initially called the positive changes following trauma "*positive vicarious reactions"* or "*posttraumatic growth"*. In a later publication it is also referred to as "*adversarial growth"* (Linley & Joseph, 2004b, p. 11).

Some authors feel that the accentuated focus on the negative sequelae of trauma and adversity, or the pathological adjustment to it, inevitably leads to a biased understanding of posttraumatic reactions (Joseph *et al.*, 1993; Linley & Joseph, 2004b). They stress the importance of, when attempting to fully understand reactions to trauma and adversity, being considerate of the potential for positive

effects. These authors explain that traumatic events have been reported to have very positive effects, such as discovering an inner strength that one might not previously have been aware of and a greater closeness and intimacy to loved ones. A greater appreciation for life has also been reported to have developed after actual trauma, as well as vicarious trauma (Linley & Joseph, 2004a).

Feeling wiser and more experienced at life is also reported quite often. Those in the helping professions who witness growth and resilience in their clients, find this immensely inspiring, which might also facilitate growth in their own lives. Tedeschi and Calhoun (2004, cited in Linley & Joseph, 2004a, p. 6) capture this notion quite well by stating that *"…in listening to clients with respect for their strength and ability to change, we find ourselves changed for the better"*. The present study was also somewhat focused on determining whether claims workers react mostly negatively to trauma or whether they perhaps exhibit positive effects in some cases.

In addition, Linley and Joseph (2004a) point out that an empathic connection with someone who is suffering, is the obvious portal through which a person is vicariously affected. However, it remains a fascinating question as to why some would experience negative effects whilst others experience positive growth. This question, unfortunately, is still a long way from being answered. McCann and Pearlman (1990), for instance, propose that the therapists' contact with traumatic materials lead to disturbances in their assumptive world, which may result in negative reactions.

In contrast, Linley and Joseph (2004a) suggest that these disruptions might actually lead to growth, dependent on the way in which these psychological effects are managed. They propose that the trauma-related material can either be ignored as being irrelevant to a person's own life or, alternatively, it might be assimilated within one's assumptive world or accommodated by modifying this assumptive world. What these authors call the *"organismic valuing theory"* (Linley & Joseph, 2004a, p. 10), shows that therapists or other exposed workers are better equipped to accommodate the challenges to their assumptive world more positively when they have sufficient social support. This would ultimately lead to psychological growth. They further argue that, when these important facilitative factors are not present, the therapist is more likely to assimilate the traumatic materials within their pre-existing assumptions about the world or the self. This, on the other hand, might ultimately leave the person at greater risk for future traumatisation or a more negative accommodation.

Waysman *et al.* (2001, p.532) focused more on the role of specific psychological resources and pointed out that adversities might have, what they call *"salutary consequences"*, or beneficial effects. Their study sought to identify effects that would buffer the impact of trauma. The focus was firstly on identifying direct effects or those effects that are operative at all times. At the same time, the study also sought to identify moderating effects, or those affects that are operative only during adverse times. The aforesaid study particularly identified hardiness as having a direct effect and more conclusively, as being a moderator towards trauma. Hardiness was found to be associated with an overall lower vulnerability towards

negative outcomes and was identified as a protective factor (Waysman, *et al.*, 2001). Also focusing more on psychological factors and resources, Linley and Joseph (2004b) identified a wide range of psychological as well as environmental factors that play a role in both adversarial growth and vicarious traumatisation. The nature of the stressor, cognitive appraisal, socio-demographic variables, social support, personality, cognitive processing and affect, were all identified as playing a contributing role in both cases.

In addition, Newman and Kaloupek (2004) also identified positive effects of trauma-focused research on participants. These were empowerment, enlightenment, stigma normalisation and breaking the silence, which demonstrated clear benefits. Altruism, kinship with others and feelings of being worthwhile were reported by research participants as a result of receiving favourable attention from researchers (Newman & Kaloupek, 2004). From the researcher or research institute's point of view, positive outcomes that were reported entailed the fostering of valuable relationships, gains in resources and gains made in terms of recognition. In conclusion, Joseph *et al*. (1993) also presented evidence of positive changes in outlook, following disaster.

As can be seen, vicarious trauma and adversarial growth are equally complex phenomena. One has to agree, however, that juxtaposing these two contrasting concepts, effectively broadens one's insight. It creates a deeper understanding and clearly offers a more balanced view of the effects of trauma. Without considering the positive effects alongside the negative, one would have a very one-sided, less

reflective and thoughtful view of trauma. Therefore, the positive effects of trauma were also demarcated as of significant importance to this study. It was felt to be important to also effectively interpret any significantly positive effects observed.

In continuation of the discussion, other important concepts related to vicarious trauma, which are also of importance to the study, will each be considered in the next section.

1.4 Other important study variables

When talking about trauma and more specifically vicarious trauma, certain other important terms emerge repeatedly from the literature, such as **secondary traumatic stress, compassion fatigue** and **burnout** (Annschuetz, 1999; Bell, Kulkarni & Dalton, 2003 ; Hesse, 2002; Lev-Wiesel & Amir, 2001; Pieper, 1999; Reibel, Greeson, Brainard and Rosenzweig, 2001; Sabin-Farrell & Turpin, 2003; Sexton, 1999; Stamm *et al*., 2002; Steed & Downing, 1998). These concepts all have a bearing on this study and will each be expanded on individually. There is a considerable overlap between the conditions described under each of these terms, but Linley and Joseph (2004a) managed to disentangle them quite effectively. Their understanding of each of the terms will be explored in the ensuing paragraphs.

According to Linley and Joseph (2004a), the term **secondary traumatic stress or STS** originally referred to the emotional duress experienced as a result of dealing with traumatised clients. This term is important to the proposed study, seeing that claims workers are in constant contact with traumatised clients. STS is

referred to by some of the authors as a phenomenon almost parallel to posttraumatic stress disorder or PTSD (Hesse, 2002; Linley & Joseph, 2004a; McNally, 2003; Sexton, 1999). The difference in the case of traumatic stress is that exposure is indirect, whereas PTSD is a result of direct experiences of trauma (Linley & Joseph, 2004a). Figley (1995, cited in Levin & Greisberg, 2003, p. 2) summarizes the formulation of STS as the *"cost of caring"* from which symptoms manifest, which they also view to be very similar to those of PTSD. These include re-experiencing of the witnessed event, avoidance of recollections of the event, numbing in affect and function, and continual arousal.

STS was later renamed **compassion fatigue or CF,** as it was believed to be a less stigmatising term (Linley & Joseph, 2004a). These terms can therefore be used interchangeably and refer more to the actual emotional and behavioural responses to trauma. Both definitions are seated in a more clinical view, namely that of the DSM-IV diagnostic system with respect to PTSD, and are therefore largely symptom-based. For the purpose of the study, however, the term secondary traumatic stress (STS) is used throughout the methodology, results and discussion chapters, instead of compassion fatigue. Seeing that claims and underwriting workers are not in the care-giving profession per se, it was thought that STS would be a more fitting term.

The constellation of symptoms associated with STS and CF is again described to bear close resemblance to those of PTSD, as listed by the DSM-IV diagnostic system. It is important to mention here that vicarious trauma and STS/CF are phenomena specific to professions dealing with traumatised clients (Sabin-Farrell

& Turpin, 2003). This study also attempted to learn whether STS/CF occurs in claims workers who similarly engage with the trauma of others on a daily basis. It was expected that this variable would play a far less prominent role in terms of the comparison group of underwriting clerks, seeing that they do not typically deal with traumatised clients. As indicated previously, there are many categories of trauma that are relevant to the proposed study and burnout will be explored next.

Burnout, in contrast to secondary traumatic stress/compassion fatigue, can be experienced in any client-centred profession. It is especially at the order of the day when working with any difficult population (McCann & Pearlman, 1990). The insurance industry is indeed a very problem-laden, client-centred industry and burnout is therefore an equally important concept to this study. It can be defined as *"…a state of physical, emotional and mental exhaustion caused by long-term involvement in emotionally demanding situations"* (Pines & Aronson, 1988, cited in Hesse, 2002, p. 297). It is understood as the body's way of responding to continuous occupational exposure to psychologically taxing interpersonal situations. This includes dealing with clients who are upset, in emotional pain and having to continuously convey empathy to them (Annschuetz, 1999). Both claims workers and underwriting clerks deal with clients on an ongoing basis and might encounter such and other difficulties regularly, a point which the present study investigated quite scrupulously.

The definition of burnout is also very symptom-based, describing feelings of exhaustion, reduced feelings of accomplishment and depersonalisation (Hesse, 2002;

Sabin-Farrell & Turpin, 2003; Sexton, 1999). Symptoms reported by McCann and Pearlman (1990) also include depression, cynicism, boredom, loss of compassion and discouragement. These authors point out that burnout is a particular threat in cases where persons feel that their efforts have no impact upon the root causes of crime and violence. Claims workers might very well feel this way as, no matter how many claims they settle, it has no impact on the causes of crime or violence whatsoever and there is no end to their work. They experience a steady influx of new claims day after day.

In contrast, underwriting clerks are expected to share much less of these concerns about crime and might not see their efforts as being quite as futile. McCann and Pearlman (1990) also add that burnout is the final common pathway in cases where there is continued exposure to traumatic material that are not assimilated or worked through properly. This inability to process traumatic materials might also ring true for claims workers, as they often do not have the necessary support structure to aid this process.

When it comes to measuring work-related trauma and vicarious trauma, Stamm (2003) shares the notion that the phenomena described thus far are all interrelated and she also feels that each should be considered when thinking about vicarious trauma or its impact. Beth Hudnall Stamm is a Research Associate Professor of Psychology at Idaho State University and vicarious trauma and posttraumatic stress disorder have been at the core of many of her studies. She developed the Professional Quality of Life – or the ProQOL-RIII Scales, which were

utilised as part of the present study. These scales specifically measure vicarious trauma along the dimensions of compassion satisfaction, secondary traumatic stress/compassion fatigue and burnout. Stamm further believes that these closely related concepts are also highly relevant to professional quality of life.

It is important to point out here that Stamm's use of the term "*professional quality of life"* does not quite have the same connotations as in psychology literature. The use of the term, therefore, has to be understood within the context of the test itself. Stamm (2003, p. 4) points out that "*professional quality of life"* is featured in the name of the test as they realised, after the marketing thereof, that focusing the overall effort on a positive construct such as professional quality of life made it easier to support a positive system change. It also prevents or restructures the negative effects of caregiving and reinforces the positive effects associated with having to provide empathy.

The ProQOL-RIII test was believed to be relevant to the population of this study, as it is a scale designed to specifically measure traumatisation and specifically vicarious traumatisation, as it occurs in the domain of one's profession (Stamm, 2003). Measuring vicarious traumatisation where it occurs and determining how it impacts at a professional level were therefore considered to be most appropriate to the present study.

The next part of the discussion focuses on the role of the DSM-IV in the diagnoses of direct and indirect traumatisation.

1.5 The DSM-IV:

1.5.1 The diagnosis of direct traumatisation

The **DSM-IV diagnostic system** looks at the manifestation and impact of trauma on the individual by mainly focusing on posttraumatic stress disorder. PTSD is seen as an emotional disorder that can follow any traumatic event (Barlow & Durand, 2001). The DSM-IV clearly describes the setting in which trauma is most likely to occur. Exposure to a traumatic event accompanied by fear, helplessness or horror, would be a requirement for PTSD to transpire.

This diagnostic system further makes the distinction in experiences at the moment of trauma (intense fear, helplessness and horror) and symptoms that are experienced in the aftermath that are grouped together in terms of the re-experiencing of the event. These include persistent avoidance behaviour and continual symptoms of increased arousal that were not present before the trauma (Barlow & Durand, 2001). For further information, *Appendix A* to this document can be viewed for a full description of the criteria for and symptoms of PTSD.

In conclusion, the diagnosis of PTSD is not an easy task. Schützwohl and Maercker (1999) feel that too clear-cut diagnostic boundaries, such as those of the DSM-IV, often exclude individuals with clinically significant PTSD symptoms. This happens because the clinical picture presented by some sufferers is so variable (Schützwohl & Maercker, 1999). This makes the diagnosis of vicarious truamatisation an even more challenging and elusive undertaking.

1.5.2 The diagnosis of vicarious trauma

As previously stated, the symptoms of vicarious traumatisation are strongly equated with those of posttraumatic stress disorder or PTSD (Hesse, 2002; McNally, 2003; Sabin-Farrell & Turpin, 2003; Sexton, 1999; Stamm, 1997; Steed & Downing, 1998). Some authors have attempted to connect the symptoms even more closely (Hesse, 2002; McNally, 2003). Hesse (2002) for example, goes as far as to suggest that severe secondary traumatic stress/compassion fatigue (STS/CF) and PTSD are tantamount.

Other similar attempts have been made to incorporate STS/CF into a wider definition of PTSD by using what McNally refers to as "*conceptual bracket creeping*" (2003, p. 231). However, the DSM-IV at present does not make provision for criteria specific to the diagnosis of vicarious trauma, which complicates the matter. Davidson and Foa (1991, cited in Sue, Sue & Sue, 1994, p. 164) raises the issue that a broader category, which could perhaps be called "*Disorders of Psychological Trauma*", should be introduced into the DSM-IV, as not all aspects of psychological trauma such as vicarious trauma or secondary traumatic stress are sufficiently addressed by it at present.

Schützwohl and Maercker (1999) also commented that using the DSM-IV criteria causes some people with genuine PTSD symptoms to be excluded from the diagnosis, because they do not display the requisite three avoidant symptoms. They suggest that the avoidant symptoms are too exclusive and that they should either be reconsidered, or reduced from three symptoms to two. The fact that some

individuals suffer from clinically significant symptoms of PTSD but do not meet the full set of diagnostic criteria, has given rise to the introduction of "*partial- or threshold PTSD"*. This is used to describe "*subsyndromal*" forms of PTSD, such as vicarious trauma (Schützwohl & Maercker, 1999, p. 156).

Although this debate will not be developed further here, it is important to mention this disagreement to indicate exactly where the diagnosis of vicarious trauma is at and to point out some of the attempts that have been made to adopt a much broader view of traumatisation than merely focusing on PTSD. One of the groups of symptoms that would pose specific implications to the general work performance of claims workers, is that of persistent avoidance-behaviour which entails *"…the avoidance of stimuli associated with the trauma and numbing of general responsiveness"* (Barlow & Durand, 2001, p. A-6 Appendix A).

This avoidance-behaviour is expressed across all life situations but in the working environment, for instance, it could have serious implications for both the employer and employee. Avoidance-behaviour in the work context would typically manifest as avoiding certain tasks (Annshuetz, 1999) or certain clients (Perry, 2003). It could even manifest in avoidance of the workplace altogether, where high absenteeism would be prevalent (Worktrauma.org, 2005). Stamm (2003) shares the view of the close relation between vicarious trauma and PTSD. The ProQOL-RIII Scales (Stamm, 2003) which were administered, focus some of the items around the core traits of PTSD such as avoidance behaviour, sleep disturbance, exaggerated startle responses, preoccupation with the traumatic events, withdrawal, feelings of

being disconnected from others, sudden intrusive thoughts and feelings of helplessness. AtHealth (2003) also explains that, in addition to the core symptoms, low self-esteem is very commonly associated with PTSD. A sense of gloom and feelings of a foreshortened future are also described, which indicates the adoption of more pessimistic appraisals of one's life circumstances. As low self-esteem and pessimism are both closely associated with PTSD, it will also be tapped into by the study. Next the further relevance of self-esteem and optimism/pessimism to the study will be considered in more detail.

1.6 The role of self-esteem and optimism/pessimism in the study

Other variables also of interest to the study are self-esteem and levels of optimism/pessimism. Sierra Pacific Network (2001) suggests that **self-esteem** is a property innate to all humans. We all have a regard for ourselves, being low or high; positive or negative, meaning that you can not *not* have a regard for yourself. Self-esteem, for the purpose of this study, can be defined as a generalised positive/negative attitude toward oneself and the level of confidence about one's mental and physical abilities (Mehrabian, 1998).

In the context of a claims worker or underwriting clerk, self-esteem would typically refer to, for instance, people's regard for themselves and the level of confidence in their skills. It would also include the regard in terms of the worker's ability to cope with stressful events, such as difficult negotiations with clients or being confronted with their trauma. Several studies have indicated that exposure to trauma can in fact encroach on one's self-esteem (AtHealth, 2003; PTSD Alliance,

2003; Sierra Pacific Network, 2001; Tracy, 2002). Those with low self-esteem often have little confidence in their talents and question their ability to perform acceptably in difficult situations (Sierra Pacific Network, 2001). In addition, AtHealth (2003) states that exposure to trauma indeed has negative effects on self-esteem, as it becomes increasingly hard for the exposed or affected persons to feel good about themselves. Sometimes, because of how they behaved at the time of the exposure to trauma, they might see themselves as worthless, unintelligent and incompetent.

Furthermore, low self-esteem can inhibit one's capabilities and affect work performance (Sierra Pacific Network, 2001). It can also undermine career - and self-development, inhibit a sense of success and personal worth, affect relationships with friends and significant others, and affect how one generally feels about oneself (Sierra Pacific Network, 2001). AtHealth (2003) adds that trauma can cause a person who is experiencing trauma symptoms or posttraumatic stress disorder (PTSD) to eventually start believing that they don't have the ability to recover or get better and view their being affected as a sign of personal weakness. A point that makes the investigation of self-esteem even more relevant, is the fact that low self-esteem is not only a result of PTSD, but can also act as a vulnerability predisposing one to PTSD. In reverse, high self-esteem again acts as a protecting factor (Tracy, 2002).

Another secondary effect often reported after traumatisation, is the adoption of a more **pessimistic** orientation or position (Dheer, Jaiprakash, Sharma & Singh, 2003). A sense of gloom and feelings of a foreshortened future, as discussed under the previous heading, are also described by the DSM-IV following trauma (Barlow &

Durand, 2001). This signifies the adoption of more negative appraisals of one's life circumstances or pessimism. Being constantly exposed to negative events, such as traumatic materials, could change our beliefs about the world. A person starts seeing the world as an out-of control, dangerous and meaningless place and gravitates toward seeing their life circumstances and future in an increasingly pessimistic light (Mehrabian, 1998; Sabin-Farrell & Turpin, 2003). In this frame of mind, it becomes increasingly difficult to remember the positive aspects of one's life and an overall cynical and pessimistic view is eventually adopted. Pessimism and a sense of helplessness were, for instance, reported in 55% of participants who were constantly exposed to low intensity conflict situations (Dheer, *et al*., 2003).

Optimism, on the other hand, refers to the emotional and cognitive gravitation towards feeling that the good things in life outweigh the bad (Mehrabian, 1998). Optimists are generally inclined to believe that good, rather than bad things are happening to them and will continue to happen to them. Those who possess both higher self-esteem and optimism are more likely to view their future and life circumstances in a more hopeful way. They are also likely to feel more confident, to be more resilient and to persist more under difficult circumstances. In the case of claims workers, having to deal with traumatic materials and negative life events on an ongoing basis, might compromise self-esteem and optimism. It was interesting to determine if claims workers' expressions of self-esteem and optimism/pessimism differed significantly from those of the comparison group of underwriting clerks. To this end, optimism/pessimism was also measured as part of the present study.

Albert Mehrabian (1998), who is involved with the University of California in the USA, developed the Mehrabian Self-Esteem and Optimism-/Pessimism - , or the MSE and MOP Scales, to tap into and measure these concepts. These scales were administered and interpreted as a second tier to the study.

Apart from the wide array of PTSD associated symptoms described, and the secondary difficulties often experienced, there are also relatively lasting cognitive changes that are equally closely associated with indirect trauma. These will be considered next.

1.7 Theories of Cognitive change

The **Cognitive theories** specifically describe the permanent changes to cognitive processes associated with vicarious trauma quite comprehensively. These cognitive changes are pivotal when looking at vicarious trauma, as they are the very mechanisms that give impetus to and maintain the process of vicarious traumatisation. According to this group of theories, there are changes in our views and beliefs about ourselves and our world following a traumatic event (Sabin-Farrell & Turpin, 2003). For instance, persons who are normally very self-sufficient and independent, might suddenly start seeing themselves as having no control and as being increasingly helpless. Claims workers might very well exhibit similar changes when compared to their counterparts from the underwriting department.

Cognitive theorists further suggest that our world and experiences are viewed and filtered through schemas or what Sabin-Farrell and Turpin (2003, p. 456) refer to as "*core beliefs*". All new experiences that are congruent with our schemas are

assimilated and incongruent experiences are rejected (Sabin-Farrell & Turpin, 2003). According to the Cognitive Constructivist Development Theory, information heard from trauma victims may change these schemas to accommodate various resultant fear-driven and previously incongruent beliefs about the world we live in (McCann & Pearlman, 1990). Constant exposure to client's experiences of breached trust, human cruelties, powerlessness, ever present dangers and testimonies of how unfair life can be, may well result in changes to the listener's schemas. This typically happens in order to assimilate this information in an attempt to make sense of these testimonies. These altered schemas are carried with the person into every situation and the effects extend into every domain of existence, which includes clinical functioning, interpersonal relationships, social functioning and working life. As a result, the world is typically viewed through lenses that are coloured by these traumatic experiences.

Victor Frankl (1963, cited in Joseph *et al.*, 1993) postulated decades ago already, that the need for finding meaning is a fundamental human motivation. The underlying premise to the Cognitive Constructivist Development Theory is that all humans construct their own personal realities by developing complex cognitive structures. From these we interpret events in our continuous pursuit of meaning. These cognitive structures continuously develop and become increasingly complex over one's life span through the interaction with others and the meaningful environment (McCann & Pearlman, 1990). These structures are also referred to as schemas or mental frameworks which encompass beliefs, assumptions and

expectations about the self and the world that enable individuals to make sense of their experiences.

McCann and Pearlman's (1990) major argument is that direct or indirect trauma can disrupt these schemas. They postulate further that the unique way in which trauma is experienced, depends in part on which schemas are most central to the individual. If affected by trauma, these schemas impact profoundly upon the person's beliefs. Changes that occur to these schemas and beliefs due to trauma are also viewed as relatively lasting seeing that our schemas evolve in order for us to make sense of our world and what happens to us and those around us. Also, those who continuously listen to accounts of victimisation and trauma may internalise the memories of these events which may lead to temporary or even permanent alteration of the memory system (McCann & Pearlman, 1990). These alterations can also potentially become disruptive or intrusive to the person's psychological or interpersonal functioning.

McCann and Pearlman (1990) explain that, like the trauma victim, the listener may also experience some of the clients' traumatic imagery or associated emotions as returning fragments without context or meaning. They could take on the form of flashbacks, nightmares or intrusive thoughts (Rae Jenkins & Baird, 2002). The latter constitutes, which some believe, to be the hallmark of posttraumatic stress disorder.

The most pronounced changes reported by McCann and Pearlman (1990) essentially involve the self- and professional identity, spirituality and world view. One's psychological belief system, especially those beliefs relating to dependency/trust, safety, power, independence, esteem, intimacy and control are equally vulnerable to change. As an example, when a listener pays attention to testimonials of how people are traumatised and violated by others, they themselves might become suspicious of people's motives, distrustful or cynical. The person may feel increasingly unsafe and uneasy, which might result in being overly cautious.

Falsetti, Resick and Davis (2003, p. 391) call this tendency "*overacommodation*" where, instead of believing that a criminal human being is dangerous, they start believing that all humans are dangerous and that the world is completely unsafe. Persons might also start feeling helpless, vulnerable or even paralysed and might start questioning their own efficacy and sense of power in the world. Restrictions in the person's own freedom of movement and personal autonomy might become diminished and the person might also experience decreased esteem for others or the human race in general (McCann & Pearlman, 1990). A sense of alienation might be experienced as well as feelings of having no control over one's life.

In addition, Sabin-Farrell & Turpin (2003) identify three basic beliefs that are particularly susceptible to trauma. These are the belief that you are invulnerable; a positive view of yourself (self-esteem) and the belief that the world is a just and meaningful place. Evaluating self-esteem and levels of optimism/pessimism, also

helped to indirectly address these three basic beliefs. Similarly, it helped to determine whether they differed between the group of claims workers compared to the underwriting clerks.

Taking this view further, Steed and Downing (1998) add that the effects spiral even farther outward to a spiritual level, whereby the person's experience of his body and physical presence in the world is affected. In addition to this, changes in religious and spiritual beliefs have been reported to follow trauma. For instance, individuals might engage in what Falsetti *et al*., (2003, p. 392) call "*transformational coping*". The person essentially starts searching for new meaning amidst senseless events by typically asking certain questions such as "*Why is God punishing me*?", and by concluding that they have done something wrong and are deserving of this punishment. Others might even go as far as to abandon their religious beliefs altogether as they might conclude that a righteous God would not let such terrible things happen to them. In some cases a person might still hold on to the religious beliefs by using what is called "*conservational beliefs"*, in concluding that they could not have survived or remained sane without their faith (Falsetti *et al*., 2003, p. 392).

Although it is somewhat unclear to predict what coping strategy a person will employ or to even isolate any contributing factors, it is still important to know that religiosity and spirituality can be altered in an effort to make sense of trauma and adversity. It is also important to know that there is a very complex relationship between traumatic experiences and one's religion and spirituality.

In conclusion, Falsetti *et al.* (2003) suggests that the development of posttraumatic stress disorder could very well be symptomatic of a conflicted belief system where the beliefs about oneself, the world and others might no longer hold any sense after being confronted by a life threatening or horrific event.

As can be seen, the cognitive effects of trauma are extremely complex and far reaching and can best be explained by an equally holistic view on traumatisation, as postulated by the Bio-psychosocial theorists, which will be considered next.

1.8 Bio-psychosocial theories

The **Bio-psychosocial theories** also see traumatisation as surprisingly complex, involving a multifaceted interplay of biological, psychological and social factors (Barlow & Durand, 2001). Schwartz (1990) suggests that, due to the intricate nature of posttraumatic stress disorder (PTSD), different facets of one's life are impacted on by this disorder, something which would also largely be true of vicarious trauma. Pharmacological, psychotherapeutic and social interventions are all needed to successfully address the full range of effects of traumatisation.

It is further believed that we bring our inherent biological and psychological vulnerabilities with us into each life situation. The greater the vulnerability, the greater the likelihood that traumatisation will occur. Schwartz (1990) explains that some studies have indicated pre-existing psychopathological conditions. The most common is believed to be behavioural problems, such as hypervigilance,

explosiveness, aggression, defiant behaviour, anxiousness and even attention deficits which might be predisposing to the development of PTSD.

Other authors mention that biological and psychological predispositions to PTSD are to a great extent inherited as part of our genetic make-up (Barlow & Durand, 2001; Sue *et al*., 1994). Social factors are believed to play a precipitating role. For instance, social status and ethnicity would determine the typical social environment, frequency of traumatisation and the type of traumatising events that are most likely to occur (Barlow & Durand, 2001). It would also determine the type of support structure a person has to draw upon. This social setting therefore typically acts as the trigger for these predispositions (Barlow & Durand, 2001). Within the setting of the claims worker, the constant contact with the trauma of clients could not only serve as triggers for predispositions, but could also diminish the sense of self-esteem and lead to the adoption of a more pessimistic outlook, which are both important concepts to this study.

Furthermore, social withdrawal is not uncommon after trauma and this avoidance behaviour is fully described by the DSM-IV (please refer to *Appendix A* for further details). Not only thoughts about the traumatic event are avoided, but also contact with strangers or places that could lead to victimisation or anything that might symbolise or resemble any part of the traumatic event (Schwartz, 1990). There is also a markedly diminished interest in significant activities that the person might have enjoyed in the past. To completely understand the full reach of traumatisation and its impact on the person, one needs to consider the effects from a

Bio-psychosocial perspective and also have to look at theories on the role of the workplace. Workplace theory is of particular importance to the study, as the perceptions and experiences of claims workers will be investigated within their domain as workers.

1.9 Workplace theories

In modern day living, most of us are required to work in order to make an existence. Often the **workplace** and work-related experiences can be the very source of traumatisation (Annschuetz, 1999; Bell *et al*., 2003; Murphy, 1996; Sabin-Farrell & Turpin, 2003; Sexton, 1999; Steed & Downing, 1998; Worktrauma.org, 2005). This largely rings true for claims workers and also, to a lesser extent, for underwriting clerks. Both groups operate within the same industry and are likely to share *some* of the work stresses, though the added stress of exposure to traumatised clients might place claims workers at an even greater risk.

Lynott (2005) states that underlying **work-related stress**, irrespective of the cause, is silently eating away at the morale of workers, their productivity and eventually company profits. In the case of claims workers in particular, indirect trauma, secondary traumatic stress/compassion fatigue and possible burnout could be primary contributors to the elevated levels of stress. Lynott (2005) sees work-related stress typically as "*…the harmful physical and emotional responses that occur when the requirements of a job do not match the capabilities, resources or the needs of the worker"* (Lynott, 2005, para. 7). When the needs of workers are neglected and capabilities are lacking, work performance is sure to be undermined, which sets a

vicious cycle with wide implications in motion. With Lynott's (2005) definition in mind, claims workers might especially be at risk of elevated stress, as they do in fact lack training or capabilities in dealing with the trauma encountered by them. They seldom have the necessary support structure available to address their needs and to avoid any harmful resultant responses.

Seeing that traumatic materials are largely encountered in the workplace and as the client/worker dynamics in the claims department might further add to the possibility of traumatisation, it is also important to look at **workplace trauma** and how it occurs. According to workplace theorists, this form of trauma is inflicted as a consequence of working conditions, or during the course of work-related duties (e.g. Bell *et al*., 2003; Sabin-Farrell & Turpin, 2003; Sexton, 1999; Steed & Downing, 1998; Worktrauma.org, 2005).

This term not only refer to the exposure to the trauma of others. It is further defined as the adverse effects and impact on the employee's physical and/or emotional wellness, health and safety, as a result of physical and/or emotional violence experienced in the workplace (Worktrauma.org, 2005). Emotional violence is defined as the single or cumulative instance/s of emotional abuse, pressurising or threatening, which can be experienced directly, indirectly, overtly or covertly by persons in the circumstances related to their work (Worktrauma.org, 2005). It further refers to instances where a person's right to dignity and respect is challenged with the likelihood of impacting on their emotional safety and well-being.

This phenomenon is often referred to as **workplace bullying** within organisations (Worktrauma.org, 2005). In the domain of the proposed study, bullying is *not* expected to be inflicted by the organisation itself, but is more likely to occur in the domain of client relations. The circumstances under which claims workers interact with clients are often very problem-laden and emotionally charged. Clients who have suffered extensive losses frequently enter these negotiations in a traumatised state and with a mindset of having to fight for what is rightfully theirs. Some clients could be described as "*difficult people*", or could also be labelled as *"Jerks"* or "*Toxic people*", which refer to those who continuously use insulting forms of communication such as yelling, whining or sarcasm to express how they feel or what they think (Raynes, 2001, p. 33).

These labels also refer to those who attempt to manipulate the behaviour and attitudes of others by making them feel inferior and completely at their mercy. The people described here typically have a negative impact on organisations by creating fear, intimidation, confusion and they lower job morale, job satisfaction and productivity (Raynes, 2001). It is expected that claims workers might be placed under considerable pressure by clients and that they might be faced with hostility and, quite possibly, verbal abuse and personal affronts. These insulting forms of communication might add to the problem of traumatisation. Although clients might not intentionally behave in this way and might even still be distraught after a significant loss, the insults and bullying could still have a negative impact on claims workers.

As stated earlier, claims workers and the comparison group of underwriting clerks share some work stresses. Bullying was believed to be one of them as much of the underwriting clerk's time is devoted to problem management. Negotiations around problems are destined to lead to the insulting forms of communication described in the preceding paragraphs, but it was expected to occur to a lesser extent within this comparison group. The ProQOL-RIII Scales (Stamm, 2003) were used during the study to obtain measures of trauma and more specifically vicarious trauma. These subscales are designed to tap into any aspects of one's work that might be traumatising, frightening, or that might be causing secondary traumatic stress. In the case of claims workers as well as underwriting clerks, bullying was believed to be frightening and potentially traumatising.

In the case of claims workers, they also have the added secondary traumatic stress of having to deal with the trauma of clients. It was initially expected that the greater prevalence of potentially frightening and traumatising aspects in the case of claims workers would result in significantly higher ProQOL-RIII scores compared to those of underwriting clerks. The proposed study also looked closely at these inadvertent yet potentially harmful experiences described here, to find out if they do occur and to what degree each of the study groups are affected.

In continuation of the topic of workplace theories, Sexton (1999) looks at trauma and vicarious trauma specifically on an organisational level. He suggests that there are powerful unconscious processes that operate in human service organisations. He proposes that a whole organisation can become trapped into a

similar state of mind to that of the client group it serves. He strongly feels that, the more distressed the client group, the stronger the unconscious projective identification between client and worker and the more likely it is that the client's problem will be played out within the organisation. Sabin-Farrell and Turpin (2003, p. 455) refer to this phenomenon as **"emotional contagion"**, where the emotional distress of one person is "*contagious*" and passed on from one person to another.

The emotional contagion hypothesis proposed by Verbeke (1997), explains how the emotions of two people, such as the claims worker and the client, are transmitted from the one to the other during their interactions via verbal and, more specifically, non-verbal cues. There is also more and more attention focused on the understanding of the processes and outcomes of collective emotion (Barsade, 2002).

Some theorists have gone so far as to say that emotional contagion not only happens at an individual level, but that feelings, such as aggression, supremacy, pessimism or jealousy may also be the way by which group entities are known. This means that the development of group emotion can often define a group and largely distinguish it from other collections of individuals (Barsade, 2002). According to Barsade (2002, p. 1), several authors have presented evidence of this phenomenon which is called "*mood convergence*" within groups. They explain that the moods of different teams of workers or sportsmen can converge and that this work-group mood is something that can be both recognised and reliably measured by group members, as well as external observers. Although the study did not measure the typical work-group mood of the study groups per se, it is nonetheless possible that claims workers,

for instance, might be exhibiting an overall mood of distress as a result of their constant exposure to trauma. Furthermore, this mood might also include fear or unsettlement, as a result of difficult client relations and subsequent bullying. This might also be the case in terms of the comparison group of underwriting clerks

Although words are central to our understanding in general, it does not play a huge role in emotional contagion (Barsade, 2002). Non-verbal cues and direct interpersonal contact are of greater significance here and emotional contagion is believed to be an automatic, very quick, continuous and subconscious process. Emotions are transferred from one person to the next. One ultimately becomes aware of experiencing the particular emotion, but the initial processes that lead to it are subliminal and automatic (Barsade, 2002). Psychological researchers have found that the first step of this process involves the automatic, non-conscious mimicry in which people spontaneously mimic one another's facial expressions, body language, speech patterns and vocal tones (Barsade, 2002). To this Barsade (2002) adds that this mimicry is an innate human tendency, even observed in day-old infants.

The second step of this contagion process is derived from the automatic afferent feedback one receives from mimicking these nonverbal behaviours and expressions of the other person. Through mimicking the associated facial, postural, and vocal feedback, one then starts experiencing the emotion itself brought about by the physiological feedback from the muscular, visceral, and glandular responses (Barsade, 2002). In the case of claims workers, they might be identifying strongly with distressed clients and might even, unconsciously, pass on some of the trauma to

their colleagues and family members. Underwriting clerks do not necessarily deal with traumatised clients, but the negative emotions from bullies, as well as upset and irate clients, might be caught by them and passed on to others they come into contact with.

However, much of the negotiations between these different workers and their clients occur by telephone, and one might wonder if this same phenomenon would apply to telephonic interactions. McCalla and Ezingeard (2005, p. 1) are presently conducting research on the impact of service technologies, such as telephones, on the emotional dynamics between boundary-spanning personnel and the end-user customer. They have reason to believe that telephonic liaison, or what they refer to as "*voice-to-voice*" interactions, can also lead to emotional contagion. They argue that emotional expression always occurs during any emotional episode, be it face-to-face, or telephonic. They hypothesise that the customer now responds to content language, voice intonations and the use of emotional signalling words as emotional cues. In addition, Zempetakis (2004) also reported that there are many cues in one's tone of voice that indicates emotion that can be responded to.

Zilberman-Ziklik (2004) also hypothesized during a similar study, that conveying positive emotions by telephone service employees to customers, and vice versa, is expected to induce similar positive customer/worker reactions as is the case with face-to-face interactions. In addition, Verbeke (1997, p. 621) reports that negative emotions are as "*infectious*" as positive emotions. So, one can assume that

the conveying of negative emotions by telephone, would also be expected to induce similar negative customer/worker reactions.

These studies seem to indicate that voice-to-voice emotional contagion is possible and might even be somewhat similar to face-to-face contagion. But, when considering these theories more carefully, one would come to the conclusion that face-to-face contagion might naturally be more potent. One has to bear in mind that, in the case with face-to-face encounters, one simply has more interpersonal information to respond to. The two interacting parties would have both visual as well as auditory cues in the form of nonverbal behaviours and expressions of emotion in addition to the verbal cues. Nonverbal cues and direct interpersonal contact are also believed to be of greater significance in the process of emotional contagion than the words we hear (Barsade, 2002).

In the case of voice-to-voice transactions, the client and worker only have content language, voice intonations and the use of emotional signalling words as emotional cues to respond to. In other words, they only have auditory information to their disposal. The study was of interest to establish whether the conveying of specifically distress and negative emotions telephonically, will in fact have the same impact on the study groups than would face-to-face encounters. It was interesting to examine whether telephonic encounters and subsequent emotional contagion are equally potent as is the case with face-to-face encounters in terms of both study groups.

In closing of the introduction to the study, the major conclusions in terms of the demarcated literature and theories are summarised.

1.10 Conclusions

This chapter started off by broadly contextualising the study and demarcating the literature that is most relevant to this study. This was done to create an apposite backdrop against which vicarious traumatisation (VT) in claims workers can be investigated and understood, compared to the group of underwriting clerks. As no literature on VT in claims workers could be found, various somewhat similar groups of workers, such as jurors, legal representatives, researchers and journalists were identified and literature on these groups were decided to be most relevant and informative to the study. Literature on health- and mental health workers, however, still features quite prominently throughout the discussion. This is due to the fact that much of our understanding and the theories on VT, have emerged from research efforts with these groups of workers.

The main conclusions that were reached by looking at this literature are, firstly, that traumatisation does not need to occur directly for VT to transpire and that the exposure to the trauma of others on an ongoing basis is sufficient for VT to occur. This conclusion is of central importance to the study, as claims workers are confronted by the trauma of their clients on a daily basis. This largely places them within the possible reach of VT. It was also concluded that, studying VT in claims workers would be both interesting and useful, as no literature could be found on this

phenomenon within this particular population of workers. Seeing how serious and lasting the implications of VT can be, it was believed to be well worth investigating.

Another important point raised by the literature is that VT should not be looked at in isolation, but that various related concepts should also be considered in order to broaden our understanding of traumatisation and VT. It is due to this argument that compassion satisfaction, burnout and secondary traumatic stress/compassion fatigue were measured in claims workers, as indicators of VT. Scores on these variables were then compared to those in terms of the group of underwriting clerks.

Equally important, the available literature also points out that trauma and VT not only results in negative effects or pathological outcomes, but that many positive effects are also associated with this phenomenon. Again, one has to look at both negative and positive aspects, in order to more fully understand trauma and VT. Focusing purely on the negative sequelae of traumatisation will lead to a biased and limited understanding of traumatisation in general and also of VT. It is in the light of these aforementioned reasons that the use of the ProQOL-RIII Scales was deemed very appropriate to this study.

Firstly, this scale taps into secondary traumatic stress and burnout as measures of VT. Secondly, it also takes some positive aspects of VT into account by measuring compassion satisfaction. Finally, VT is often equated strongly with posttraumatic stress disorder (PTSD) and the ProQOL-RIII Scales have also taken

this into account, by focusing some of the items around the core traits of PTSD. As can be seen, the ProQOL-RIII Scales adopt a very comprehensive view of VT in keeping with its complex nature and the challenges associated with the diagnosis of this phenomenon.

It was also concluded that self-esteem, pessimism and optimism would be of some importance to the study. Firstly it is often reported that traumatisation, VT and PTSD have encroaching effects on one's self-esteem. Secondly, optimism and pessimism were also deemed relevant as traumatisation, VT and PTSD typically cause one to gravitate towards a more pessimistic appraisal of oneself, one's abilities and one's general outlook on life. This notion is, of course, strongly related to the central premise of the Central Cognitive Development theory on VT, which describes negative changes in one's central schemas and beliefs that are thought to be the most salient cognitive effects of VT. The Mehrabian Self-esteem (MSE) and Optimism/Pessimism (MOP) Scales were chosen to tap into these different variables that are also quite closely associated with VT.

In keeping with the complex, multidimensional view on VT, several theories were chosen in continuation of this comprehensive conceptualisation of VT. On an individual level, cognitive changes are considered and are further expanded upon by including the Bio-psychosocial perspective on VT, which also illustrates its surprisingly wide reach. Workplace theories were considered to be equally important as trauma and VT would, in the case of the study groups, be incurred at the workplace. The typical working environment of the claims worker also poses certain

challenges, such as workplace bullying, that could further add to the possibility of traumatisation. As the comparison group of underwriting clerks also focus considerably on problem management, they were expected to also be affected by bullying, but to a lesser extent. This point was looked at more closely to determine if this is in fact the case, and if so, how these two groups differ in terms of this variable. Drawing emotional contagion into the theoretical framework, largely explains how VT is transmitted and how it can infect not only an individual, but an entire group, or even an organisation. This makes one even more aware of its potential impact. The study also attempted to establish whether face-to-face contagion is more powerful than voice-to-voice contagion.

The next chapter will be focusing on explicitly stating the study aims and hypotheses that were pursued and delineating them more clearly.

2 RESEARCH AIMS AND HYPOTHESES

The research aims and hypotheses are presented as a separate, though very short, chapter. It was thought that, due to the central role of the study aims and hypotheses, that it would be appropriate to separate and highlight this important information.

2.1 Study aims

The overall focus of this research study falls on the experiences of claims workers in the short-term insurance industry, compared to those of underwriting clerks, when dealing with clients and potentially traumatising materials. A multidimensional look into traumatisation and vicarious traumatisation, the main study variables, will be undertaken. This will be made possible by not simply obtaining a score on trauma and vicarious trauma alone, but to rather consider these concepts in terms of three important aspects closely associated with it. These are compassion satisfaction, burnout and secondary traumatic stress. Furthermore, the study is also concerned with establishing whether those workers dealing with clients telephonically and face-to-face are affected to a greater extent than those who only have telephonic contact with clients. Stated differently, whether face-to-face contact with traumatised and upset clients is more conducive to trauma and vicarious trauma compared to voice-to-voice transactions, is also of interest.

Measures of the three aforementioned variables will therefore be collectively used as the measure of traumatisation and more specifically vicarious trauma. Whether these workers are affected by trauma and traumatic materials is of central

interest to the study, and to also explore the extent and the ways in which they are affected. To this end, self-esteem and optimism/pessimism are drawn into the equation as study variables, in conjunction with trauma and vicarious trauma.

2.2 Study hypotheses

The five research hypotheses of the investigation are as follow:

H1 There will be a significant difference in trauma and vicarious trauma scores between claims workers and the comparison group of underwriting clerks, whereby claims workers are expected to score higher in terms of burnout and secondary traumatic stress and lower in terms of compassion satisfaction.

H2 There will be a significant difference in trauma and vicarious trauma scores of workers dealing with clients purely telephonically, compared to those who deal with clients telephonically and face-to-face.

H3 Claims workers will exhibit lower scores on a measure of self-esteem relative to the comparison group of underwriting clerks.

H4 Claims workers will gravitate towards a more pessimistic position relative to the comparison group of underwriting clerks.

H5 It is expected that there will be an inverse relation between the negative dimensions of trauma and vicarious trauma (being burnout and secondary traumatic stress) and self-esteem as well as optimism. Similarly, it is expected that there will be a positive relation between the positive dimension of trauma and vicarious trauma (being compassion satisfaction), self-esteem and optimism.

The abovementioned hypotheses that are central to the study were derived from the existing theories on trauma and vicarious trauma that were outlined in the previous chapter. They are also, furthermore, derived from the fact that the working conditions of claims workers are in some respects quite similar to the working conditions of other groups of workers outlined by the literature as being conducive to vicarious trauma.

Scale measures will be at the core of this study, in an attempt to elucidate if claims workers are affected by trauma, and particularly vicarious trauma, as opposed to underwriting clerks. Scores on the Professional Quality of Life Compassion Satisfaction and Fatigue Subscales Revision III (ProQOL-RIII Scales (Stamm, 2003)) will act as the measure of trauma and vicarious trauma, that will be compared across the two groups. The Mehrabian Self-Esteem Scale (MSE) and the Mehrabian Optimism/Pessimism (MOP) Scale (Mehrabian, 1998) will also be administered to determine whether there are any significant differences between the two groups in terms of these variables.

The next chapter will be focusing on the research design and the methodology employed during this particular investigation.

3. RESEARCH DESIGN AND METHODOLOGY

3.1 Research design

Concepts of interest to the study were formulated into distinct study variables prior to data collection. These were then measured systematically by the use of pre-existing instruments, being the ProQOL-RIII Scales (Stamm, 2003), the MSE and MOP scales (Mehrabian, 1998). This observational method yielded numerical raw data in the form of test scores which are analysed statistically. The main interest is in frequency patterns and in any significant observable differences between the two comparison groups regarding the study variables, being vicarious trauma, on the basis of compassion satisfaction, burnout and secondary traumatic stress, as well as self-esteem, pessimism/optimism. In view of the aforesaid and seeing that hypothesis testing is at the core of the study, it is therefore primarily quantitative in nature.

It is also quasi-experimental in the sense that the research design resembles that of an experimental design, in that there are outcome measures and experimental units. However, there is no manipulation of the independent variable and no random assignment to the main study groups. Instead, the study utilises a naturally occurring sample and comparison group – that of claims workers and underwriting clerks respectively.

3.2 A description of the target population

The workers identified for the proposed study operate in the short-term insurance industry, which refers to a formal social device for reducing risks (Insweb Learning Center Insurance Glossary, n.d.). The primary focus of the proposed study falls on the population of **claims workers,** which refer to those in the employ of an insurer who seeks to determine the extent of the firm's liability or loss when a claim is submitted. These workers typically range from junior claims clerks, to team leaders or claims managers. Some companies also employ in-house assessors or loss adjusters, who conduct more in-depth investigations of claims, who would also fall under the category of claims workers. These various groups of workers are often collectively referred to as claims representatives (Insweb Learning Center Insurance Glossary, n.d.), but for the purpose of this study they will be referred to as claims workers.

A relatively equal number of workers from the underwriting departments were also approached to participate as a comparison group. The comparative nature of the study along the dimensions of the various study variables, brought about that a considerable amount of the information generated by the study pertains to this comparison group. **Underwriting clerks** are technicians that are trained in evaluating the degree of insurability of risks and in determining the rates and coverage that can be offered (Insweb Learning Center Insurance Glossary, n.d.). The term "*underwriter*" is derived from the age old practice of each person/company willing to accept a portion of the risk, writing his name under the description of the risk (Insweb Learning Center Insurance glossary, n.d). Finally, underwriting clerks

also amend policies according to clients' ever changing insurance needs. As can be seen, underwriting duties differ significantly from those of the claims workers which qualify them as an excellent comparison group. Claims workers and underwriting clerks operate within exactly the same industry, that of short-term insurance, and are likely to share some of the same stresses and pressures, but dealing with traumatised clients and traumatic materials is what greatly sets them apart.

The age group that was of interest to the study spanned 25 to 45 years. The reason for having highlighted this age-group, is the fact that this age range is seen as being in the establishment career phase (Bergh & Theron, 2003). During this phase, jobs and careers are seen as more permanent and stable. This phase is also seen as the creative and most productive years. Other reasons for having focused on this age group are that, firstly, career exploration or experimentation is partly diminished. Secondly, workers seem to be more career-focused and usually have comprehensive knowledge of their field of work, its demands, difficulties and challenges. This also means that workers would have a better idea of what is required of them. Consequently, they might have a clearer idea of what the job is costing them physically, emotionally, psychologically and mentally, and exactly how they are affected by it.

Fourthly, workers would generally be in a better position to judge themselves, their experiences and their performance in relation to job demands, challenges and requirements. Finally, in terms of the practicalities of the study, it was also believed

that this age group would be more target rich with regards to the required years of service and necessary job experience.

Participants were initially also required to be in a claims - or underwriting position for at least five years, which would have further ensured that they have adequate ideas and knowledge of the nature and challenges associated with their respective positions. To this, several Human Resource directors and managers of the participating insurers responded that the staff turnover within their respective companies is relatively high. They subsequently felt that two years experience would be more realistic. They were also confident that, after two years, the workers would have sound knowledge within their respective positions and would already have experienced most challenges posed by the various positions.

The general feeling was that focusing the study on five years of service would drastically influence the response rate and that it would also not be very representative of the average years of service of their staff corps. As a result, the minimum years of service to qualify for participation were amended to two years.

3.3 Participants

A total of 75 insurance workers participated in the study, of which 44 were claims workers and 31 formed the comparison group of underwriting clerks (please also see *Table 1* for descriptive statistics in terms of the biographic variables).

Table 1. Descriptive Statistics: Biographic Variables

GROUPS:		**Claims workers (*N*=44)**		**Underwriting clerks (*N*=31)**	
VARIABLE		**FREQUENCY**	**PERCENT**	**FREQUENCY**	**PERCENT**
Gender	Male	13	29.55	4	12.90
	Female	31	70.45	27	87.10
Age	25-30 years	17	38.64	12	38.71
	31-35 years	11	25.00	10	32.26
	36-40 years	3	6.82	4	12.90
	41-45 years	13	29.55	5	16.12
Years of Service	2-4 years	15	34.09	12	38.71
	5-8 years	17	38.64	10	32.26
	9-12 years	5	11.36	6	19.35
	13-16 years	2	4.55	2	6.45
	17+ years	5	11.36	1	3.23
Dealings	Telephonic only	30	68.18	25	80.65
	Telephonic & face-to-face	14	31.82	6	19.35

As can be gathered from *Table 1*, each person was required to elect biographic information in terms of predetermined categories rather than stating the actual values such as age or years of service. Of the participants, 17 were male (23%) and 58 female (77%) with an age range of 25 to 45 years of age. As the participants did not state their actual age, but instead chose an applicable age category, an average age is not available. However, the majority of the participants in terms of the amalgamated study sample were between 25 and 30 (*n*=29 or 39%),

followed by 28% (*n*=21) who were between 31 and 35. Only 9% (*n*=7) were between 36 and 40 and the remaining 18% (*n*=18) were between 41 and 45.

In terms of years of service, 71% of the amalgamated sample has been working in either of the departments of interest to the study for less than 8 years and only 29% have more than 8 years of service. When looking at this 29% of the sample, as little as 6% have between 13 and 16 years of experience and only 3% of the participants have been working within the departments of interest for more than 16 years. Finally, 55 of the participants (73%) deal with clients purely telephonically and only 20 participants (27%) interact with clients telephonically and face-to-face. None of the participants chose category 2 (face-to-face only), which indicates that they work with clients purely telephonically or telephonically and-face-to-face.

Finally, considering that group (claims workers versus underwriting clerks) is a primary independent variable, it was deemed to be of some interest to establish whether the two groups were equivalent in terms of the biographic variables. To this end, Chi-square tests for independence were performed on age, years of service, gender and dealings by group.

Next, the data collection procedures that were employed will be described.

3.4 Data collection procedures

Major short-term insurers were identified from the internet and from the Johannesburg Telephone Directory, and six well-known companies were earmarked

for participation. Of these six companies, only three eventually participated. Each insurer's Human Resource director or manager was approached and, following a brief discussion, was e-mailed a general letter inviting their participation (please see *Appendix B*). In the case where permission was granted, an introductory meeting was scheduled with the various departmental - or branch managers.

Two of the three insurers opted for supervised onsite completion of scales. The respective managers discussed the study with their staff and all interested parties were invited to report to their respective boardroom facilities on the morning of the data collection. Respondents therefore participated voluntarily and their managers were kind enough to allow them to be excused from their desks for 45 minutes at a time. The scales were disseminated for instantaneous completion in these boardroom facilities to one group of participants at a time (either claims or underwriting) by the research student.

In the case of the remaining insurer, all arrangements were made telephonically in order to streamline the process. They, in turn, preferred to have their employees complete the scales at their desks during a quiet moment, and the scales were subsequently left with the Human Resource manager. The test packages were distributed to all interested claims workers and underwriting clerks at two of their branches. Arrangements were made to again collect the completed scales from a designated person approximately two weeks later. Each test package was also furnished with a security envelope which has a tamper proof seal to ensure that no information could be viewed by any unauthorised person. It was decided in advance

that any envelopes with damaged seals would be excluded from the dataset, but at the time of the collection of the forms, it was found that all the seals were visibly intact.

The test packages used in terms of all three participating insurers consisted of a Subject Information Sheet (as per *Appendix C*); Informed Consent Form (*Appendix D*), Biographic Details and Test Instructions Sheet (*Appendix E*), the ProQOL-RIII Scales (*Appendix F*) and the Mehrabian MSE- and MOP Scales (*Appendix G*). It should perhaps be mentioned here that most participants requested not to sign the consent forms as they felt that they could be identified from their signatures. It was explained to them emphatically that their employers would not have access to any of the documents. They nonetheless consented to participate, but only on the condition that they did not have to sign any documents. This request was respected and honoured and consent was only conferred verbally.

3.5 Instruments

3.5.1 Biographic Questionnaire

Information obtained from this questionnaire was used for classification of participants. In this questionnaire participants were asked which department they work in, which age group they belong to, which gender they are and how many years they have been of service in the particular department. They were also asked which mode of interaction applied to their position, being purely telephonic, face-to-face only or telephonic and face-to-face (please see *Appendix E*). The remainder of the document consisted of test instructions in order to help keep participants on track in terms of completing the scales.

3.5.2 The ProQOL-RIII Scales

The ProQOL-RIII Scales (Stamm, 2003) were used to obtain an objective measurement of the level of traumatisation and vicarious traumatisation by tapping into three related concepts. These concepts are compassion satisfaction, burnout and secondary traumatic stress (please see *Appendix F*). It is a self-report Likert-type scale, consisting of 30 items that are scored according to *0 (never)* to *5 (very often)*, which takes approximately 10 minutes to complete. The scale does not clearly discriminate between trauma and vicarious trauma and measures both constructs. It is designed to tap into any aspect of one's work that might be traumatising or frightening, whether it is experienced directly or vicariously. As both constructs are important to the study, the use of the ProQOL-RIII was believed to be quite appropriate.

Furthermore, this scale also does more than simply yield a composite score for trauma and vicarious trauma. It is composed of the three mentioned subscales which are believed to be more informative and fitting to the complex nature of trauma and vicarious trauma. The relationship between the three discreet subscales is usually largely obscured by a composite score. Each subscale can therefore be viewed on its own and also in relation to the other scales to generate a more comprehensive picture of trauma and vicarious trauma. It is, for instance, possible for a person to report high scores on compassion satisfaction, whilst simultaneously reporting a high score on the secondary traumatic stress scale. This is often the case with those who retain their altruistic desire to act in an empathic way towards those in distress (Stamm, 2003). On the other hand, those who exhibit high scores in terms

of burnout and secondary traumatic stress, run the greatest risk of negative outcomes. These include, but are not limited to posttraumatic stress disorder, depression and poor professional judgement, that may cost a worker his/her employment (Stamm, 2003).

3.5.2.1 Development of the scale

It is important to mention here that the ProQOL was derived from and is the current third version of the 66-item Compassion Fatigue Self Test or CFST, which was designed by Figley in 1995 (Stamm, 2003). The CFST was shortened to the current 30 items and renamed in an effort to focus the test on a more positive construct, being professional quality of life, rather than the previous negative construct that was compassion fatigue. With the longer CFST, a pooled sample of 370 people from different countries was used, of which 130 were from urban South Africa. Stamm (2003) reported that the psychometric information collected and obtained from multivariate analysis of variance did not provide any evidence of differences based on country, type of work or gender. Unfortunately, no such information is available on the shortened 30-item ProQOL-RIII Scales (Stamm, 2003).

3.5.2.2 Reliability

The author reports that this test is mainly for *screening* purposes and has been applied effectively in more than 30 countries across a wide array of professions, ranging from educators to emergency room workers. Unfortunately, these scales have not been standardised for use in terms of the South African workforce, and the

psychometric properties are therefore uncertain. However, reported reliability coefficients are .87 in terms of compassion satisfaction, .72 in terms of burnout and .80 in respect of secondary traumatic stress (Stamm, 2003). The Cronbach alphas of the three discreet subscales for the present study were also calculated and the relevant findings are reported under the results section.

3.5.2.3 Cut-off Scores

Theoretical score cut-points in the form of percentiles are also provided by the test manual (Stamm, 2003), but these were not utilised at all during the study. Instead, the test norms provided for score interpretations were used. The test manual specifically provides American-based test norms for interpretation and comparison purposes. Although it is not usually desirable to apply norms to any population other than the one the norms were standardised for, this information was nonetheless utilised. It is important to mention here, however, that the norms were used for the *sole* purpose of establishing whether an individual or aggregate score is low, average or high. It is also important to mention that an average score simultaneously indicates a moderate level of the relevant variable (Stamm, 2003). In doing so it was made possible to establish the level at which each of the subscale variables were present for each of the study groups (claims workers versus underwriting clerks).

Also, seeing that there are no South African norms available and given that these norms were not used during any analyses, it was deemed appropriate to draw upon this information, but only in this very limited. Finally, summed raw scores on each of the subscales were furthermore compared between the study groups to

determine whether there were any detectable group trends, patterns or significant differences present.

3.5.2.4 Gender differences

As pointed out earlier, the study sample was found to be predominantly female (77% females as opposed to 23% males). This did not pose any problem to the study, seeing that the variables that were examined by the subscales are not believed to be subject to gender differences. In this regard, the ProQOL-RIII manual (Stamm, 2003) clearly indicates that a multiplicity of previous studies have not yielded any gender differences on any of the subscales.

3.5.3 The MSE- and MOP Scales

The Mehrabian Self-Esteem Scale or MSE and the Mehrabian Optimism/Pessimism or MOP Scales (1998) were also completed by each of the participants to simultaneously establish whether there were significant differences in self-esteem and levels of optimism/pessimism between the two comparison groups (claims workers versus underwriting clerks). These two separate self-report scales consist of 11 and 8 items respectively and are scored according to *+4 (very strong agreement)* to *-4 (very strong disagreement)* with *0* indicating *neither agreement nor disagreement.* These scales took only approximately five minutes each to complete (*please see Appendix G*). The minimum requirements to utilise the scales posed by Mehrabian (1998) are being over the age of 14 and being fluent in English, which is far exceeded by the minimum job requirements in the insurance industry. It is argued that vicarious traumatisation could lead to low self-esteem and pessimism.

The proposed study attempted to establish if this view holds true in the case of claims workers compared to underwriting clerks.

3.5.3.1 Reliability

As was the case with the ProQOL-RIII Scales (Stamm, 2003) the scales under discussion also have not been standardised for use in the South African workforce. Therefore, the psychometric properties for these scales also remain uncertain. However, an internal consistency coefficient alpha of .86 is reported for both the MSE- and MOP Scales by the test manual (Mehrabian, 1998). The Cronbach alphas were also calculated for the present study and appear under the results section.

3.5.3.2 Norms

In the case of the MSE – and MOP Scales (Mehrabian, 1998) the manual provides a table consisting of percentiles and a standardised interpretation in terms of each percentile. In order to utilise this information, it is required that raw scores be converted to a z score. The z score is then used to find the corresponding percentile and interpretation by means of the table provided. This information is made available by the manual specifically to assist one in determining where an individual score is positioned relative to the population mean. As the present study mainly focused on inter-group – rather than intra-group comparisons, the aforesaid information was not found to be of any use to the study. Instead, the unstandardised raw scores were used, firstly to establish what the level of the variable was as expressed by each of the study groups and, secondly, to establish whether there were any significant differences between these groups. To the end of the first goal, simple

descriptive statistics were used to establish the level of the variable expressed by each of the study groups. This was done by examining the score range, mean and standard deviation expressed by each of the study groups. Concerning the second goal, statistical analyses of raw scores were carried out in order to reveal any significant differences between the study groups in terms of self-esteem and optimism/pessimism.

3.5.3.3 Gender differences

As previously pointed out, the study sample is predominantly female (77% females as opposed to 23% males). The MSE/MOP manual (Mehrabian, 1998) confirms that the genders do not significantly differ in terms of any of the scale variables and reports a correlation of .06 (p>.20) between the test scores and gender (scored 1 for females and 2 for males). Therefore, the norms discussed again apply equally to men and women.

3.6 Ethics

The University of the Witwatersrand's standards of ethics were strictly adhered to and the study only commenced once approval was received from the Wits Human Ethics Committee. The identity of each participant and participating insurer was protected by strict confidentiality and materials pertaining to each participant/insurer were treated with the utmost integrity, respect and responsibility at all times. Only the author and the research supervisor had access to the data. Participants were informed that their participation did not have any bearing on or

pose any risk to their positions at their place of employment. Their place of employment would also not be revealed anywhere in the study.

Informed permission was discussed and participants were informed that they always reserved the right to withdraw from the study at any time. Participating insurers did not in any way run any risk of being singled out, portrayed negatively, or of being identified. Amalgamated scores were used during data analyses to further protect the identity of participants. Clearly, insurers are not to blame for the unique challenges within their domain of operation and everything possible was done to ensure that the industry is portrayed fairly, respectfully and with integrity. Items of the proposed scale and the questions that were asked during the construction of descriptions were not harmful, insulting or intrusive in any way. Participating insurers were informed of the fact that professional counselling arrangements could be made with the Centre for the Study of Violence and Reconciliation, should any participant require such counselling. All research data were destroyed on completion of the project and great care was taken not to use any identifying information in the final report.

3.7 Data capturing and editing

Once the data collection was completed, any participants with missing or illegible items had the relevant scale excluded from analysis, as well as any participants who fell outside the age range of interest to the study. Less than 1.5% of the total data were excluded (87 scales were completed of which four were excluded due to missing values; a further eight participants fell outside the age range of 25-

45). Therefore, out of the total of 87 questionnaires, 75 scales were used during the final analysis. Of the 75 completed scales, 44 were completed by claims workers and the remaining 31 by underwriting clerks. Data were captured on a Microsoft Excel spreadsheet and each entry was checked several times for inaccuracies. The spreadsheets containing the data were then imported into the SAS statistical computer programme for analysis. As an extra precaution, frequency tables were performed first to check for any impossible values or outliers.

Next, an introductory overview of the statistical analysis will be given which will then be followed by a description of the sample and a comprehensive discussion of the data analysis.

3.8 Data analysis

As an overview, data-analyses broadly entailed frequency tables in terms of the biographical variables in order to describe the amalgamated sample as well as the two individual study groups of claims workers and underwriting clerks. Distribution frequencies were carried out in terms of each study variable in order to examine normality and to establish whether parametric statistical procedures would be permissible. Statistical analysis of the mean scores of these two groups was carried out to ascertain if there were any significant observable differences between them. To this end, SAS computer software version 9.1 was utilised.

A two-way multivariate analysis of variance or MANOVA was performed with respect to the three discreet ProQOL-RIII subscales (compassion satisfaction,

burnout and secondary traumatic stress). The independent variables that were used were group (claims workers versus underwriting clerks) and dealings (telephonic only versus telephonic and face-to-face).

It is important to mention here that, although there is no prescribed rule regarding minimum cell size, it is usually not recommended that a two-way MANOVA be utilised where comparison cells consist of less than ten observations. Rosnow and Rosenthal (1996) for instance, indicate that cell size is arbitrary and therefore do not provide any indication of minimum cell size. In the case of the present study, one of the comparison cells consisted of only six observations. This was somewhat problematic, but seeing that there is no textbook rule-of-thumb and seeing that this problem was limited to a single cell only, the test was nonetheless carried out. The best possible efforts were made in order to compensate for this problem, such as using a type III error in order to compensate for the unequal group sizes.

As discussed earlier, group scores were also interpreted against information provided by the ProQOL-RIII Scales manual to give meaning to the scores obtained. Scores were interpreted in terms of the provided norms only to determine the level of each of the variables exhibited by the study groups, as well as to establish how the groups compared to one another in terms of these identified levels. Although these norms are standardised in terms of the American population, it nonetheless served the purpose of indicating the level of each variable for each of the study groups as being either low, average or high.

A two-way analysis of variance or ANOVA was also performed in terms of each of the dependent variables, being compassion satisfaction, burnout, secondary traumatic stress and also including self-esteem and optimism/pessimism. This was done to establish whether there were any significant differences in terms of these variables between the study groups or possible interaction effects. The independent variables in each case were group (claims workers versus underwriting clerks) as well as dealings (telephonic only versus telephonic and face-to-face).

Examining the data in terms of dealings was of particular interest to the study. The reason being, that the theories on the development of trauma or vicarious trauma, believe face-to-face exposure to traumatic materials to be a deciding factor. Fewer studies have indicated conclusively whether vicarious trauma can occur in what McCalla and Ezingeard (2005, p.1) call "*voice-to-voice interactions*". It is also not known whether voice-to-voice emotional contagion is as powerful as face-to-face contagion. In order to examine these theories more closely, the data were split and analysed accordingly. Again, a type III error was used to compensate for any number discrepancies. Tukey-Kramer post hoc analysis was also carried out to establish which observed simple effects were significant.

To give further meaning to the scores obtained, the summed MSE (self-esteem) and MOP (optimism/pessimism) raw scores were also used to establish the level of each respective variable as expressed by each of the study groups. As the manual only provides standardised $\underline{z}$ scores and percentiles for the purpose of examining individual test scores compared to the population or sample mean, simple

statistics were utilised instead. To this end, as explained earlier, the study group means, standard deviations and score ranges were considered and compared across the various study groups.

The statistical analyses of the five study variables (compassion satisfaction, burnout, secondary traumatic stress, self-esteem and optimism/pessimism) were concluded by carrying out a simple correlation test in terms of the various dependent variables in search of any significant relationships between them. Theoretically, high levels of vicarious trauma are, for instance, not expected to correlate strongly with high self-esteem and optimism. Low levels of vicarious trauma, low self-esteem and pessimism are not expected to correlate strongly. This correlation test was performed to see if the predicted relationships also held true for the study group (claims worker and underwriting clerks).

The next chapter provides the results for the statistical analyses that were carried out as per the aforementioned paragraphs.

4 RESULTS

Firstly, the internal consistency reliability of the various scales utilised in the present study is reported, after which sample homogeneity is discussed. The statistical findings are then organised to address each of the five hypotheses that are central to the study.

4.1 Reliability of the scales in the present study

The reliability coefficients for the ProQOL-RIII subscales that are reported by the test manual are .87 in terms of compassion satisfaction, .72 in terms of burnout and .80 in respect of secondary traumatic stress (Stamm, 2003). The Cronbach alphas for the three discreet subscales for the present study were also calculated and compared to those reported by the test manual. In terms of the compassion satisfaction test items, the calculated alpha was .87 which is identical to the alpha reported by the ProQOL-RIII manual. In terms of the burnout scale items, the alpha obtained for the study sample was only .70 whereas the ProQOL-RIII manual reported an alpha of .72. Finally, in terms of the secondary traumatic stress items, the alpha obtained was .85 which is higher than the alpha of .80 reported by the manual. In the case of each of the subscales, the item-total correlation for each individual item was >.20, therefore no items needed to be omitted from the study.

Regarding the MSE – and MOP Scales (Mehrabian, 1998), the internal consistency alphas reported by the test manual are .86 for both scales. Regarding the present study, an alpha of .74 was obtained for the MSE scale and an alpha of .71 for

the MOP scale. The item-total correlation in terms of each of the items for both scales were >.20, and as a result, no items needed to be omitted from the study.

As can be seen, the alphas obtained for each of the scales in terms of the present study were within an acceptable range for the type of study at hand. Next, the sample homogeneity is considered.

4.2 Sample homogeneity of the biographic variables

As discussed previously, group (claims workers versus underwriting clerks) is a primary independent variable and it was therefore decided to be of some importance to establish whether the two groups were equivalent in terms of the biographic variables. To this end, Chi-square tests for independence were performed on age, years of service, gender as well as dealings by group.

At first, a very large percentage of the cells had expected frequencies of less than five, which would have rendered the test invalid (Rosnow & Rosenthal, 1996). In order to rectify this problem, certain categories were combined in order to achieve cells with sufficient expected frequencies required for the Chi-square tests:
Firstly, the four different age categories were collapsed into three (25-30 years; 31-35 years and 36+ years). Secondly, the five categories for years of service were reduced to only three (2-4 years of service; 5-8 years of service and 9+ years of service). The number of dealings categories (telephonic only versus telephonic and face-to-face), were left unchanged seeing that there were only the two categories and that all expected frequencies were more than the required five. Finally, concerning

gender, one cell-size discrepancy remained. One cell had an expected frequency of less than 5 as a result of the fact that there were only four male underwriters in the entire sample. Considering that this only involved a single cell and that all other cells fell within the required range of expected frequencies, this was not considered to have any influence on the validity of the test. *Table 2* below reflects the descriptive statistics for the biographic variables after the number of categories were reduced as outlined on the previous page.

Table 2. Descriptive Statistics: Biographic Variables (collapsed categories)

GROUPS:		**Claims workers (*N*=44)**		**Underwriting clerks (*N*=31)**	
VARIABLE		**FREQUENCY**	**PERCENT**	**FREQUENCY**	**PERCENT**
Gender	Male	13	29.55	4	12.90
	Female	31	70.45	27	87.10
Age	25-30 years	17	38.64	12	38.71
	31-35 years	11	25.00	10	32.26
	36+ years	16	36.36	9	29.03
Years of Service	2-4 years	15	34.09	12	38.71
	5-8 years	17	38.64	10	32.26
	9+ years	12	27.27	9	29.03
Dealings	Telephonic only	30	68.18	25	80.65
	Telephonic & face-to-face	14	31.82	6	19.35

The Chi-square tests of independence did not detect any group differences for the biographic variables ($p>0.05$). Therefore, the claims workers and underwriting clerks were found not to differ significantly in age, years of service, gender or dealings (please see *Table 3*).

Table 3. Chi-Square Tests of Independence Table: Biographic Variables by Group

VARIABLE	SOURCE	DF	CHI-SQUARE VALUE
Age	**Group**	2	0.64 (NS)
Gender	**Group**	1	0.09 (NS)
Years of Service	**Group**	2	0.85 (NS)
Dealings	**Group**	1	0.23 (NS)

4.3 The ProQOL-RIII Scales as a measure of trauma and vicarious trauma

Before the actual testing or the first study hypothesis commenced, distribution analysis was first carried out on the three discreet subscales (compassion satisfaction, burnout and secondary traumatic stress). In terms of the compassion satisfaction scale, a relatively normal bell shaped curve with kurtosis of 0.33 was observed. The distribution frequency curve was somewhat skewed to the left (-0.70).

The burnout scale also followed a relatively normal bell shaped curve with almost undetectable skewness to the left (-0.10). The distribution frequency curve was slightly platykurtik with kurtosis of -0.73. When looking at the secondary traumatic stress scale, the distribution frequency curve is skewed to the right to some extent (0.68) with kurtosis of 0.19. Each of the aforementioned discreet subscales possesses all of the properties of an interval scale. This, combined with the normality being within the acceptable range, made the use of parametric statistical procedures appropriate.

The first hypothesis predicted that there will be a significant difference in trauma and vicarious trauma scores between claims workers and the comparison group of underwriting clerks.

To test this hypothesis, a two-way MANOVA was carried out on the three discreet ProQOL-RIII subscales simultaneously in terms of group (claims workers versus underwriting clerks) and dealings (telephonic only and telephonic and face-to-face). The descriptive statistics for the ProQOL-RIII Scales are reported by *Table 4* and *Table 5* offers the results of the two-way MANOVA.

Table 4. Descriptive Statistics: ProQOL-RIII Subscales by Group and Dealings

GROUP:		**Claims workers**			**Underwriting clerks**	
DEPENDENT VARIABLE	**N**	**MEAN**	**SD**	**N**	**MEAN**	**SD**
Compassion Satisfaction	44	36.59	7.55	31	35.48	8.01
Burnout	44	19.64	5.39	31	20.45	5.63
Secondary Traumatic Stress	44	16.52	8.79	31	17.48	8.70
DEALINGS:		**Telephonic only**			**Telephonic and face-to-face**	
DEPENDENT VARIABLE	**N**	**MEAN**	**SD**	**N**	**MEAN**	**SD**
Compassion Satisfaction	55	35.89	7.12	20	36.80	9.33
Burnout	55	19.91	5.67	20	20. 15	4.99
Secondary Traumatic Stress	55	16.25	8.01	20	18.75	10.40
GROUP*DEALINGS:		**Claims workers**			**Underwriting clerks**	
DEPENDENT VARIABLE	**N**	**MEAN**	**SD**	**N**	**MEAN**	**SD**
Compassion Satisfaction						
Telephonic only	30	37.03	6.28	25	34.52	7.92
Telephonic and face-to-face	14	35.64	9.97	6	39.50	7.71
Burnout						
Telephonic only	30	18.63	5.49	25	21.44	5.61
Telephonic and face-to-face	14	21.48	4.64	6	16.33	3.67
Secondary Traumatic Stress						
Telephonic only	30	14.03	6.84	25	18.92	8.61
Telephonic and face-to-face	14	21.86	10.30	6	11.50	6.71

Table 5. Two-way MANOVA with Interaction Table: ProQOL-RIII Subscales by Group and Dealings

INDEPENDENT VARIABLES		VALUE	DF	F
Group	Wilks' Lambda:	0.86	1:71	3.76 (NS)
Dealings	Wilks' Lambda:	0.98	1:71	0.50 (NS)
Group*Dealings	Wilks' Lambda:	0.85	1:71	3.92 *

* $p<0.05$

The results indicated that there were no significant differences between claims workers and underwriting clerks ($p>0.05$) on any of the subscales. The first research hypothesis was, therefore, not supported. There were also no significant differences observed for dealings ($p>0.05$) in terms of the same subscales. However, interesting interaction effects were uncovered. Two-way ANOVA's were performed on each of the subscales (compassion satisfaction burnout and secondary traumatic stress) to further explore the uncovered interaction effects. The univariate two-way ANOVA's detected interaction effects between group and dealings for burnout ($F1,71 = 7.86$; $p<0.01$) as well as for secondary traumatic stress ($F1,71 = 11.18$; $p<0.01$). No interaction effect, however, was observed in terms of compassion satisfaction ($F1,71 = 2.18$; $p>0.05$).

These univariate two-way ANOVA's at the same time also commenced to explore the **second hypothesis**, that there will be a significant difference in trauma and vicarious trauma scores between workers who deal with clients purely telephonically compared to those who deal with clients face-to-face and telephonically. The descriptive statistics are provided by *Table 4* and a summary of the ANOVA procedure is displayed by *Table 6.*

Table 6. Two-way ANOVA with Interaction Table: Individual ProQOL-RIII Subscales by Group and Dealings

DEPENDENT VARIABLE	SOURCE	DF	SS	F
	Dealings	1:71	41.37	0.69 (NS)
Compassion Satisfaction	**Group**	1:71	5.79	0.10 (NS)
	Dealings*Group	1:71	130.31	2.18 (NS)
DEPENDENT VARIABLE	**SOURCE**	**DF**	**SS**	**F**
	Dealings	1:71	12.26	0.44 (NS)
Burnout	**Group**	1:71	22.48	0.81 (NS)
	Dealings*Group	1:71	219.03	7.86 **
DEPENDENT VARIABLE	**SOURCE**	**DF**	**SS**	**F**
	Dealings	1:71	0.52	0.01 (NS)
Secondary Traumatic Stress	**Group**	1:71	96.09	1.44 (NS)
	Dealings*Group	1:71	746.15	11.18 **

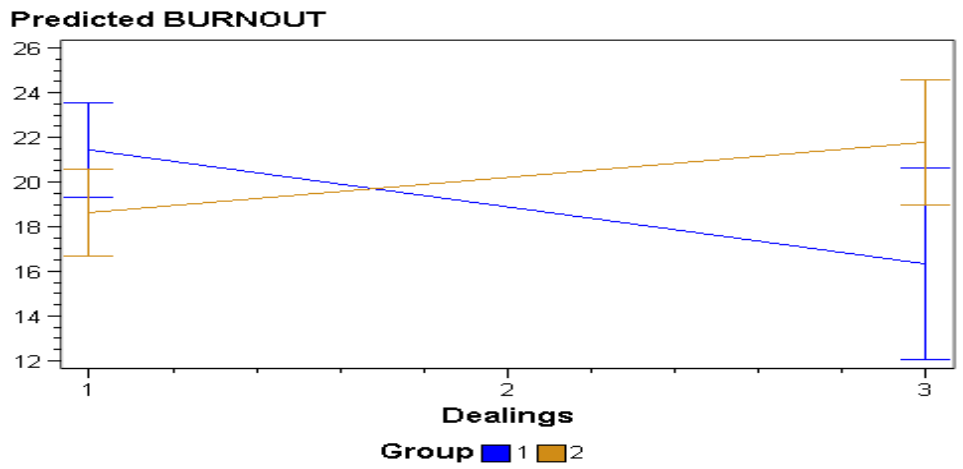
** $p<0.01$

To briefly recapitulate, there were three dealings stipulated in the biographic questionnaire being: *1. telephonic only; 2. face-to-face only* and *3. telephonic and face-to-face.* None of the participants indicated that they deal with clients purely on a face-to-face basis. Subsequently, no participants were assigned to group 2 and only groups 1 and 3 were used during analysis.

In terms of compassion satisfaction, no significant difference or any interaction effects were observed ($p>0.05$). Regarding burnout and secondary traumatic stress, no significant differences were found, but interesting interaction effects were revealed (please see *Table 6* and *Figure 1*). Firstly, the results indicate that claims workers dealing with clients telephonically and face-to-face, were experiencing the most strain and burnout ($M=21.78$). Underwriting clerks who deal with clients purely telephonically, were experiencing the second most burnout ($M=21.44$). Claims workers dealing with clients purely telephonically, experienced the third most burnout ($M=18.63$) and underwriters who deal with clients telephonically and face-to-face, were experiencing the least burnout of the four groups ($M=16.33$).

Tukey-Kramer post hoc analysis indicated that that there was a significant difference between the two groups of underwriting clerks ($p<0.05$): underwriting clerks who deal with clients telephonically scored significantly higher in terms of burnout ($M=21.44$) than did those who deal with clients telephonically and face-to-face ($M=16.33$).

Figure 1. Burnout Interaction by Group and Dealings



Dealings: 1 - Telephonic only 3 - Telephonic and face-to-face

Groups: 1 - Underwriting clerks 2 - Claims Workers

When looking at secondary traumatic stress (STS) in terms of group and dealings, no significant difference was found but once again interaction effects were revealed (please see *Table 6* and *Figure 2*). The results indicate that claims workers who deal with clients telephonically and face-to-face, were experiencing the most secondary traumatic stress (*M*=21.86). Underwriting clerks who deal with clients telephonically only, were experiencing the second most STS (*M*=18.92) and claims workers who deal with clients purely telephonically, experienced the third most STS (*M*=14.03). Finally, underwriting clerks dealing with clients on a telephonic and face-to-face basis experienced the least STS out of the four groups (*M*=11.50). Tukey-Kramer post hoc analysis indicated significant differences between the following:

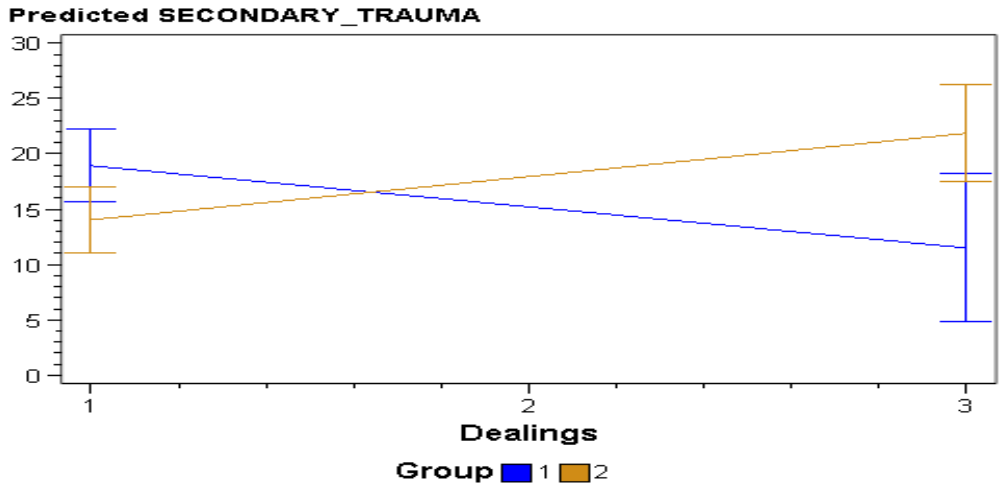
1. There was a significant difference in secondary traumatic stress (STS) scores ($p<0.05$) between underwriting clerks dealing with clients purely telephonically ($M=18.92$) and those who deal with clients telephonically and face-to-face ($M=11.50$). This indicates that underwriting clerks who deal with clients purely telephonically are experiencing significantly higher levels of STS compared to underwriters who deal with clients telephonically and face-to-face.

2. There was a significant difference in STS scores ($p<0.05$) between underwriting clerks who deal with clients purely telephonically ($M=18.92$) and claims workers who deal with clients purely telephonically ($M=14.03$). This finding indicates that underwriting clerks who deal with clients purely telephonically are experiencing significantly higher levels of STS than do claims workers who deal with clients purely telephonically.

3. There was a significant difference in STS scores ($p<0.05$) between claims workers who deal with clients telephonically and face-to-face ($M=21.86$) and underwriting clerks who deal with clients telephonically and face-to-face ($M=11.50$). This result suggests that claims workers who deal with clients telephonically and face-to-face are experiencing significantly higher levels of secondary traumatic stress than underwriting clerks who deal with clients telephonically and face-to-face.

4. Finally, there was also a significant difference in STS scores ($p<0.01$) between claims workers who deal with clients telephonically and face-to-face ($M=21.86$) and claims workers who deal with clients purely telephonically ($M=14.03$). This means that claims workers who deal with clients telephonically and face-to-face are experiencing significantly higher levels of STS compared to those claims workers who deal with clients purely telephonically.

Figure 2. Secondary Traumatic Stress Interaction by Group and Dealings



Dealings: 1 - Only telephonic 3 - Telephonic and face-to-face

Groups: 1 - Underwriting clerks 2 - Claims Workers

4.3.1 Group levels of trauma and vicarious trauma

As mentioned at the outset of this section of the discussion, the ProQOL-RIII Scales (compassion satisfaction, burnout and secondary traumatic stress) served as the measure of trauma and vicarious trauma. To give further meaning to the test scores acquired, it was also deemed necessary to be able to determine the *level* of each variable expressed by the claims workers and underwriting clerks. In order to establish if a group score was low, average/moderate or high, the ProQOL-RIII manual (Stamm, 2003) was consulted and scores were further interpreted by comparing them to the norms provided. Although the norms are standardised for use in the American population, it was nonetheless possible to utilise this information to pinpoint the level of each variable.

The average score for compassion satisfaction provided by the test manual, which simultaneously indicates moderate levels of this variable, is 37 (*SD* 7; alpha scale reliability .87). Those with a score above 41 are experiencing high levels of compassion satisfaction which means that they are deriving a considerable amount of compassion and professional satisfaction from their positions. On the other hand, a score below 32 indicates low levels of compassion satisfaction, which indicates that some problems are experienced within these positions. This, in turn, suggests that not much compassion or professional satisfaction is forthcoming from doing this particular job.

In the case of claims workers, the mean scores for the compassion satisfaction scale were 35.48 and in the case of underwriting clerks it was slightly higher at

36.59. As can be seen, both these means are slightly below the American norm of 37, which nonetheless indicates *average or moderate* levels of compassion - and professional job satisfaction.

In terms of the burnout scale and compared to the American norm, both groups again exhibited fairly *average, moderate* scores: underwriting clerks *M*=20.45; claims workers *M*=19.64. The American based average score for this scale is usually 23 (*SD* 6.0; alpha scale reliability .72), which again indicates a moderate level of the variable. A score above 28 represents high levels of burnout, which indicates difficulties in dealing with job demands and workload. Scores below 19 indicate positive feelings about one's job and general efficiency in meeting job demands. As can be seen, in terms of both study groups, their mean scores fell directly on this conceptual borderline, leaning very slightly towards the more positive extremity of the scale. These relatively low burnout scores indicate some positive feelings and meeting some job demands efficiently.

Finally, regarding the secondary traumatic stress scale, both groups exhibited *high levels* of this variable when compared to the American norm (underwriting clerks *M*=17.48 and claims workers *M*=16.52). The American based average score for secondary traumatic stress is 13 (*SD* 6.0; alpha reliability .80) and, as was also the case with the preceding two subscales, this score also indicates moderate levels of the variable. A score below 8 usually signifies low levels of secondary traumatic stress and suggests that persons are not traumatised by their work. A score above 17 indicates high levels of secondary traumatic stress. This, in turn, indicates that some aspects of the relevant work position are frightening or traumatising. The mean

scores for both claims workers and underwriting clerks were in the region of 17, therefore not dramatically elevated but still considered to be high. These elevated scores therefore indicate that there are indeed aspects of both claims and underwriting positions that are frightening or traumatising to the respective workers.

4.4 The MSE Scale as a measure of self-esteem

Prior to testing the next or third study hypothesis, distribution analysis was first conducted. The summed MSE (self-esteem) scores presented with a distribution frequency curve that is relatively skewed to the right (0.83) with kurtosis of 0.09. Despite the considerable skewness of the distribution, the aforementioned results are nonetheless within an acceptable range to allow for the use of parametric statistical procedures. Also, this variable possesses all of the properties of an interval scale, which further permitted the use of parametric tests.

The **third hypothesis**, that claims workers would exhibit significantly lower self-esteem scores compared to underwriting clerks, is not confirmed by the results (please see *Table 7* for the descriptive statistics). A two-way ANOVA of self-esteem in terms of group (claims workers versus underwriting clerks) and dealings (telephonic only versus telephonic and face-to-face) revealed no significant difference ($p>0.05$). Please see *Table 8* for a summary of the ANOVA procedure.

Table 7. Descriptive Statistics: MSE Scale by Group and Dealings

GROUP:		**Claims workers**			**Underwriting clerks**	
DEPENDENT VARIABLE	**N**	**MEAN**	**SD**	**N**	**MEAN**	**SD**
Self-Esteem	44	5.95	8.24	31	5.84	8.61
DEALINGS:		**Telephonic only**			**Telephonic and face-to-face**	
DEPENDENT VARIABLE	**N**	**MEAN**	**SD**	**N**	**MEAN**	**SD**
Self-Esteem	55	4.65	5.22	20	6.36	9.21
GROUP*DEALINGS:		**Claims workers**			**Underwriting clerks**	
DEPENDENT VARIABLE	**N**	**MEAN**	**SD**	**N**	**MEAN**	**SD**
Self-Esteem						
Telephonic only	30	6.57	9.13	25	6.12	9.49
Telephonic and face-to-face	14	4.64	5.98	6	4.67	3.33

Table 8. Two-way ANOVA with Interaction Table: MSE Scale by Group and Dealings

DEPENDENT VARIABLE	**SOURCE**	**DF**	**SS**	**F**
	Dealings	1:71	36.62	0.51 (NS)
Self-Esteem	**Group**	1:71	0.57	0.01 (NS)
	Dealings*Group	1:71	130.31	0.01 (NS)

4.4.1 Group levels of self-esteem

As was the case with the ProQOL-RIII scores, the group scores for self-esteem were also interpreted further. This was again done in order to give meaning to the scores by establishing the level of self-esteem exhibited by the claims workers and underwriting clerks.

In order to pinpoint the levels of self-esteem expressed, one has to find a mean score for each group. Firstly, in terms of the self-esteem scale, scores may range from -44 (being the lowest possible score one can achieve) to 44 (being the highest possible score). In the case of this scale, zero is the midmost or fixed central point. In terms of self-esteem, the two study groups (underwriting clerks versus claims workers) exhibited fairly similar scores. The group of underwriting clerks yielded an *M* of 5.84 and *SD* of 8.61. The scores ranged from -8.00 to 28.00. In the case of the claims workers, the *M* was fairly similar at 5.95, with a similar *SD* of 8.23. The score range was also fairly alike, ranging from -7 to 27.

This finding confers with the results of the statistical analyses performed, which indicated that there were no significant differences between the two study groups in terms of self-esteem. This finding also does not support the expectation posed by the third hypothesis, that claims workers would exhibited significantly lower self-esteem scores due to vicarious trauma, compared to underwriting clerks. As can be seen, the mean scores in terms of both groups are less than one standard deviation above the midmost or fixed point of the scale (being zero) which indicates an *M* close to zero. This result then signifies that the group means are very

moderate, and that the levels of self-esteem exhibited in both cases were neither high, nor low.

4.5 The MOP Scale as a measure of optimism/pessimism

Prior to testing the fourth study hypothesis, distribution analysis was first carried out. The summed MOP (optimism/pessimism) scores presented with a distribution frequency curve that is relatively bell-shaped. Kurtosis was -0.19 and skewness 0.04 which is well within the acceptable range for parametric statistical procedures. In addition, this variable possesses all of the properties of an interval scale, which further permitted the use of parametric tests.

The **fourth hypothesis**, that claims workers will gravitate towards a more pessimistic position relative to the comparison group of underwriting clerks, was also not confirmed by the study findings (please see please see *Table 9* for the descriptive statistics). A two-way ANOVA of optimism/pessimism in terms of group (claims workers versus underwriting clerks) and dealings (telephonic only versus telephonic and face-to-face) revealed no significant difference ($p>0.05$). Please see *Table 10* for a summary of the ANOVA procedure.

Table 9. Descriptive Statistics: MOP Scale by Group and Dealings

GROUP:		**Claims workers**			**Underwriting clerks**	
DEPENDENT VARIABLE	**N**	**MEAN**	**SD**	**N**	**MEAN**	**SD**
Optimism/Pessimism	44	9.61	8.45	31	9.06	9.03
DEALINGS:		**Telephonic only**			**Telephonic and face-to-face**	
DEPENDENT VARIABLE	**N**	**MEAN**	**SD**	**N**	**MEAN**	**SD**
Optimism/Pessimism	55	8.65	7.06	20	9.65	9.19
GROUP*DEALINGS:		**Claims workers**			**Underwriting clerks**	
DEPENDENT VARIABLE	**N**	**MEAN**	**SD**	**N**	**MEAN**	**SD**
Optimism/Pessimism						
Telephonic only	30	10.73	9.10	25	8.36	9.31
Telephonic and face-to-face	14	7.21	6.51	6	12.00	7.74

Table 10. Two-way ANOVA with Interaction Table: MOP Scale by Group and Dealings

DEPENDENT VARIABLE	**SOURCE**	**DF**	**SS**	**F**
	Dealings	1:71	0.05	0.00 (NS)
Optimism/Pessimism	**Group**	1:71	18.69	0.25 (NS)
	Dealings*Group	1:71	164.57	2.19 (NS)

4.5.1 Group levels of optimism/pessimism

As was the case with the other scales utilised during the study, the optimism/pessimism scores for claims workers and underwriting clerks were similarly interpreted further. These interpretations gave meaning to the acquired scores in that it established the levels of the variable expressed. When looking at the optimism/pessimism scale, scores may range from -32 (being the lowest possible score one can obtain) to 32 (being the highest possible score). In terms of this variable, the two study groups (underwriting clerks versus claims workers) exhibited slightly less similar scores than was the case with self-esteem. Statistical analysis, however, nonetheless indicated that there were no significant differences between the two study groups in terms of optimism/pessimism.

The group of underwriting clerks yielded an *M* of 9.06 and *SD* of 9.03. The scores ranged from -7.00 to 32.00. In the case of the claims workers, the *M* obtained was 9.61, with an *SD* of 8.45. Their scores ranged from -11 to 29. As can be seen, the mean scores in terms of both groups are approximately one *SD* above zero (the midmost or fixed point of the scale). This result indicates that optimism/pessimism scores are very *moderate* and that both groups where neither noticeably optimistic nor palpably pessimistic in their appraisals, but that they rather remained fairly neutral in their appraisals. This means that relatively equal amounts of optimistic and pessimistic appraisals were exhibited by both groups. This finding also does not support the expectation that claims workers would gravitate towards a more pessimistic position due to vicarious trauma, when compared to underwriting clerks.

4.6 Relationships between the ProQOL-RIII -; MSE - and MOP Scale variables

A Pearson correlation test was carried out to explore the relationship between the different study variables. The ProQOL-RIII discreet subscales (compassion satisfaction, burnout and secondary traumatic stress) as a measure of vicarious trauma, were correlated with the Mehrabian Self-Esteem (MSE) and Optimism/Pessimism (MOP) Scales. This was done to test the **fifth and final hypothesis**, which is the expectation that there will be an inverse relation between the negative dimensions of vicarious trauma (in terms of burnout and secondary traumatic stress) and self-esteem as well as optimism.

Furthermore, it was also expected that there will be a positive relation between the positive dimension of vicarious trauma (in terms of compassion satisfaction), self-esteem and optimism. The simple correlations test was done in order to establish whether these theoretical relationships between the study variables will also hold true in terms of the study groups. The descriptive statistics are reported by *Table 11* and the Pearson Correlation Coefficient that was calculated is reported by *Table 12.*

Table 11. Descriptive Statistics: ProQOL-RIII Subscales; MSE Scale and MOP Scale

DEPENDENT VARIABLE	N	MEAN	SD	MEDIAN	MINIMUM	MAXIMUM
PROQOL-RIII SUBSCALES:						
Compassion Satisfaction	75	36.13	7.71	37	12	50
Burnout	75	19.97	5.47	21	8	32
Secondary Traumatic Stress	75	16.92	8.71	16	2	43
MSE SCALE						
Self-Esteem	75	5.91	8.34	4	-8	28
MOP SCALE						
Optimism/Pessimism	75	9.39	8.64	10	-11	32

Table 12. Pearson Correlation Test of ProQOL-RIII Subscales; MSE Scale and MOP Scale

Pearson Correlation Coefficients, *N* = 75

	Compassion Satisfaction	Burnout	Secondary Traumatic Stress
Self-Esteem	0.10	-0.07	- 0.21
Optimism/Pessimism	0.30 **	-0.25 *	-0.16

** p<0.05; **p<0.01*

The only significant correlations that were found was, firstly, a positive relationship between optimism/pessimism and compassion satisfaction ($r(73) = 0.30$; $p<0.01$). This means that higher optimism scores will result in higher compassion satisfaction scores or that lower optimism scores will result in lower compassion satisfaction scores. Secondly, a negative relationship was also found between burnout and optimism/pessimism ($r(73) = 0.25$; $p<0.05$). This means that higher

optimism scores will result in lower burnout scores and vice versa. Surprisingly, neither compassion satisfaction nor burnout correlated significantly with self-esteem. It was also interesting to learn that secondary traumatic stress did not correlate significantly with either self-esteem or optimism/pessimism (p>0.05). Especially in the case of optimism/pessimism and self-esteem, no relation was found between these two variables (p=0.17). Regarding self-esteem, there was, however, a tendency for those experiencing higher secondary traumatic stress to score lower in terms of self-esteem. Although this correlation was not significant (p=0.07) the result nonetheless indicates that there is a pattern of lower self-esteem responses exhibited by those with higher secondary traumatic stress.

The next chapter will focus more comprehensively on discussing the various findings that were outlined by this chapter.

5 DISCUSSION

The discussion of the research results are organised to first address the characteristics of the sample. Then each of the five hypotheses is addressed systematically, whilst simultaneously affording attention to related points that emerged in terms of each.

5.1 Discussion of the sample characteristics

A naturally occurring sample was utilised for data collection and, subsequently, no random assignment to the main study groups was possible. This raised some concerns about how representative the main study samples were of the general population of claims workers and underwriting clerks. For this reason, prior to the data collection, the research student attended general meetings with the various Human Resources and departmental managers of the participating companies. During these meetings some of these managers expressed certain viewpoints pertaining to the characteristics of their worker corps. It was thought sensible to include this information to some extent to offer some verification that the samples were in fact quite representative, and to also clarify certain findings briefly regarding the study samples.

Firstly, the descriptive statistics revealed that, in terms of the age distribution of the amalgamated sample, the majority of participants were between the ages of 25 and 35 (n=51). There were surprisingly few middle aged workers between 36 to 40 years of age (n=7) and only 18 participants were between the ages of 41 to 45.

The above findings concurred with what the respective managers pointed out. In their experience, the population of claims workers and underwriting clerks are relatively young populations and that, due to the high staff turn-over, there are fewer middle aged and not as many older workers. These mainly clerical positions also do not require any tertiary education for the most part, which attracts younger workers and school-leavers. They also explained that there have been continued restructuring within the majority of short-term insurance companies during the past decade which predominantly impacted on middle aged workers. The latter was due to an effort to create equal equity opportunities for previously disadvantaged groups.

The high staff turn-over and the impact of the restructuring efforts were also clearly visible in the architecture of the amalgamated sample in terms of years of service. As pointed out earlier, as much as 71% of the participants have been working in either of the departments of interest to the study for less than eight years. Only 29% of the amalgamated sample showed more than eight years of service. During further consultations with some of the managers regarding these aspects, these findings were believed to be accurate and quite representative of the overall trend in terms of years of service throughout the short-term insurance industry.

It was also pointed out during these preliminary meetings that both the claims and underwriting departments are believed to be female dominated. Descriptive statistics confirmed this observation quite strongly in the sense that as much as 77% of the entire sample consisted of female participants. Seeing that the various scales used are not subject to gender differences (Mehrabian, 1998; Stamm, 2003), this did

not pose any problems with regards to the study. Finally, due to the largely administrative nature of underwriting and claims duties, the various managers pointed out that their workers predominantly deal with clients telephonically as opposed to face-to-face. This was again verified in the sense that 55 of the participants (73%) indicated that they deal with clients purely telephonically and only 20 participants (27%) indicated that they interact with clients telephonically and face-to-face. None of the participants indicated that they deal with client face-to-face only. As no participants were assigned to category 2 (purely face-to-face interaction), this category was subsequently omitted from the analysis.

The next step of the study entailed further statistical analyses that will be discussed under the ensuing headings.

5.2 Discussion of the statistical analysis results

5.2.1 The ProQOL-RIII Scales as a measure of trauma and vicarious trauma

The **first study hypothesis** was tested by means of a two-way MANOVA test. This hypothesis postulated that there will be a significant difference in trauma and vicarious trauma scores between claims workers and underwriting clerks, along the dimensions of compassion satisfaction, burnout and secondary traumatic stress. No significant differences were found between the two groups on any of these variables or subscales, and the first hypothesis is subsequently rejected, which has several important implications.

Firstly, it does not mean that claims workers are *not* affected by the traumatic materials from clients as they did in fact exhibit somewhat elevated secondary traumatic stress scores (*M*=16.52). These scores indicate that there are some frightening or traumatising components to their work. What is surprising is the fact that underwriting clerks, who do not typically deal with traumatic materials from clients and who were not expected to have elevated secondary traumatic stress scores, nevertheless exhibited equally high scores (*M*=17.48). Interestingly this score is also slightly higher than the mean score for the claims workers. What is also surprising is the fact that it was initially thought that claims workers were those in need of emotional support to curb trauma and vicarious trauma. However, it was discovered during the course of the study, that underwriting clerks are in equal need of help and support. The factors that might quite possibly be attributing to the fear and traumatisation implied by the elevated secondary traumatic stress scores are considered next.

5.2.1.1 The role of bullying

At the outset of the study, it was expected that bullying would play a considerable contributing role in the trauma and vicarious trauma sustained by claims workers and underwriting clerks. As pointed out earlier, bullying and verbal abuse cause extensive amounts of stress and can result in trauma and even serious psychiatric injury (The Field Foundation, 2005). Although the human body is able to withstand substantial levels and periods of stress, when the stress is prolonged, the body inevitably sustains damage through ongoing exposure to raised levels of glucocorticoids (The Field Foundation, 2005). In this regard Jordan (2001) also

warns that, no matter how resilient persons are and no matter how well they are coping, they could easily become overwhelmed if the traumatic event is persistent. Moreover, the fight or flight stress response, which is designed for responding to physical danger, is also activated by psychological danger such as bullying and verbal abuse (The Field Foundation, 2005). Eventually, the mere prospect of going to work, or the thought or sound of the bully approaching, immediately activates this stress response. However, this stress response mechanism is designed to operate only momentarily or intermittently. When activated for unusually long periods, it causes the person physical, mental and emotional strain and even injury (The Field Foundation, 2005).

Before the study commenced, it was thought that bullying would more or less play an equalising role in terms of both study groups and that the *additional* traumatising component, exposure to traumatic materials, would play a considerable role in terms of claims workers. As explained earlier, this variable is mostly absent in terms of underwriting clerks and it was believed that claims workers would exhibit higher levels of vicarious trauma as a result of this added stressor. In light of the results obtained, this was clearly not the case.

Although vicarious traumatisation through exposure to traumatic materials still remains a considerable risk to claims workers, it seems that the effects of bullying were underestimated and proved to be of equal, if not greater concern in terms of both groups of workers. This relates back to what Quine (1999) alluded to

in the sense that workplace bullying is more widespread than is often realised. Similarly, it is on the increase and a major concern to many employers worldwide.

Moreover, it can happen at any time and in any work-related context. Exactly how widespread it can become was clearly illustrated by Quine's (1999) report, which indicated that 38% of the nursing home staff that participated in her study experienced bullying directly at the hands of clients. As much as 42% of the same participants witnessed the bullying of colleagues. In the case of the groups of workers focused on by this study, it was expected that bullying would play *some* role, but it was not anticipated that it would, in the end, feature more prominently than exposure to traumatised clients and traumatic materials. From the preliminary meetings with Human Resource - and other departmental managers, bullying was highlighted to be a far more prevalent and serious problem than was first realised. This belief was also clearly reflected in the research results and particularly by the elevated secondary traumatic stress scores exhibited by both study groups.

When reflecting on the nature of worker/client relations, it becomes quite easy to comprehend why bullying is taking place. It also becomes clear why it plays such an important and significant role in terms of the elevated secondary traumatic stress scores. As pointed out earlier, claims workers are called upon to interact with clients in order to negotiate monetary compensation for losses suffered by their clients. Therefore, these workers interact with clients around losses and traumatic events. Consequently, they are constantly exposed to the trauma and traumatic materials from their clients. This trauma and shock on the clients' part set additional

hurdles that might add to the complicated nature of the negotiations. To even further complicate matters, clients might not accept the outcome or the length of time it takes to finalise the claim. Amidst all this emotional turmoil it is easy for tempers to flare or for clients to break down and express intense emotional distress. In the case of underwriters, a fair amount of their interaction with clients is centred upon problems that need to be solved or errors that need to be corrected. Quite often, underwriting errors can cost clients money which add to their irritation and annoyance. As can be seen, the very nature of these negotiations is quite challenging, problem-laden and is very conducive to bullying.

Meier (1993, cited in Raynes, 2001, p. 33) often describes bullies as "*difficult people*" or labels them as "*Jerks"* or "*Toxic people*", referring to those who continuously choose to use insulting forms of communication. This would include yelling, whining or sarcasm to express how they feel and what they think. Given the circumstances under which claims workers as well as underwriting clerks are called to interact with clients, one can easily appreciate that such forms of communication might occur quite frequently. It is also easy to comprehend that clients might resort to such styles of communication when they are traumatised, upset or annoyed. They might similarly opt for problematic communication styles during attempts to either get an annoying problem sorted out without delay or to expedite claims settlements or refunds owed to them. Especially when a client is unhappy with the outcome of a claim or a problem, problematic communication styles might even be more likely to occur.

Raynes (2001) theorises that these communication styles are especially prevalent in cases where individuals feel that they are entitled to something. In the case of the present study, clients might feel that they are paying customers and are therefore entitled to instantaneous problem solving, immediate attention or expeditious claims settlements. They might even feel that they are owed a specific size of settlement, whether it is vindicated or not, and might not want to settle for anything less. In the face of this sense of entitlement, people are most likely to believe that their bad behaviour is justified and are more prone to resort to aggressive and hostile communication styles (Raynes, 2001). In cases where the client is always considered to be right by an organisation, clients might be experiencing an even greater sense of entitlement and importance. These very attitudes can become problematic, as they create status and control differences between the client and worker that could greatly encourage bullying (Raynes, 2001).

Within the domain of claims workers in particular, it is also quite plausible that clients might not only resort to bullying due to a sense of entitlement, anger or annoyance. They might also unintentionally use destructive communication styles out of shock, anxiety or even feelings of hopelessness and defeat in the aftermath of their traumatic experience, or after having suffered a significant loss.

Raynes (2001) adds that those who are fearful of being wronged or cheated in some way are also very likely to resort to problematic communication styles. Seeing that the majority of client/worker negotiations conducted during claims settlements are based on reaching indemnity in the form of financial compensation for a loss,

clients might easily fear not being compensated adequately. Putting a monetary value on something that was important to the client, that might have had added sentimental worth or that might have been priceless to the person, can easily become challenging. As previously explained, clients often enter these negotiations with a mindset of having to fight for what is rightfully theirs. Underwriting clerks, to a lesser extent, undertake some negotiations around money which could also elicit similar behaviours. Brinkman and Kirschner (1994, cited in Raynes, 2001, p. 40) explain that people often opt for pushy and aggressive communication styles when they have a specific goal in mind such as "*getting the job done*" by literally "*rolling*" over those who might be getting in the way. Raynes (2001) also makes it clear that, when people feel that they or their interests are being threatened, they might even explode into a rage or fit of temper.

Notwithstanding this, the impact of these behaviours, as stated earlier, is very negative, creates fear, intimidation, confusion and lowers job morale, job satisfaction and productivity (Raynes, 2001). Such impact is reflected unambiguously in the high secondary traumatic stress scores exhibited by both groups of workers. In addition, The Field Foundation (2005) states that these prolonged negative stresses caused by bullying could result in considerable injury to one's health. They report that chronic fatigue and anxiety, depression, immune system suppression, panic attacks, aches, pains and numbness could follow from prolonged exposure. Other stress and anxiety related conditions such as irritable bowel syndrome, have also been associated with enduring bullying (The Field Foundation, 2005). Whilst there

is no official diagnosis yet, The Field Foundation (2005) view the symptoms of being bullied as similar to those of posttraumatic stress disorder.

As can be gathered from this discussion on bullying, these behaviours qualify as being continuously traumatising and frightening. They also seem to play a significant role in terms of both study groups when considering the elevated secondary traumatic stress scores. The very nature of client/worker dynamics makes these behaviours inevitable. Even if they are unintentional and inadvertently a result of trauma and distress on the clients part, they are nevertheless disruptive, upsetting and harmful to those on the receiving end.

As stated at the beginning of the discussion section, these results do not imply that vicarious trauma does not play a significant role. It still remains a considerable threat as it is, by nature of the client/worker interactions, ongoing and constant. Before offering further attention to this point, it is important to first consider the nature and role of burnout as observed by the study.

5.2.1.2 The role of burnout

As explained in the preceding section of the discussion, it was hypothesised that, due to bullying *as well* as the added stress of dealing with traumatised clients and traumatic materials, claims workers would exhibit significantly higher trauma and vicarious trauma scores compared to underwriting clerks. The above hypothesis further postulated that claims workers would exhibit lower levels of compassion satisfaction and higher levels of burnout and secondary traumatic stress compared to

underwriting clerks. The statistical analysis results indicated that there were no significant differences between the study groups regarding these variables. What is more, is that the results also seemingly indicate that exposure to client trauma and traumatic materials do not have a significant effect on claims workers, and that vicarious trauma does not play a particularly important role. This could be gathered from the fact that the claims worker's trauma and vicarious trauma scores are quite similar to those of the underwriting clerks, who do not normally deal with traumatised clients or any traumatic materials.

However, when looking at the data more closely and when drawing dealings (telephonic only versus face-to-face and telephonic) into the focus of the study, a different picture emerges. Examining the groups of claims workers and underwriting clerks as a whole somewhat obscured certain interesting findings. A two-way ANOVA that was performed on the three discreet ProQOL-RIII subscales, offers some additional insight into the typical working conditions of these workers. However, to fully understand trauma and vicarious trauma in claims workers and underwriting clerks, one has to first consider burnout.

According to Stamm (2003), who largely devised the ProQOL-RIII Scales, elevated burnout scores firstly indicate that the emotional demands of the particular job are high. In a more practical sense, it also indicates a high or even unmanageable workload and unsupportive environment. This means that, in the case where a job is indeed emotionally demanding, a greater workload would lead to greater and more frequent exposure to such emotionally demanding situations. Eventually this will

result in feelings of hopelessness and augmented difficulty in dealing with work or performing one's job effectively.

Returning to the present study's results, data were firstly split according to group (claims workers and underwriting clerks) as well as dealings (telephonic only versus telephonic and face-to face). This also commences the discussion in terms of the **second study hypothesis**, that there would be a significant difference in trauma and vicarious trauma scores between workers who deal with clients purely telephonically compared to those who deal with clients telephonically and face-to-face.

Again, no significant differences were found between claims workers and underwriting clerks but some very significant interaction effects were uncovered with respect to burnout and secondary traumatic stress. The results of the univariate two-way ANOVA's firstly indicated that claims workers who deal with clients telephonically and face-to-face were experiencing the most strain and burnout (M=21.79). Underwriting clerks who deal with clients purely telephonically showed the second most exhaustion and strain (M=21.44). Claims workers who deal with clients purely telephonically experienced the third most burnout (M=18.63), whereas the underwriting clerks who deal with clients telephonically and face-to-face, experienced the least burnout (M=16.33). The Tukey-Kramer post hoc analysis indicated that there was a significant difference only between the two groups of underwriting clerks ($p < 0.05$).

This means that the underwriters who deal with clients purely telephonically experienced their work to be more emotionally demanding, compared to the underwriters who deal with clients telephonically and face-to-face. As alluded to earlier, burnout scores also indirectly signify the size and manageability of workload (Stamm, 2003). Therefore, the significant difference observed in the scores of the two groups of underwriting clerks indicates that, not only is the work more emotionally demanding, but that the workload between the two groups could also be disproportionate. It is therefore plausible that those underwriting clerks who deal with clients purely telephonically could also have a significantly greater workload compared to those who deal with clients telephonically and face-to-face.

Considered from a different perspective, the greater workload implied by the significantly higher burnout scores, also translates to a greater frequency or rate of exposure to bullying. Therefore, the more clients an underwriting clerk deals with, the greater the chances of encountering an unhappy client that might resort to bullying. As there is a general lack of academic information on the work conditions of these clerks, the Human Resource – and other departmental managers were asked to briefly respond to this finding. They explained that most underwriting procedures can be done telephonically and clients are mostly not required to meet with underwriting clerks in person. As a result, these workers are constantly talking to clients telephonically instead. They agreed for the most part that the workload becomes very demanding, as there are often not even a few minutes to regroup between calls. Most days when the one call is concluded, the next caller is already waiting to speak to the person.

Policies are usually amended, where possible, whilst they have the client on the line, but with more complicated instructions or where approval from management is required, these instructions are put aside whilst they are attending to the next caller. Therefore, daily backlogs are inevitable and are constantly mounting. The majority of these managers confirmed that these workers often have to work after office hours in order to attend to the more complex instructions once the incoming calls have ceased. They also responded that the nature of the workload of those underwriting clerks who deal with clients telephonically and face-to-face, is nonetheless very demanding, but is usually less of a problem to manage. They mostly identify problems, obtain the necessary managerial approval and perform the amendment whilst the client is there. Clients who visit the insurer's offices usually require a satisfactory answer or course of action to be taken before they conclude their meeting.

During these face-to-face consultations with clients, the underwriting clerks usually only take more important calls from other clients and mostly have the opportunity to attend to the problem at hand without incessant interruptions. As can be seen, within this set-up the worker is sometimes less prone to developing an unmanageable backlog. The explanations offered here are quite reasonable and one has to agree that the nature of the two positions outlined here are quite different. It is also easy to see how the one is by nature less manageable than the other.

The difference in mean scores in terms of the two groups of claims workers, although not significant, were nevertheless noticeable, which also has important

implications. Firstly, the difference in burnout scores between the two groups of claims workers indicates that those workers who deal with clients telephonically and face-to-face experience their work to be more emotionally taxing than assisting clients purely telephonically. It also indicates that they probably have a more challenging workload than those workers who deal with clients purely telephonically. Claims workers who deal with clients telephonically and face-to-face might be required to consistently work harder to remain ahead. Seeing that elevated burnout scores also indicate a greater workload, this furthermore implies that the rate of exposure to the trauma of clients and bullying would naturally also be accelerated. Simply put, the more clients claims workers assist, the greater the ratio of exposure to trauma, traumatic materials and bullying.

Again Human Resource - and other relevant managers were asked for their views on this matter. They explained, firstly, that not all claims procedures can be done telephonically and there are subsequently less calls. This, however, necessitates more face-to-face meetings with clients. Very often, claims workers are in the same position as underwriting clerks where they frequently spend the entire day taking one call after the other without a breather in between. They also explained that face-to-face contact with clients are often more demanding as these meetings are usually more emotionally intense and can become rather drawn out. In response to this, it is not difficult to imagine that seeing the expression on someone's face and witnessing their distress could be more moving than only listening to the voice of someone who is equally upset. Barsade (2002) specifically states that, during face-to-face interactions, non-verbal cues are paramount and of much greater

importance than even spoken words. With voice-to-voice interactions there are much less non-verbal information that evokes emotion and responses. Goldenberg (2002) also stated that, seeing interviewees weep were particularly difficult to deal with and that this in itself was more distressing to research interviewers than the gravity of what the interviewee was saying.

In conclusion, the elevated burnout scores therefore imply a greater emotional burden as well as a higher rate of exposure to trauma and vicarious trauma brought about by dealings with traumatic materials and bullying. The secondary traumatic stress scores, which are the actual measure of trauma and vicarious trauma, will be examined next.

5.2.1.3 Secondary traumatic stress (STS) results

As stated earlier, the univariate two-way ANOVA's revealed significant interaction effects with respect to burnout and secondary traumatic stress. The aforementioned section discussed the burnout interaction effects, whereas this part of the discussion focuses on those interaction affects observed for secondary traumatic stress or STS.

The added stress for claims workers of having to deal with traumatic materials, only becomes evident when continuing to look at scores in terms of group (claims workers versus underwriting clerks) and dealings (telephonic only versus face-to-face and telephonic). The two highest scoring groups in terms of STS are once again claims workers who deal with clients telephonically and face-to-face

(*M*=21.86) and underwriting clerks who deal with clients purely telephonically (*M*=18.92). The Tukey-Kramer post hoc analysis indicated this difference to be significant ($p< 0.05$).

To repeat briefly, bullying occurs within both the primary study groups (claims workers and underwriting clerks). Seeing that the burnout scores for these two highest scoring groups were almost identical (*M*=21.79 with respect to the first and *M*=21.44 with respect to the latter) it could be argued that they have an equivalent workload and that both positions are equally emotionally demanding. The fact that the claims workers who deal with clients telephonically and face-to-face still scored significantly higher in terms of STS, means that there is an additional factor causing more trauma and vicarious trauma in this group. Since the exposure to traumatised clients and traumatic materials are the only other features that chiefly set these groups apart, it would be fair to argue that the significant difference in STS scores could be as a result of these.

Also, when looking at the two lowest scoring groups in terms of STS, there is a difference between the mean scores, although not significant. Claims workers who deal with clients purely telephonically scored the second lowest in terms of STS (*M*=14.03) and underwriting clerks who deal with clients telephonically and face-to-face scored the lowest (*M*=11.50). Again, bullying occurs with respect to all participants and the burnout scores indicate that workloads and job demands between the two aforementioned groups are also relatively equivalent (*M*=18.63 with respect to the first group and *M*=16.33 with respect to the latter). The slightly more

pronounced difference in scores STS scores between these two groups, could likewise be attributed to the one group dealing with traumatic materials whereas the other group does not. This difference, however, is marginal and not as accentuated as was the case with the two highest scoring STS groups. This could be owed to the fact that this specific group of claims workers are not exposed to client's trauma on a face-to-face basis as they only deal with clients telephonically. This point will be returned to and explored more comprehensively when face-to-face versus voice-to-voice interactions are considered at greater length.

These are nonetheless very important findings as one of the main aims of the study was focused on establishing if exposure to traumatic materials would have a significant impact on claims workers and to what extent it would affect them compared to the underwriting clerks. These findings imply that the extent of traumatisation incurred is dependent on, not only group, but also dealings and that, if the latter was ignored, the rather intricate pattern of effects that emerged herein would largely have gone undetected.

Revisiting the theories on vicarious trauma momentarily, it becomes quite evident that the nature of negotiations between claims workers and clients possesses certain characteristics that are conducive to the development of vicarious trauma. At the outset of the study, it was pointed out that most vicarious trauma studies are centred on health – and mental health professionals. It was also stated that claims workers are not believed to have much in common with these professionals. Within the scant literature regarding the impact of vicarious trauma on less obvious groups,

it was discovered that claims workers, for instance, have more in common with researchers, jury members, journalists and legal representatives. There is a clear lack of literature pertaining to insurance workers per se, and particularly the prevalence of trauma and vicarious trauma within this population. This necessitates that conclusions be drawn from similar groups that have in fact been researched in this regard (Goldenberg, 2002; Stamm, 1997)

One particularly compelling study that was outlined in chapter one, entailed a group of researchers interviewers who seemed to have much in common with claims workers. Goldenberg (2002) produced a study of researchers who interviewed Holocaust survivors. This study specifically looked at the impact on the research interviewers of listening to survivor narratives.

Although the narratives heard by these research interviewers might have been filled with more recollections of traumatic events than might have been the case with claims workers, this group of interviewers is nonetheless believed to have much in common with the said study group. For one, they are indeed a less obvious group when it comes to studies of the affects of trauma and vicarious trauma than are therapists or mental health workers. Also, most claims workers generally conduct interviews (telephonic or face-to-face) with clients after they have suffered a loss arising from accidents, natural disasters or at the hands of criminals. These interviews often entail detailed recollections of the event in order to compile claims records. For instance, on 11 April, 2002, the British Broadcasting Corporation (2002) published statistics that proved South Africa to be the crime capital of the

world. The visible "*architecture of fear"* in our country (BBC News, 2002, para. 7) was also specifically commented on.

Similarly, if one looks at South African newspaper reports on how horrifying criminal encounters often are, one has to bear in mind that some insurance clients might have lived through similarly disturbing events. It is also not uncommon for claims workers to have to deal with clients shortly after loosing a loved one in an accident that gave rise to the claim, especially seeing that most short-term personal-lines policies include personal accident cover. It was, in fact, confirmed with each of the participating insurers that they do grant such cover. This policy extension provides cover in terms of death, loss of a limb, or permanent disablement as the result of an accident.

As can be gathered from the preceding paragraphs, some claims, by their nature, would involve listening to disturbing and unsettling events that are narrated by clients when these events are investigated for claims record purposes. In addition, the motivation of the research interviewers featured in Goldenberg's (2002) study is quite similar to that of claims workers, which is to elicit information around a specific traumatic event. Goldenberg (2002) reported that some of the participating researcher interviewers reported insomnia, anxiety and minor depression after each interview. If and when claims workers interview particularly traumatised clients, it is quite possible for them to experience similar problems. Some of Goldenberg's (2002) participants reported that it was particularly difficult to listen to narratives accompanied by crying. In such cases the researchers reported the content to be less

important and that their felt distress rather arose from the mere fact that the interviewee was weeping. Again, it is not impossible to imagine that insurance clients who have been through disturbing events might also express similarly intense emotions. Goldenberg (2002) describes the unequivocal psychological harm that was expressed by these participants that, at times, shared features with posttraumatic stress disorder. Having mentioned these similarities in circumstances between Goldenberg's (2002) study group and the ones investigated by the present study, it could be plausible that claims workers might be affected in a similar way.

Another equally interesting study that was briefly mentioned in chapter one (Stamm, 1997), indicated that the staff of a Holocaust Memorial Museum experienced somewhat lasting emotional distress after preparing Holocaust artefacts for display. The exposure to and handling of disturbing personal belongings of Holocaust victims and other reminders of the Holocaust, caused considerable distress in these workers (Stamm, 1997). Similarly, claims workers are also often exposed to rather disturbing traumatic materials. The participating insurers confirmed that post mortem reports, medical records and death certificates are required to settle personal accident claims. Moreover, these claims are all accompanied by a photograph of the deceased or injured in the form of a copy of the person's identity document. In other cases, the scene of an accident or crime is photographed for claims record purposes. Photographs of salvage (car wrecks) are also frequently placed on file in order to qualify these claims. Often, people are killed or seriously injured in these collisions and the photographs of the wrecks can be quite graphic and unsettling.

Drawing these parallels between claims workers and existing research conducted with respect to other similar groups, give one but an idea as to the nature of these traumatising work-related duties. Exactly how these duties might cause trauma and vicarious trauma also becomes somewhat clearer. The elevated secondary traumatic stress scores of both study groups indicate that there are indeed traumatising aspects related to these work positions. Drawing such parallels is quite useful but not as effectual and valuable as actual research information. Much more academic information, especially of a more qualitative nature, is needed on insurance workers to establish exactly what these aspects are, to capture their specific nature and to unpack how they occur within this unique context.

When reflecting on particularly how claims workers might be affected by these traumatic materials, McCann and Pearlman (1990) point out that one can not remain completely unmoved and unchanged by listening to details of traumatic events. They also state that the changes in one's thinking frequently persist for quite some time. These theories similarly indicate that these changes are most certainly lasting, seeing that our schemas continuously evolve in order for us to make sense of our world and what happens to us and those around us (McCann & Pearlman, 1990). Also, those who constantly listen to accounts of victimisation and trauma may internalise the memories of these events. This can lead to temporary or even permanent alteration of the memory system (McCann & Pearlman, 1990). These alterations can also potentially become disruptive or intrusive to the person's psychological or interpersonal functioning. Research has shown that dealing with frightening and disturbing events on a daily basis indeed changes your beliefs about

people, life and the world we live in (McCann & Pearlman, 1990; Sabin-Farrell & Turpin, 2003). Moreover, these authors report that research subjects often state that they feel quite disappointed by humankind. These subjects also indicated that they no longer believe in the inherent goodness and kindness of human beings as they experience more proof to the contrary. This series of statements all relate back to what Falsetti *et al.* (2003, p. 391) calls "*overacommodation*" where, instead of believing that criminal human beings are dangerous, one starts becoming increasingly suspicious of everyone's motives. One becomes distrustful or cynical and eventually believes that most humans are dangerous and that the world is completely unsafe (Falsetti *et al.*, 2003). These overaccommodating thoughts also influence one's behaviour accordingly.

Responding to these points made, necessitates the drawing of yet another parallel with Goldenberg's (2002) study. This study indicated that the researchers who conducted the Holocaust interviews indeed expressed an overall sadness and disappointment in humanity. Some of these researchers felt haunted by certain descriptions of the evil within the human race. In conclusion, claims workers are also constantly exposed to the dark side of humanity, especially when dealing with crime-related claims. Constantly having to listen to client's experiences of breached trust, human cruelties, powerlessness, omnipresent dangers and testimonies of how unfair life can be, it is easy to see that they might also be similarly affected. Future qualitative studies could certainly assist in confirming whether the phenomena described here, also occur in claims workers. Moreover, it would confirm if and how accurate the deductions made and the parallels drawn with other studies are.

Next, emotional contagion is looked at more closely.

5.2.1.4 Face-to-face versus voice-to-voice emotional contagion

The discussion of the second hypothesis, that there would be a significant difference in trauma and vicarious trauma scores between workers who deal with clients purely telephonically compared to those who deal with clients telephonically and face-to-face, is continued under this section. This time the discussion focuses more closely on the mode of interaction from a different perspective, that of emotional contagion. Whether voice-to-voice emotional contagion is as powerful as face-to-face contagion, is at the core of this part of the discussion.

Still focusing on the data obtained from the ProQOL-RIII subscales along the dimensions of compassion satisfaction, burnout and secondary traumatic stress, emotional contagion is considered in terms of these variables. Emotional contagion has been fairly well researched and several theories have emerged which not only explain this phenomenon, but also provides compelling validation thereof (Barsade, 2002; Sabin-Farrell and Turpin 2003; Sexton, 1999; Verbeke, 1997). Along with the theories on vicarious trauma and how it occurs, theories on emotional contagion offer additional insight and a further plausible explanation of how trauma and emotional distress expressed by clients can be "caught" by the claims and underwriting workers.

As previously stated, traditionally emotional contagion is viewed as the process whereby emotional distress of one person is contagious and passed on from

the one to the next via interpersonal interaction. As stated earlier, the emotional contagion hypothesis proposed and clarified by Verbeke (1997) explains how the emotional states between two people, such as worker and client, are transmitted from the one to the other. This happens during their interactions via verbal and, more importantly, non-verbal cues. As previously pointed out and as can be gathered from the discussion on dealings thus far, many of the participants only have telephonic contact with clients. The problem lies therein that the most conclusive studies on emotional contagion have been carried out in terms of face-to-face contact between subjects.

The most recent emergent literature on this subject, however, does indicate that emotional contagion can in fact happen telephonically (e.g. McCalla & Ezingeard, 2005; Verbeke, 1997; Zempetakis, 2004; Zilberman-Ziklik; 2004). According to a study conducted by McCalla and Ezingeard (2005, p.1) there is reason to believe that telephonic liaison, or what they refer to as "*voice-to-voice*" interactions, can similarly lead to emotional contagion as would face-to-face dealings. They argue that emotional expression always occurs during any emotional episode, be it face-to-face or telephonic. They theorise that the persons involved in voice-to-voice interactions typically respond to content language, voice intonations and the use of emotional signalling words as emotional cues.

Zempetakis (2004) agrees that there are many cues in one's tone of voice that indicate emotion which can be responded to under these circumstances. The statistical analysis confirmed that there were no significant differences in secondary

traumatic stress scores in terms of group (claims workers versus underwriting clerks) or dealings (telephonic only versus face-to-face and telephonic). There were, however, several interaction effects that had been discussed earlier. Underwriting clerks who deal with clients *purely* telephonically, expressed the second highest secondary traumatic stress scores (18.92) out of the entire sample. This result could be indicative of the notion that emotional contagion can transpire from voice-to-voice interactions, given their elevated secondary traumatic stress scores in spite of not having face-to-face contact with clients.

Elevated STS scores across the two modes of interaction (telephonic only versus face-to-face and telephonic) exhibited by the two highest scoring secondary traumatic stress groups, indicate that contagion between client and worker can, by the same token, take place telephonically or face-to-face. Firstly, claims workers who deal with clients telephonically and face-to-face exhibited the highest secondary traumatic stress scores (21.86). Secondly, as stated in the previous paragraph, underwriting clerks who deal with clients purely telephonically, exhibited the second highest scores (18.92). These elevated scores clearly indicate that, traumatic materials and the emotional exchanges during bullying affects claims workers and underwriting clerks, irrespective of the mode of interaction.

Similarly, the results also point towards the fact that face-to-face exposure to traumatic materials could have more adverse effects than being exposed on a voice-to-voice basis only. The studies on face-to-face and voice-to-voice contagion that were considered earlier seemed to indicate that face-to-face as well as voice-to-voice

emotional contagion are equally possible and even somewhat similar. However, when considering these theories more carefully, it is fair to believe that face-to-face contagion might by nature be more potent. As previously stated, face-to-face encounters simply yield more interpersonal information to respond to, being visual as well as auditory in nature.

Further study findings also indicate that non-verbal cues and direct interpersonal contact are of greater significance during the process of emotional contagion, compared to only listening to words (Barsade, 2002). Although words are central to our understanding in general, they do not play a paramount role in emotional contagion (Barsade, 2002). Goldenberg (2002), as was also reported earlier, found that some of the participating researchers acknowledged that it was particularly difficult to deal with interviewees who were visibly upset. In such cases, the researchers reported that listening to what was being said was less important, and that their felt distress arose purely from seeing the interviewee weeping. This point also offers some support to the notion put forth by Barsade (2002), that words are far less important than non-verbal cues.

When looking at the two groups of claims workers (those who deal with clients telephonically only versus those who deal with clients face-to-face and telephonically), a definite difference emerges, which largely supports the abovementioned argument that was put forth by Barsade (2002) and Goldenberg (2002). One has to bear in mind that these are also the *only* groups that are exposed to traumatic materials. Tukey-Kramer post hoc analysis indicated a very significant

difference between these two groups of participants ($p < 0.01$). Those dealing with clients face-to-face and telephonically exhibited a mean secondary traumatic stress score of 21.86, and those who deal with clients purely telephonically scored 14.03. Again, a substantial part of this observed difference would have to be attributed to a difference in workload and job demands that were also observed between these two groups, as indicated by their burnout scores (21.79 and 18.63 respectively).

After having taken these possible differences into account, there is, however, still a much greater difference in the secondary traumatic stress scores of the claims workers who deal with clients telephonically only, versus those who deal with clients face-to-face and telephonically. This difference could be owed to the fact that the higher scoring group is also typically exposed to the traumatic materials of clients on a face-to-face basis. This would then offer support to the notion that face-to-face and voice-to-voice contagion are not equally powerful, seeing that trauma contagion seems to be more powerful and more prevalent in those participants that also deal with clients face-to-face.

Furthermore, when looking at the secondary traumatic stress scores of the two underwriting or comparison groups, the aforementioned also seems to be true, but the results are somewhat more difficult to interpret. The effects are also less obvious and straightforward than is the case with claims workers. For one, the heaviest and least workloads that were observed in claims workers are completely reversed in the case of underwriting clerks. The underwriting group that deals with clients telephonically and face-to-face expressed a mean score of 11.50, whereas the

other group dealing with clients purely telephonically scored 18.92. The differences in workload and job demands between these two groups as indicated by the burnout scores (16.33 and 21.44 respectively) are somewhat less pronounced than is the case with the secondary traumatic stress scores. One could argue that the greater workload of the one group immediately overshadows the effects that direct traumatisation might have. But, there is still a slightly more pronounced difference in secondary traumatic stress scores, even after the effects of difference in workload and job demands have been taken into consideration.

This difference could be owed to the effects of direct, face-to-face traumatisation. Stated differently, the difference in burnout scores is smaller than the difference between secondary traumatic stress scores. This indicates that the larger difference in secondary traumatic stress scores is owed to something other than just workload and job demands, quite possibly that of direct exposure to bullying. As stated earlier, future qualitative studies and interviews with claims workers and underwriting clerks in particular, would be necessary to verify the deductions made here.

Further pondering the phenomenon of emotional contagion, the constant exposure to clients' traumatic experiences, morose feelings and bullying, may not only result in transmission of these negative emotions. It could also result in changes to these workers' schemas in order to assimilate and make sense of this negative information (McCann & Pearlman, 1990). In addition, Sexton (1999) suggests that, the more distressed a client, the stronger the unconscious projective identification

between client and worker. The more readily emotional distress is passed on, the more likely schemas will need to be adjusted to incorporate this negative information. In line with the clients' posttraumatic emotional distress, the claims worker might also start seeing the world as an out-of-control, dangerous and meaningless place. They might equally gravitate towards seeing their life circumstances and future in an increasingly negative or pessimistic light (Mehrabian, 1998; Sabin-Farrell & Turpin, 2003). This is also in line with the theories on vicarious trauma whereby affected persons typically exhibit symptoms or affects parallel to that of the traumatised client (Lev-Wiesel & Amir, 2001).

Interestingly, the two highest scoring secondary traumatic stress groups agreed more strongly with the perception that they are in fact "*infected"* by the traumatic stress of those that they are dealing with. Item nine of the ProQOL-RIII Scales (please see *Appendix F*) specifically posed this statement to participants. With regards to this item, the two highest scoring secondary traumatic stress groups in general agreed more strongly with this notion, than did the lower scoring secondary traumatic stress groups. Stated more specifically, claims workers who deal with clients telephonically and face-to-face and underwriting clerks who deal with clients purely telephonically, scored a mean of 3.36 with regards to this test item. Claims workers who deal with clients purely telephonically and those underwriting clerks who deal with clients telephonically and face-to-face only scored a mean of 0.81 with respect to the same item. Responses to a single test item might not be sufficient to reveal any clear pattern in beliefs or offer any comprehensive insight into the matter. The fact remains, however, that there was nonetheless a

striking difference in the responses made to this item between the highest and lowest scoring secondary traumatic stress groups. This indicates that those with the highest secondary traumatic stress scores admit that they are somehow infected by the trauma from those they deal with, and that clients are passing on some of their trauma to them.

It would be fair to argue that the client, who experienced this trauma directly, might have done so much more intensely than might be the case with claims workers. One has to, nonetheless, bear in mind that the client suffered a single extremely intense incident, whereas the claims worker's exposure to trauma and traumatic materials might be far less intense, but is constant and ongoing. Listening to distressing testimony after distressing testimony, and being infected by the traumatic stress of each client, might be affecting these workers quite adversely. The added effects of bullying, on top of this ongoing exposure to trauma, could be further exacerbating these overall feelings of being traumatised and infected by trauma. As has been pointed out on several occasions, some of the individual secondary traumatic stress scores were disquieting, whereby 44% of the entire sample at times expressed alarming levels of this variable.

These concluding points are very important and should not be disregarded or taken lightly. The next section will be focusing on post-traumatic stress disorder, which could be *another* impediment to the more seriously affected individuals.

5.2.1.5 Trauma, vicarious trauma and posttraumatic stress disorder

Before moving on to the next study hypothesis, it was felt important to ponder the subject of bullying and traumatic materials and their implications a while longer. The Field Foundation (2005) clearly states that workplace bullying can undoubtedly, as is the case with vicarious trauma, cause great stress, injury to health and particularly posttraumatic stress disorder (PTSD). Especially when one starts looking at individual secondary traumatic stress scores again, there are without a doubt quite a number of workers who are in serious need of help. Although this part of the discussion moves away form the actual central study hypotheses, it was nonetheless deemed important to take this turn and consider individual secondary traumatic stress scores more closely.

The reason why secondary traumatic stress warrants an even closer and more detailed look is the fact that it is a measure of the actual trauma incurred by the various participating workers. Seeing that trauma (direct and vicarious) is of central importance to the study, this topic indeed deserves further consideration. To briefly review what was explained earlier, the American normed average secondary traumatic stress score is 13. If a score is 17 or above, it is strongly recommended that the person identifies the source of the trauma and to also strongly consider discussing it with a colleague, a supervisor or a health care professional (Stamm, 2003). Many of the individual scores were disturbingly high indeed. Out of the 75 participants, 33 scored above 17. Nine participants scored between 17 and 19; 17 participants scored between 20 and 29 and six participants scored between 30 and 36.

The highest score was an alarming 43 and this individual is clearly in dire need of help.

It is important to perhaps mention here that some participants are, however, much less affected than others. This is confirmed by the fact that the majority of participants (amounting to 56% of the overall study sample) scored low in terms of secondary traumatic stress. It is also very important to mention that the vast majority of claims are very unremarkable, uneventful and mundane. They involve such things as minor collisions, loss of or damage to personal property, broken car windows and lightning damage to household equipment. They also more often than not involve petty crimes where clients do not come into direct contact with criminals. Also, the majority of interactions with claims workers and underwriting clerks may very well not involve any problems, bullying or any traumatic narrations or materials from clients. But, there are still those incidents, though less frequent, that clearly impacted upon some participants, as indicated by their disquieting secondary traumatic stress scores.

The high secondary traumatic stress scores indeed raise a very important point, which is the possible incidence of PTSD. Considerably elevated secondary traumatic stress scores suggest that the person could very well be suffering from PTSD. This is so because the secondary traumatic stress items of the ProQOL-RIII Scales (Stamm, 2003) are specifically formulated around the core symptoms of the DSM-IV, such as avoidance behaviour, sleep disturbance, exaggerated startle responses, preoccupation with the traumatic events, withdrawal, feelings of being

disconnected from others, sudden intrusive thoughts and feelings of being helpless (Barlow & Durand, 2001). High scoring individuals would then, naturally, be exhibiting many of the trait symptoms of PTSD. The amalgamated group scores largely obscure the likelihood of PTSD and the disturbing magnitude of some of the scores. It was also a very large portion of the total sample that exhibited these very high scores – as much as 44%.

Firstly, out of the 33 highest scores, 14 were underwriters (representing 45% of the underwriting sample) and 19 were claims workers (amounting to 43% of the claims worker sample). The individual with the alarming score of 43 is a claims worker and the average score for the 19 most at risk claims workers, is 24.16. The average score for the 14 most at risk underwriters, is 25.21. This is *considerably* higher than the American normed average score of 13, which is also indicative of moderate levels of secondary traumatic stress. It is also much higher than 17, which is the cut-off score above which secondary traumatic stress scores are considered to be high.

In addition, when looking at individual responses, 31 of these highest scoring individuals expressed clear difficulty in separating their work life from their private lives. Item seven of the ProQOL-RIII Scales proposes to the participants that it is difficult to separate their personal from their professional lives (please see *Appendix F)*. This statement suggests that the effects of the traumatising and distressing aspects of their work spiral out into their personal lives and continue to affect them in most other situations, even away from work. Of the entire sample of 75 participants,

a total of 36 of the individuals expressed a clear difficulty of separating their work life from their private lives. As many as 31 of these responses occurred within the 44% of individuals who scored highest in terms of secondary traumatic stress. These results clearly support and tie in very well with the Bio-psychosocial views on the spiralling effect of traumatisation and how it permeates into all other aspects of our existence (Barlow & Durand, 2001).

Although secondary traumatic stress scores are of central importance to the study, scores on the other related study variables were similarly considered in search of further insight into trauma and vicarious trauma in the study groups. The burnout and compassion satisfaction subscales will first be looked at individually to first obtain a general view of the level of each of these two variables expressed by the participants. Then the subscale scores will be considered in relation to one another and secondary traumatic stress. According to Stamm (2003) there are more and least desirable combinations of high scores which is the rationale for looking at the subscale scores in this way.

When looking at individual burnout scores in particular, the findings are much more encouraging than was the case with secondary traumatic stress. According to the ProQOL-RIII manual (Stamm, 2003) and the American norms, scores of 28 or above indicate that the person is not as effective in this particular position as is desired. To briefly reiterate what was stated earlier, both study groups were exhibiting fairly average and moderate scores (claims workers M=19.64; claims workers M=20.45), which is just below the American average of 23. Out of the total

of 75 participants, only 9% of the entire sample scored above 28, which indicates high levels of burnout. Seven participants scored between 28 and 30, of which two were claims workers and five were underwriting clerks. Burnout seems to be slightly more prevalent amongst underwriting clerks, but still represents a relatively low incidence (only 2.66% of the claims sample and 6.66% of the underwriting sample experienced some degree of burnout).

Regarding the compassion satisfaction scores, the ProQOL-RIII manual (Stamm, 2003) stipulates that, according to the American norm, a score of 28 or below indicates that the person might be experiencing some problems at work. The further below 28 the score, the more serious the work-related problems and the lesser the pleasure and satisfaction derived from doing this work.

To briefly restate what was explained previously, the claims workers scored a mean of 35.48, whereas underwriting clerks scored 36.59. These scores are slightly below the American average of 37, which also indicates moderate levels of this variable. The mean scores for both study samples therefore indicate that they lean slightly more towards below average levels of compassion satisfaction, but are nonetheless deriving some pleasure and fulfilment from doing this work. Of the entire amalgamated sample, 16% scored below the cut-off of 28, which indicates low levels of compassion and professional satisfaction. Of the 75 participants, ten scored between 20 and 28 and two participants scored below 20 (18 and 12 respectively). Of the 12 lowest scoring participants, six were from the underwriting departments and another six from the various claims departments.

According to the ProQOL-RIII manual (Stamm, 2003), the most concerning and least desirable combination of scores entail those who have high secondary traumatic stress (STS) scores and high burnout scores. These individuals are at the greatest risk for negative outcomes, including but not limited to bad professional judgement, making more errors, doing poor administration and overall unsatisfactory work performance. They also run the greatest risks of developing depression and/or posttraumatic stress disorder (Stamm, 2003).

Of the entire sample of 75, eight individuals exhibited a combination of high burnout scores (28 and upwards) combined with high secondary traumatic stress scores (17 and upwards). These results translate to 11% of the total sample, who are running the risk of loosing their employment due to bad judgements and poor performance. They are also the most at risk of developing depression and/or posttraumatic stress disorder. Although this percentage is not particularly high, it is nonetheless disturbing to find that there are nonetheless individuals who are running these risks and facing these difficulties at present.

Next, the effects of trauma and vicarious trauma on self-esteem are unpacked.

5.2.2 The MSE Scale as a measure of self-esteem

Regarding the **third study hypothesis**, that claims workers were expected to exhibit lower self-esteem scores than underwriting clerks, no significant difference in mean scores between the two groups was observed. The two-way ANOVA also did not uncover any interaction effects in terms of group (claims workers versus

underwriting clerks) or dealings (telephonic only versus telephonic and face-to-face). In view of this, the null hypothesis was accepted.

Notwithstanding the above results, the data nonetheless yielded interesting findings. What was revealed was that both claims workers and underwriting clerks exhibited similar, moderate self-esteem scores, which were neither high nor low. As explained earlier, the self-esteem scale has a midmost point (or zero) which indicates moderate self-esteem or relative unresponsiveness. A score around zero would indicate very neutral appraisals about oneself and one's worth. In the case of both study groups, the mean score was less than one standard deviation above zero (claims workers M=5.95, SD 8.24; underwriting clerks M=5.84, SD 8.61). In conjunction with the average levels of burnout and compassion satisfaction exhibited by both groups, this indicates that some job demands are met satisfactorily and that the persons are performing somewhat efficiently.

Considering the high secondary traumatic stress scores and considering the view that trauma and vicarious trauma encroaches on one's self-esteem, it was rather surprising that low self-esteem was not prevalent. However, one can not help but contemplate if and how the levels of self-esteem might have differed if the workers had not been exposed to work-related traumatic materials and bullying at all. It would also have been interesting to know what the respective self-esteem levels might have been prior to commencing employment in the various departments, compared to the scores after considerable exposure to vicarious trauma and bullying.

However, this kind of information is not available and it would be extremely difficult to conduct pretest-posttest research in order to entertain these questions.

Given the data that was yielded on the claims workers and underwriting clerks, one of two suppositions can be made in this regard. Firstly, one could argue that the average self-esteem scores indicate that the levels of secondary traumatic stress experienced are not sufficient to induce low self-esteem. Alternatively, they might have possessed high self-esteem prior to their employment in the insurance industry, which might have been lowered due to their exposure to trauma and vicarious trauma. Tracy (2002) specifically identified high self-esteem to be a protecting factor against trauma. The effects of trauma and vicarious trauma in these workers might have been substantially buffered by healthy levels of self-esteem, but constant and ongoing exposure to these stressors might nonetheless have reduced their self-esteem to more moderate levels. Which of these statements are most accurate and to what extent each statement is true is, unfortunately, very difficult to say.

Although self-esteem levels were not distressingly low and do not present reason for concern, it is still plausible that the trauma and vicarious trauma experienced, might nonetheless be affecting the self-esteem of claims workers and underwriting clerks. It would have been far more reassuring if they had exhibited higher, more desirable levels of self-esteem than was the case. High self-esteem scores would definitely have offered more decisive evidence that participants' schemas, mental frameworks and beliefs about themselves are unaffected by bullying

and exposure to traumatic materials. Amid the moderate levels of self-esteem, one can not completely overrule the possibility that workers are not being affected adversely. Moreover, the Pearson correlation test indicated that, although there was not a significant relationship between self-esteem and secondary traumatic stress, there was nonetheless a pattern in responses. Those with higher secondary traumatic stress tended to score lower in terms of self-esteem. This finding therefore concurs to some extent with the notion that trauma and vicarious trauma encroaches on one's self-esteem (AtHealth, 2003; PTSD Alliance, 2003; Sierra Pacific Network, 2001; Tracy, 2002).

Even though the levels of self-esteem did not lean strongly towards low levels, bullying and the exposure to the trauma of others nevertheless pose a threat to both claims workers and underwriting clerks. Their constant exposure to clients' testimonies of how people are treated by criminals and of how little worth a human life holds to them, might very well instil burgeoning feelings of worthlessness, especially in the case of claims workers. The neutrality exhibited in terms of self-esteem implies that many participants do not have a particularly high regard for themselves. This also means that they are likely to be experiencing some decline in their belief in themselves and their capabilities in general (Sierra Pacific Network, 2001).

In addition, the constant experiencing of bullying at the hands of others similarly seems to have resulted in some negative changes to their schemas about themselves, otherwise self-esteem scores would have reached more satisfactory

levels. When considering the nature of bullying, it becomes more apparent why self-esteem scores would be affected adversely. To recapitulate, bullying is typically ongoing verbal attacks of a person with the aim of undermining their self-confidence (Quine, 1999). These attacks pose a threat to the recipient's professional status and usually entail belittling opinions, public professional humiliation and accusation of lack of effort or skills (Quine, 1999). Unfortunately, more often than not, the attacks are not limited to a person's professional standing, but are frequently aimed at the recipient's *personal* standing. Under these circumstances, name-calling, personal insults, accusations of lack of intellect or capabilities are aimed at the recipient (Quine, 1999).

In this way, recipients are made to feel unintelligent and incompetent, and to start questioning their professional *and* personal worth. Insulting communication styles and bullying have been shown to negatively influence one's self-confidence and self-esteem, lower self-image, and to cause a general loss of self-worth and self-love (The Field Foundation, 2005).

The constant criticism and verbal abuse associated with bullying often facilitates the cultivation firstly, of more negative thoughts and feelings toward oneself, which ultimately leads to the lowering of one's self-esteem (Sierra Pacific Network, 2001). In order to assimilate and make sense of the constant negative information that claims workers and underwriting clerks are faced with daily, resultant negative changes to their schemas about themselves are quite inevitable. While the forms of trauma and vicarious trauma incurred by these workers might be

mild in comparison to life threatening events, their encounters are nonetheless continual, ongoing and an inescapable part of their jobs. Even though self-esteem was not low per se, one has to nonetheless bear in mind that the self-esteem scores were also not within a higher, healthier and more desirable range.

Next, the effects of trauma and vicarious trauma on levels of optimism/pessimism are offered some consideration.

5.2.3 The MOP Scale as a measure of optimism/pessimism

The **fourth hypothesis**, that claims workers will gravitate more towards a generally pessimistic outlook than underwriting clerks, was also not confirmed by the results. The statistical analysis, in the form of a two-way ANOVA, indicated that there were no differences or any interaction effects in terms of group (claims workers versus underwriting clerks) or dealings (telephonic only versus telephonic and face-to-face). In view of this, the null hypothesis was again accepted.

As was the case with the self-esteem scores, the mean scores for both study groups were very similar and again leaned towards neutrality (claims workers *M*=9.61, *SD* 8.45; underwriting clerks *M*=9.06, *SD* 9.03). The mean optimism/pessimism scores for both groups were slightly higher than was observed for self-esteem, the first being just more and the latter just less than one standard deviation above zero. The optimism/pessimism scores are nonetheless still indicative of fairly moderate levels, being neither pessimistic nor optimistic, and indicate a reasonable amount of unresponsiveness towards one's life and experiences.

As was also the case with self-esteem, one can not help to contemplate if and how the optimism/pessimism measures would have differed, if the workers had not been exposed to work-related traumatic materials and bullying. Once more, scores on these variables prior to commencing employment in the various departments, compared to their scores after considerable exposure to trauma and bullying, would have answered several looming questions. However, this kind of information is not available.

Given the data at hand, one of two similar suppositions can be made, as in the case of self-esteem. Firstly, one can argue that the moderate or neutral scores (neither optimistic nor pessimistic) could indicate that the levels of secondary traumatic stress experienced are not sufficient to induce full-blown pessimism. Alternatively, participants might have been much more optimistic prior to their employment in the insurance industry, which might have been lowered due to their exposure to trauma and vicarious trauma. Again, it would be impossible to say which of the two suppositions are most accurate as well as the extent to which each statement is true.

As stated under the previous heading, neutral or nonaligned scores is not necessarily a desirable outcome. It also does not mean that participants are not being affected by trauma and vicarious trauma. Higher, more desirable levels of optimism would have been far more reassuring and would have provided more clear substantiation that the participants' schemas, mental frameworks and beliefs about the world and their lives are healthy and intact. The moderate levels of

optimism/pessimism and the somewhat unresponsiveness and neutral position do in fact suggest that participants might nonetheless be adversely affected by traumatic materials and bullying, or else they would have exhibited more optimism and sanguinity.

As pointed out earlier, Victor Frankl (1963, cited in Joseph, *et al*., 1993) posited decades ago that the need for finding meaning is a fundamental human motivation. The underlying premise to the Cognitive Constructivist Development Theory is also that all humans construct their own personal realities by developing complex cognitive structures (McCann & Pearlman, 1990). From these we interpret events in our continuous, innate pursuit of meaning. These structures encompass our beliefs, assumptions and expectations, not only about ourselves, but also about what happens in the world. These enable us to make sense of all our experiences (McCann & Pearlman, 1990).

Again, a daily reality overflowing with negative events, such as traumatic materials and bullying, would have to have some influence on our core beliefs (McCann & Pearlman, 1990). It could be less disruptive at first, but could eventually lead to fairly lasting cognitive changes whereby inner experiences such as thoughts, perceptions and interpretations are negatively transformed (McCann & Pearlman, 1990). These persistent negative thoughts, perceptions and interpretations can be described as pessimism.

In addition, McCann and Pearlman (1990) indicate that trauma and vicarious trauma could affect a person's sense of control in life and one's view of the world. Similarly, Sabin-Farrell & Turpin (2003) also indicate that one's belief of general invulnerability is also very susceptible to disruption as a result of trauma or vicarious trauma. Pessimism and a sense of helplessness were, for instance, reported in 55% of participants who were constantly exposed to low intensity conflict situations (Dheer, *et al*., 2003). The participants central to the present study all experience a considerable amount of conflict on a daily basis, as was elucidated by the discussion on their work conditions and bullying in particular.

Also, during a very interesting study with a group of professional newspaper journalists, it was found that continuous exposure to events involving trauma demonstrated change in their cognitive schemas, which is so often associated with vicarious trauma (Pyevich, *et al*., 2003). These authors also found their major beliefs regarding personal invulnerability, meaning, self-worth and overall benevolence of the world to be considerably impacted upon. Their schemas became increasingly negative and were hindering the development of adaptive schemas by rather promoting maladaptive ones (Pyevich, *et al*., 2003).

Although the study participants are not overwhelmingly pessimistic, they nonetheless seem to have been affected by their work-related trauma and vicarious trauma, though only to a moderate extent. Their neutrality and unresponsiveness seem to suggest a lack of passion, enthusiasm and joviality. These stressors, though mild compared to other traumatic experiences, are furthermore continuous, recurrent,

inextricably part of their realities and pose a constant threat. These workers might be coping well at present but any added work or personal pressures could potentially cause a downward spiral. In this regard Jordan (2001) warns that, no matter how resilient persons are and no matter how well they are coping, they could easily become overwhelmed if they loose their supports or if the traumatic event is persistent. Even though the study participants are not dramatically affected by their work-related stresses, the already undesirable levels of self-esteem and optimism/pessimism expressed by them could be increasing their risk for developing more serious difficulties.

Lingering on the subject of self-esteem and optimism/pessimism, the overall results in terms of these variables are further considered under the next heading.

5.2.3.1 Overall trends in self-esteem and optimism/pessimism

As pointed out in the preceding sections, the results for the self-esteem and optimism/pessimism measures seemed to indicate that self-esteem was somewhat more affected within the work context of claims workers and underwriting clerks, than was optimism/pessimism. The mean scores for both variables leaned towards moderate levels, but in the case of self-esteem, the mean scores were closer to zero than was the case with optimism/pessimism (please see *Table 11* of the results section). One can conclude from this that there is greater consistency in negative appraisals toward the self than was the case with negative appraisals of life in general.

This finding makes considerable sense when one again briefly considers the difference in the nature and prevalence of bullying and exposure to traumatic materials. Bullying affects both claims workers and underwriting clerks whereas vicarious trauma is limited to claims workers. Furthermore, bullying is mostly aimed at the person's professional and even personal status and capabilities, with the *intention* of undermining self-confidence and self-worth (Quine, 1999). The exposure to traumatic materials and the trauma of clients in the case of claims workers has a less malicious and vindictive element to it than does bullying. Claims workers are inadvertently exposed to the trauma and traumatic materials of their clients whereas bullying is deliberate and intentional. It is also quite possible that bullying might bring about far stronger reactions and emotions from the study participants than do unintended emotional tumults and distress from clients.

Within this framework and within the context of the said workers, it is quite easy to understand why self-esteem would be affected to a greater extent. This finding offers further support for the finding that was highlighted early on in the study, in that bullying seems to play a far more significant role in the lives of claims workers and underwriting clerks, than was first anticipated.

The next section pursues the relationship between self-esteem, optimism/pessimism and posttraumatic stress disorder.

5.2.3.2 Self-esteem, optimism/pessimism and posttraumatic stress disorder

The lower scores in terms of self-esteem and optimism/pessimism combined with the very high secondary traumatic stress (STS) scores exhibited by a large portion of the participants, raises another important point. As previously stated under the discussion of trauma, vicarious trauma and posttraumatic stress disorder, high STS scores suggest that the person could be suffering from PTSD. This is so because the items of the ProQOL-RIII Scales that measure STS are formulated around the core traits of PTSD (Stamm, 2003). Falsetti *et al.* (2003), also suggest that the development of PTSD is usually symptomatic of a conflicted belief system that is brought into being by augmented negative information about the self and the world in general.

Similarly, AtHealth (2003) also explains that in addition to the core symptoms, low self-esteem is very commonly coupled with PTSD. A sense of gloom and feelings of a foreshortened future are also associated with PTSD. This indicates the adoption of more pessimistic appraisals of one's life circumstances following trauma (Barlow & Durand, 2001). Even when one revisits the scores of the overall sample, self-esteem and optimism/pessimism levels were very moderate, neither high nor low, and they leaned towards a *neither here nor there,* neutral and unresponsive position. This pattern of neutrality was not only observed in the self-esteem and optimism/pessimism scores, but was also found to be the case with compassion satisfaction and burnout scores. With regards to self-esteem and optimism/pessimism in particular, the participants were neither passionate, excited and in high spirits, nor excessively despondent, unhappy or overly apathetic. One

might think that a nonaligned position is more desirable than an overall negative one. However, this ubiquitous neutrality exhibited by the study groups could quite possibly indicate the onset of emotional detachment and flattened affect. Both these concepts are very closely associated with PTSD, as described by the DSM-IV (Barlow & Durand, 2001).

This unenthusiastic position or propensity towards neutrality could be indicative of disinterest, indifference and a loss of passion rather than a sign of some invulnerability. They do not appraise themselves particularly positively or negatively and also remain quite neutral in terms of their perceived self-worth and esteem. Although this is not indisputable evidence that PTSD might exist within the study groups, it is nonetheless an important point to consider, seeing that some participants did in fact exhibit disquieting levels of secondary traumatic stress. It can therefore be concluded quite reasonably that some individuals might very well be experiencing PTSD. To answer this question more firmly would, however, require more specific screening than was the case with the present study. At this point, drawing conclusions from the information at hand, one can only hypothesize about the possible presence of PTSD.

The next section looks at correlations that were either present or absent for the various study variables in relation to one another.

5.2.4 Relationships between the ProQOL-RIII -; MSE - and MOP Scale variables

A Pearson correlation test was carried out in conclusion of the statistical analyses and in testing the **fifth hypothesis**. The fifth study hypothesis formulated the expectation that there would be an inverse relation between the negative dimensions of vicarious trauma (in terms of burnout, and secondary traumatic stress) and self-esteem as well as optimism/pessimism. Furthermore, it was similarly expected that there would be a positive relation between the positive dimension of vicarious trauma (in terms of compassion satisfaction), self-esteem and optimism. For the large part, this hypothesis was found to be inaccurate with the exception of compassion satisfaction, which correlated significantly with optimism ($p<0.01$) and burnout that correlated significantly with pessimism ($p<0.05$).

In response to the first correlation, it is understandable that there would be a significant positive correlation between compassion satisfaction and optimism. This relationship is quite logical in the sense that, as one is more satisfied with one's working conditions and job demands, the more optimistic one tends to be. The one, in effect, seems to imply the other, in the sense that compassion satisfaction automatically involves a greater sense of optimism and sanguinity. Stamm (2003) confirms that greater levels of compassion satisfaction naturally entails more positive feelings such as drawing pleasure from your work and feeling positively about your colleagues. One would also feel positive about one's capacity to contribute to this work setting and even the greater good of society (Stamm, 2003).

The second correlation that was revealed indicated that there was a significant relationship between optimism/pessimism and burnout whereas there was no correlation between optimism/pessimism and secondary traumatic stress. This result implies that burnout rather than vicarious trauma would cause a person to gravitate towards a more pessimistic outlook (please see *Table 12* for test results). This, however, does not mean that trauma and vicarious trauma would have absolutely no effect on levels of optimism/pessimism. It simply means that burnout had a more significant relationship with optimism/pessimism. Seeing that burnout had such a low incidence compared to secondary traumatic stress, this could account for the overall levels of optimism not being affected more adversely. If burnout had been higher and more prevalent, one might have seen a greater tendency towards pessimism. High levels of secondary traumatic stress coupled with high burnout levels could have served as a double-edged sword to the participant's levels of optimism.

Nevertheless, the negative relationship revealed between burnout and optimism/pessimism is quite logical and expected in the sense that, as burnout and exhaustion increases, one would naturally feel less optimistic, a scenario that is neither surprising nor unforeseen. Similarly, Stamm (2003) has indicated that high levels of burnout are indeed associated with the gradual increase in feelings of despondency and negativity. The negativity referred to in this regard would also include feelings that one's efforts are making no difference, that one is fighting a futile battle and that work life is too demanding and difficult (Stamm, 2003). Here also, the one would imply the other in the sense that work-related fatigue and

exhaustion would naturally involve a greater sense of hopelessness, cynicism and pessimism. Pearlman & McCann (1990) also agrees, as previously pointed out, that those who suffer from work-related exhaustion and burnout, who feel that their efforts are futile, would be especially prone to feeling hopeless, cynical and pessimistic. The work of claims workers and underwriting clerks are of such that there is no end to it, which might instil feelings of futility. Claims workers might feel that, despite their best efforts, no difference is made to the root causes of crime and trauma. No matter how many claims they settle or how many clients they help to recover their losses, accidents, crime and traumatisation continues unabated and unhindered. Underwriting clerks might feel the same because, no matter how many problems they solve and how many difficult clients they appease, tomorrow will bring new problems, more irate clients and more bullying.

Seeing that vicarious trauma is at the core of this study, it was of far greater importance to explore secondary traumatic stress, which served as a measure of trauma and vicarious trauma, in relation to self-esteem as well as optimism/pessimism. It was rather surprising that secondary traumatic stress, in this study, did not correlate significantly with either self-esteem or optimism/pessimism. This finding was quite unexpected, considering that much research evidence has been found that clearly show that trauma and vicarious trauma usually encroach on one's self-esteem as well as induce pessimism (AtHealth, 2003; Barlow & Durand, 2001; Dheer *et al.*, 2003; Mehrabian, 1998; PTSD Alliance, 2003; Sabin-Farrell & Turpin, 2003; Sierra Pacific Network, 2001; Tracy, 2002). With regards to self-esteem in particular, the results of the Pearson correlation test suggested a tendency

or pattern in responses in relation to secondary traumatic stress. Those with higher secondary traumatic stress tended to exhibit lower self-esteem with some consistency, but a significant correlation was nonetheless absent. In the case of optimism/pessimism, the Pearson correlation results were nowhere near the significance level and no pattern or tendency was detected.

This is probably so as the relationship between self-esteem, pessimism/optimism and trauma, is often viewed to be a very complex one, dependent on numerous other factors (Athealth, 2003; Goldenberg, 2002; Jordan, 2001; Tracy, 2002). For instance, AtHealth (2003) sees low self-esteem along with pessimism, depression, withdrawal and loneliness as typical secondary complications of trauma and vicarious trauma. These secondary complications do not necessarily stem directly from the original or primary response to the traumatic event, such as being overwhelmed with fear. It could rather be attributed to various other aspects or events that were featuring in the persons' life prior to the exposure to trauma (AtHealth, 2003). The traumatic event would then intensify whatever experiences or problems preceded the trauma.

For example, if the person was experiencing depression prior to exposure to trauma, the traumatic event would intensify these feelings (AtHealth, 2003). Similarly, if a person tends to respond to hardships by withdrawing from others, this behaviour could escalate significantly after a traumatic event (Athealth, 2003). Therefore, posttraumatic responses and the appearance of secondary complications are varied and, in part, dependent on the individual as well as experiences and

tendencies of the individual that were present prior to the trauma. Likewise, personal styles of the individual such as proneness to avoidance, denial, external locus of control, self-rejection, devaluing oneself and negativity or pessimism, could also influence the type of secondary complications that might emerge (Jordan, 2001). Conversely, personal styles that involve actively facing and integrating experiences would relatively decrease vulnerability towards different secondary complications (Jordan, 2001). Those exposed to trauma, directly or vicariously, would be especially vulnerable in developing seriously reduced self-esteem in cases where self-rejection and self-devaluing were tendencies already present prior to the trauma. Likewise, where pessimism, cynicism and a negative outlook were already present, a traumatic encounter would intensify these tendencies (Athealth, 2003)

Moreover, for some, low self-esteem, pessimism or other secondary problems may only be mild or transitory in nature (Jordan, 2001). Not everyone exposed to trauma develop more severe, lasting symptoms. For instance, more resilient individuals often manage to circumvent negative outcomes or accomplish more positive outcomes despite their significant risk for developing psychopathology (Jordan, 2001). Resilient individuals usually manage well in spite of considerable stressors, and they recover remarkably from exposure to trauma.

Another very important point is raised by Goldenberg (2002) that could further explain why no significant relationship was present. She agrees that the responses to trauma and vicarious trauma are extremely varied. However, Goldenberg (2002) points out that trauma or vicarious trauma could have the

complete opposite effect when it comes to self-esteem and an optimistic/pessimistic outlook on life. Reports have been made whereby trauma and vicarious trauma has resulted in *increased* feelings of self-esteem from comforting and helping those in distress (McCann & Pearlman, 1990). These authors continue in stating that exposure to trauma and vicarious trauma often gives one a clearer and more realistic view of oneself, the world in general and one's role in this world. Helping others often bring depth and meaning to one's life from which higher self-esteem or optimism could emanate. Also, bearing testimony of the hardships and trauma in the lives of others, have been shown to cultivate *higher* levels of optimism in the sense that one often develops a greater appreciation for one's own good fortune, one is more hopeful and has greater positivity towards one's own circumstances (Goldenberg, 2002).

In the case of the present study groups (claims workers and underwriting clerks), they might not be in a helping profession per se, but they could nevertheless be drawing some esteem from their respective roles. Claims workers would typically help a traumatised individual to recover some of what they have lost in terms of property or in a monetary sense. They could quite possibly be deriving an increased sense of satisfaction, fulfilment and pride from helping clients in this way. They might even feel that their role as a worker has some purpose and that their efforts are making a difference in some clients' lives.

Underwriting clerks might have similar experiences, derived from helping clients to eliminate problems that might be causing them much stress and irritation.

They might derive satisfaction and pride from being able to deal effectively with difficult situations and from being able to calm and placate irate, upset clients. It could be quite rewarding to be able to turn angry clients into happy, content individuals. Stamm (2003) confirms that much satisfaction can be derived from helping and assisting those in emotional distress. Although no literature could be found to this effect, it is nonetheless plausible that some clients would express appreciation, gratitude and even relief towards these workers for their efforts and for their assistance and service. It is also very unlikely that all interactions with clients would involve bullying and contagion of trauma and distress. It is quite possible that a situation that starts off with clients expressing either dissatisfaction or trauma, might end in gratitude, appreciation and thankfulness.

As can be gathered from the entire argument developed here, trauma and vicarious trauma do not have a straightforward or predictable effect on self-esteem or levels of optimism and pessimism (Athealth, 2003; Goldenberg, 2002; Jordan, 2001; Linley & Joseph, 2004a; Tracy, 2002). One person might react with distress and despondency to encounters involving trauma and vicarious trauma and might feel burdened by their involvement with traumatised clients (Annschuetz, 1999; Athealth, 2003; Hesse, 2002). The next person might be reacting to the same stressor with a sense of strength, attainment, fulfilment and increased self-esteem for being able to overcome the challenges in their lives and for making a difference in the lives of others (Goldenberg, 2002). Therefore, drawing conclusions from the aforementioned literature, exposure to trauma and vicarious trauma might result in a positive or negative effect on self-esteem. The same could be said of trauma and vicarious

trauma in relation to optimism and pessimism, in that trauma can induce greater optimism but could also bring about more pessimism. Jointly, the propositions discussed thus far clearly explain why correlations between the discussed variables were largely absent.

The next section further expands on a point that was postulated earlier in this section, that is the positive effects of trauma and vicarious trauma.

5.2.5 Positive outcomes of trauma and vicarious trauma

The negative implications and effects of trauma and vicarious trauma have thus far been discussed at some length. The overall scores displayed by the main study samples (claims workers versus underwriting clerks) in general were nevertheless quite moderate and nondescript. However promising these results might be, it is still deserving of careful consideration as there nonetheless are, as indicated by the overall high secondary traumatic stress scores, aspects of these positions that are frightening, traumatising and potentially harmful. The majority of the findings discussed therefore validate that trauma and vicarious trauma occur within the study groups at hand. It also revealed the many negative outcomes that these workers are either displaying or are being at risk of. The findings further indicate, even more so, that vicarious trauma occurs in varying degrees as confirmed by the secondary traumatic stress scores that ranged from low, desirable levels to alarmingly high levels.

At the outset of the study, it was and still is believed that the working environment of insurance workers and claims workers, in particular, have much in common with other groups where evidence of vicarious trauma have been found. These groups are (as previously outlined and justified) jurors, journalists, researchers and legal representatives. As previously stated, the scores expressed by underwriting clerks also indicate that they are equally traumatised and frightened by certain aspects of their work, which was initially not anticipated. It was argued that bullying is a factor that is contributing to elevated secondary traumatic stress scores across both the study groups, and that another variable is present in the case of claims workers. This additional variable is, as discussed on several occasions, exposure to traumatic materials. It is, unfortunately, impossible to say how much of the emotional distress and trauma is a result of vicarious traumatisation and how much can be attributed to bullying.

As pointed out earlier in the discussion, as much as 44% of the entire sample exhibited high and even disturbingly high levels of secondary traumatic stress. However, the remaining 56% exhibited quite the opposite. Despite the ongoing altercations these workers are faced with every day, and having to deal with trauma and traumatic materials, the scores of these participants indicated that they nonetheless derive pleasure, esteem and satisfaction from their respective jobs. The combination of compassion satisfaction, burnout and secondary traumatic stress scores place the majority of these workers, generally speaking, only at a moderate risk of work-related problems.

It can therefore be said that not all outcomes observed are solely negative. Scores on most of the variables were either average or moderate and therefore not reason for concern. However, it was argued earlier that the ubiquitous neutrality exhibited by the study groups might not necessarily be a sign of some invulnerability to trauma and vicarious trauma. It could quite possibly indicate the onset of emotional detachment and flattened affect that are so closely associated with posttraumatic stress disorder (Barlow & Durand, 2001). Conversely, it could also mean that they are not experiencing serious effects from dealing with trauma and bullying.

The average compassion satisfaction scores, for instance, indicate that both groups, despite their problem-laden interactions with clients, still derive some enjoyment and professional contentment from doing this work. The fairly average burnout scores expressed by both claims workers and underwriting clerks, indicate that they still exhibit some positive feelings toward their vocation and that they are, in general, meeting some job demands satisfactorily and effectively. The overall moderate self-esteem scores indicate that both study groups still have some positive regard for themselves and some confidence about their mental and physical abilities (Mehrabian, 1998). These outcomes can collectively be regarded as reasonably positive.

As discussed previously, 33 of the 75 participants expressed disturbingly high secondary traumatic stress scores, but the remaining 42 participants' scores suggest that they are happy, well-adjusted individuals who seem to take pleasure in their

work and derive considerable fulfilment and satisfaction from it. Some authors do in fact point out that much of the accent, however, have been purely on the negative sequelae of trauma and adversity or pathological adjustments (Joseph, *et al*., 1993; Linley & Joseph, 2004b). This inevitably leads to a biased and one-dimensional understanding and expectations around posttraumatic and vicarious trauma reactions.

Looking at the full range, both positive and negative reactions to trauma and adversity, allows one to more fully understand these phenomena. It is also of considerable importance to the study as some individual test scores illustrated no negative outcomes whatsoever. As stated earlier, more than half of the participants were found to be content, fulfilled and secure individuals. Such positive reactions following exposure to trauma or vicarious trauma are not uncommon and are reported quite often (Goldenberg, 2002; Joseph, *et al*., 1993; Linley & Joseph, 2004a; 2004b; Newman & Kaloupek, 2004; Waysman, *et al*., 2001).

The discovery of a previously hidden inner strength, greater closeness and intimacy to loved ones, a better appreciation for life and feeling wiser and more experienced at life, are some of the positive reactions that are frequently reported (Linley & Joseph, 2004a). In addition, McCann and Pearlman (1990) report increased depth and a sense of meaning to one's life derived from working with traumatised individuals. Increased self-esteem, a realisation and appreciation for the contributions one is making within a particular setting is also reported equally often (McCann & Pearlman, 1990). Moreover, the realisation and appreciation of the *importance* of this role one is performing, is another positive consequence reported

by the same authors. McCann and Pearlman (1990) further add that greater commitment and determination to continue with one's endeavours despite challenges and hardships are commonly described. Increased sensitivity, empathy towards others and a sense of hopefulness is derived from seeing human beings exhibit strength and endurance (McCann & Pearlman, 1990). These authors also explain that witnessing others who overcome and transform trauma into something positive, can be very inspiring to those around them (McCann & Pearlman, 1990). Goldenberg (2002) adds that those who deal with traumatised individuals often report a greater appreciation for their own good fortune, stronger self-awareness and a more solid self-identity.

Although claims workers might not be in a helping profession per se, it is not improbable that they might witness similar acts of tenacity, strength and fortitude from clients who have survived horrific events. Accidents, natural disasters, hijackings, armed robberies, and other equally traumatising encounters repeatedly give rise to claims which call clients and claims workers into interaction with one another. Subsequent dealings with clients, who have suffered considerable losses, form an inherent part of these interactions. Being inspired by how these individuals remain hopeful, rational and reasonable, is probably also not an uncommon sight for claims workers.

The far lower levels of secondary traumatic stress expressed by the 42 lowest scoring individuals show that, despite continued exposure to traumatic materials and bullying, positive outcomes are nonetheless reached. Despite the ongoing problem-

laden interactions that are sufficient grounds for vicarious traumatisation and posttraumatic stress disorder to occur, positive effects nonetheless always remain a possibility. When looking at the full range of reactions to trauma and vicarious trauma exhibited by the participants, these aforementioned statements are well supported. There were clearly both positive and negative reactions exhibited by each of the study groups. The majority of participants (56% of the entire sample) indicated no disconcerting negative outcomes. The study, unfortunately, does not offer any clear answers as to why some experience negative effects, whilst others report mainly positive effects from doing the exact same work. At this point it can be argued that vicarious trauma and posttraumatic stress disorder are equally complex phenomena and that there are several buffering affects that have to be considered.

The theories on positive reactions to vicarious trauma offer further more plausible answers to the question raised above. According to the *"organismic valuing theory"* that was previously outlined (Linley & Joseph, 2004a, p. 10), those who have sufficient social support are better equipped to deal more positively with challenges to their assumptive world. They are also more likely to experience psychological growth. To this, Harrison and Kinner (1998) add that there is strong consensus that social support is in fact crucial in reducing negative outcomes, but that *perceived* social support has consistently been found to be a stronger moderator. In addition, Quine (1999) states that a supportive environment has shown to act as a coping strategy or moderator that considerably buffer individuals from the damaging effects or work stressors, which also include bullying.

It could be argued that some claims workers and underwriting clerks might have desirable social support within or even outside of their work environment that might be sustaining them. The influence of adequate social support as well as the conception of perceived support is also clearly visible in the test results. Jordan (2001) adds that resilient individuals usually cope remarkably well with trauma and vicarious trauma, *only* if they have sufficient support. No matter how resilient persons are, they easily become overwhelmed if they lose their supports (Jordan, 2001).

In continuation of the discussion of positive reactions to trauma, Waysman *et al*., (2001) believe that hardiness also has a moderating effect on trauma. In addition to the abovementioned theories on social support and hardiness being inoculating factors, self-esteem has also been put forth as being a protecting factor (Tracy, 2002). Participants in the present study in general exhibited moderate levels of this variable, which could be interpreted in a number of ways. As previously pointed out, these workers might not be experiencing sufficiently high levels of secondary traumatic stress to induce more lowered levels of self-esteem. They might also have possessed higher levels of self-esteem prior to their employment in the various insurance departments. Higher levels, in turn, might have protected them from the full effects of trauma and bullying. Their levels, however, might have been lowered systematically nevertheless due to their exposure being constant and ongoing. The aforesaid arguments could partly explain the less than anticipated impact on these workers in general.

To this one can also add that the stressors or traumatic materials encountered in the short-term insurance industry are probably quite different to that encountered by health - and mental health workers. They might also, quite possibly, be less intense and not as extreme. As the nature and intensity of trauma, vicarious trauma and bullying were not examined per se, it is therefore difficult to state more firmly if and how these stressors are different from those that were encountered and researched in other populations of workers.

Other psychological factors and resources that have been shown to play a role in both adversarial growth and vicarious traumatisation, is indeed the nature of the stressor, as well as cognitive appraisal, socio-demographic variables, social support, personality, cognitive processing and affect (Linley & Joseph, 2004b). Harrison and Kinner (1998) agree with this statement for the large part, but place much greater emphasis on the role of cognitive appraisal of the event on how a person is likely to respond.

Study results by and large confirm the complex nature of vicarious trauma and the intricateness of the reactions to trauma and adversity, as also put forth by the literature on these issues (e.g. Joseph, *et al*., 1993; Linley & Joseph, 2004a; 2004b; Newman & Kaloupek, 2004; Waysman *et al*., 2001). These authors collectively report an impressive array of negative as well as positive responses. They indicate that positive or negative outcomes following trauma and vicarious trauma are dependent on an equally wide array of factors. For the most part it is neither possible to predict whether an outcome would be positive or negative, nor uncomplicated to

explain why a particular outcome has been achieved. Linley and Joseph (2004b) state that both positive and negative changes result from the same, shared common factor of struggling with adversity. However, this shared struggle might douse some individuals in utter despair and distress, whereas others are propelled to a higher level of functioning by it (Linley & Joseph, 2004b).

It is difficult enough to come to terms with the tremendous variedness of negative reactions, let alone bringing an equally varied range of positive reactions into the equation. There is a complex relation between trauma and negative outcomes, the likes of which are dependent on several factors prior to, during and following the traumatic event. Harrison and Kinner (1998, pp. 788-789) refer to these as "*pretrauma -, midtrauma – and posttrauma factors"*. There is an even greater complex relation between trauma and growth that still requires much investigation and improved understanding (Linley & Joseph, 2004b).

In conclusion, the positive outcomes experienced by the majority of participants, could be honed in upon and further promoted. Improved working conditions and expanding on certain existing practices could make a considerable difference in the lives of claims workers and underwriting clerks. Firstly, the lack of support perceived by those with high secondary traumatic stress scores is well worth addressing, as the implications of a lack of support can be quite far-reaching (e.g. Harrison & Kinner, 1998; Linley & Joseph, 2004a; Quine, 1999). This could easily have further contributed to the high secondary traumatic stress exhibited by 44% of the study participants. For instance, those who are experiencing emotional distress

might not be very motivated to seek help and support from colleagues or others, as they might fear being viewed as inefficient workers. They might be feeling that asking for help would be an admission that they are not coping. They might also believe that, revealing their dilemma to their employers could harm their opinion of them, and negatively affect the possibility of upward mobility within the company. In order to hide their incapability to cope with the more trying aspects of their work, they might be further isolating themselves from their colleagues and from possible resources.

An increased, accessible social support structure provided at work could be of great value in reducing the effects of vicarious trauma, and the frightening or traumatising aspects of these positions. As secondary traumatic stress scores for the overall sample were high but not disconcertingly so, not much is needed to reduce the amount expressed by them to a more acceptable and benign level. This support network should, furthermore, be made available openly and without prejudice to all workers. Making use for these resources should be encouraged, applauded and even rewarded and should not have any negative reflection on the worker.

A number of the participating managers did mention that they do have gratis psychological counselling services available to all employees. They, however, stated that their employees are unfortunately not utilising these services adequately. One Human Resource manager in particular, felt that employees often expressed fears that using the counselling service might be a bad reflection on them and their work record. Very often, workers have also indicated to this manager that they did not feel

entirely comfortable and convinced of the confidentiality promised to them. It is very unfortunate that such an invaluable resource, that is already available to all, is being left by the wayside. In cases such as these, all that is required is pursuing possible ways in which these fears and discomforts could be addressed effectively and permanently. Ways in which to encourage employees and applauding them for using this very important resource should therefore enjoy priority.

Secondly, as stated earlier in this discussion, more inoculating factors should be included in the work environment, such as greater support. Other important inoculating factors should be identified, developed and put to work. For instance, during personnel selections, those candidates who naturally exhibited certain inoculating traits more than others should perhaps be higher up on the selection short-list. A more comprehensive, multidimensional personnel selection process should also be developed in order to recruit workers more circumspectly. Foxcroft and Roodt (2001) are avid supporters of such multidimensional selection approaches. They feel that it undoubtedly promotes a better fit between the applicant's characteristics and a particular work position (Foxcroft & Roodt, 2001). Combined with performance appraisals, it becomes a powerful way of ensuring that a person makes more satisfying career-related decisions throughout their working career. Moreover, a person who is placed in a position that they are not equipped to deal with, is a tremendous disservice.

According to Lynott (2005), a work situation where job requirements do not match the capabilities, resources or the needs of the worker, can be particularly

conducive to the elevation of work-related stress. Careful selection becomes crucial, especially in a case where lacking capabilities could result in harm being done to the person. The large portion of claims - and underwriting workers who experienced alarming levels of secondary traumatic stress, is more than sufficient grounds to call for more effectual screening.

In addition, all employees should be developed continuously and growth should be facilitated consistently throughout their working career, in order to address any shortcomings, to strengthen more desirable attributes and to alleviate any trauma and vicarious trauma related problems. This might sound like a very tall order indeed, but continuously having to replace workers who resign, is no easy task either. The current high staff turn-over rates alluded to by the various managers, which were also clearly visible in the architecture of the overall sample, are not mere minor irritations but a reality and a rather serious problem. It could undoubtedly be a more cost-effective, rewarding and beneficial exercise for both employer and employee to rather develop, nurture and protect existing workers than having to constantly recruit and train new employees.

The high staff turnover rates could be further reduced in other ways. Firstly, applicants should be informed more comprehensively about the full nature and challenges of the work. This would allow a person to make a better informed choice. Secondly, better informed individuals coupled with more comprehensive and powerful selection practices could result in placing candidates in positions that are more suitable to their profile and skills. It is perhaps appropriate to state here that,

despite high levels of unemployment in South Africa, neither the employer not the employee stand to benefit from people being placed in work positions that they are ill equipped to manage.

Finally, much can also be learnt from the measures taken by other more harshly affected professions such as health- and mental healthcare professionals. A vast amount of academic information has been accumulated on these workers that other groups stand to benefit a great deal from. Many simple and efficient strategies to combat workplace stress, vicarious trauma and trauma have been developed from these research efforts (e.g. Annschuetz, 1999, Bell *et al.*, 2003; Centre for Healthy Ageing, 2005; Murphy, 1996; Perry, 2003; Reibel *et al.*, 2001). The information is already available and all that is needed is for companies, such as short-term insurers, to merely put these strategies to the test.

In conclusion to the discussion, shortcomings, possible sources of error as well as recommendations for future research will be further expanded upon in the final chapter.

6 SHORTCOMINGS, SOURCES OF ERROR AND RECOMMENDATIONS FOR FUTURE RESEARCH

The present study was mainly exploratory and investigative in nature. It was specifically aimed at establishing whether underwriting clerks and more specifically, claims workers, are at risk of being traumatised directly or vicariously by certain aspects of their work. No literature exclusive to these groups of workers could be found to possibly assist in answering the question posed.

Also, the present study merely began to answer this rather complex query. Much more research is required to fully address the issue of traumatisation and vicarious traumatisation within this population of workers. Before this can be done, the possibility as well as the complete nature of the trauma and vicarious trauma incurred by these particular groups needs further elucidation. To this end, future qualitative research endeavours could be particularly useful. Overall, more academic information, both qualitative and quantitative, is essential in order to begin to understand these two phenomena and precisely how they affect these identified workers.

The present study nonetheless raised several interesting points on a population of workers that is largely unfamiliar in research terms. Again, more research is needed before these can begin to be accepted as facts about these workers. For instance, the issue of bullying was found to be more prevalent and featured more prominently than was initially anticipated. This phenomenon therefore warrants

further investigation in order to capture its full nature and effects more comprehensively. Again, qualitative research efforts could prove to be very useful in this regard.

Furthermore, the intensity of face-to-face traumatisation and emotional contagion as opposed to voice-to-voice transmission also warrants further investigation. A qualitative research approach could again offer much needed information on the nature of and experiences around emotional contagion. The present study suggested that face-to-face encounters with bullies and traumatised clients are generally more damaging. By the same measure it confirmed that voice-to-voice encounters are nevertheless contributing to contagion of trauma and vicarious trauma, however, to a lesser extent. Seeing that the study groups are mutually exposed to both modes of interaction, each posing its risks, more information is needed in order to, firstly measure and then intercept the negative effects of both face-to-face and voice-to-voice emotional contagion.

It would be of great value if one could determine, through future research activities, exactly what measures are being taken throughout the short-term insurance industry to prevent traumatisation and vicarious traumatisation. It would be extremely valuable to establish from short-term insurance companies, which measures have been found to be effective. Upon doing so, these proven measures might then be identified and dispersed more widely to the benefit of others in the industry. As proposed under the previous heading, short-term insurers could also

benefit greatly from a rich diversity of existing strategies and interventions developed and employed by other groups affected by trauma and vicarious trauma.

As mentioned before, the amalgamated scores of these workers generally indicate that they are at moderate risk of developing complications and difficulties. However, preventing traumatisation and vicarious traumatisation from reaching more serious levels by intervening now, would be far less demanding and far more sensible. Searching for curative measures only once the levels of trauma and vicarious trauma are severe is not only perilous to these workers, but also a far more complex and exigent task. Further identifying the exact levels and the prevalence of traumatisation and vicarious traumatisation more precisely could serve as a starting point in order to address these and related problems. This information could also be useful in developing strategies to eventually reduce these associated stresses to more benign levels.

Future research, as well as qualitative research in particular, could contribute to the development of an enhanced and more suitable personnel selection process that could be followed throughout the short-term insurance industry. The development of a more effective, multidimensional selection approach will unfortunately not happen overnight, but might require the investment of several research efforts. The overall elevated secondary traumatic scores suggest that some workers are not equipped to deal with the more traumatising and frightening aspects of their work, which definitely calls for enhanced selection practices.

Moreover, as pointed out previously, improved personnel selection processes coupled with increased social support and an improved working environment, could be very functional. It might even be all that is needed in order to remedy the problems of traumatisation and vicarious trauma in claims workers and underwriting clerks. There is clearly still much that needs to be learnt if one is to fully reveal the nature and effects of trauma and vicarious trauma within this population of workers.

It is believed that the present study was successful in reaching the main aims in the sense that it succeeded in preliminarily exploring the issues of trauma and vicarious trauma. It also revealed the most salient stressors and created an awareness of the possible threats posed by them. The mere fact that these previously overlooked workers have been placed on the forefront and that some awareness has been created concerning their challenging working positions, made the study all the more meaningful. The information generated can now serve as a springboard for further study of their working conditions and the possible emanating risks.

Unfortunately, the study is also flawed and has limitations. Firstly, although the level of participation was encouraging and heartening, a sample of this size (75 participants) is nonetheless, by most standards, small. A much larger sample would have been of greater value and the information yielded by a more generous sample would have been more insightful. Unfortunately, the study coincided with one of the busiest times of the year for short-term insurers. The holiday season was upon us and this usually results in policyholders updating their cover before embarking on holiday trips. The volumes of underwriting requests therefore increase significantly

over this period. In addition, seeing that the study was conducted close to the holidays and festive season, staff were also going on annual leave. The remaining workers had to really pick up the pace to compensate for the fewer workers and in order to cope with the substantial increase in administration and incoming calls.

A larger turnout could quite possibly have resulted from merely conducting the study at a less frenzied time. Many other insurers who declined the invitation to partake did so because of the end of the year rush making it impossible for them to participate. Initially, six companies were identified for participation, however, work pressure and time constraints finally took its toll and only three companies eventually partook.

Secondly, at the outset of the study, it was hoped that interviews and in-depth answers could be utilised as a second tier to the study. Although some very valuable qualitative data was collected simultaneously, time constraints did not allow for qualitative analysis of this information and the qualitative data had to, regrettably, be excluded from the study. This information would have assisted greatly in shedding more in-depth light on the nature of trauma, vicarious trauma and bullying, and worker's experiences around these phenomena. Obtaining qualitative data on claims workers and underwriting clerks on these aforesaid phenomena, would definitely be an avenue worth exploring in future and might prove to be a valuable exercise.

From a methodological point of view, it was disappointing that the study could not reveal precisely to what extent secondary traumatic stress scores could be

attributed to bullying and what portion to traumatic materials. It seems from study results that bullying might be the most salient stressor, but it can not be said with unequivocal certainty.

Also, the measuring instruments that were utilised were chosen for their exceptionally limited length, as testing time had to be restricted as far as possible. The aim was not to occupy too much of the participant's already over-extended time. This proved to be a very useful point which mostly convinced insurers to participate, but using such short instruments had certain drawbacks. As previously stated, longer, more sensitive instruments would definitely have yielded more precise, accurate and clearer information. It is believed that, the more items a scale consists of, the more sufficiently and comprehensively a construct is measured (Foxcroft & Roodt, 2001; Neuman, 1997). However, time was of the essence which forced the use of the chosen instruments. If one could manage a follow-up study with much longer, more sensitive and better suited instruments, data would most certainly be more accurate and conclusions more compelling and decisive.

Also, the questions posed by the scales might have lead participants, prompting a particular response pattern. Although this is a very common occurrence that continuously poses a threat to many research efforts, it could nonetheless distort results. Furthermore, as stated at the outset of the study, none of the scales used were standardised in South Africa. Overall, if this research were to be reworked, it would be better to utilise tried and tested instruments developed for the South

African context instead of having used scales of which the psychometric properties are uncertain.

Also, a very important fact that could have had negative implications was only discovered during the completion of the tests by the last group of participants, when it was already too late to remedy the problem. It became evident that not enough emphasis was made on the matter of confidentiality during the discussion with this group of participants. It was, nonetheless, mentioned that the study would be completely confidential and this point was dwelled upon considerably.

However, it seemed that this point was not stressed strongly enough and that the last group of participants were not completely at ease. Judging by the kinds of questions that were raised by these participants, it suddenly and unexpectedly became clear that participants still felt relatively wary and uneasy. They were not entirely convinced that their employers would not have access to the information. The fact that preceding groups did not utter these concerns does not mean that they did not have them as well. They were only brought to the attention when a brave enough participant finally stood up and specifically raised the issue. Once this happened, agreement and similar concerns were expressed by other participants in the group.

Needless to say, this kind of uneasiness and dubiousness might have had far reaching consequences for the study results. Should this have happened, it would be disappointing as participants were afforded an invaluable opportunity to make their

problems and job challenges known. Should they have chosen to conceal their true feelings, it would have been disappointing and a wasted opportunity on their part.

Unfortunately, these and similar problems are not unique to the present study as it always poses a threat to research in general. Transient conditions that temporarily upset us could quite easily prevent us from performing as well as we normally do (Foxcroft & Roodt, 2001). Similarly, immediate environmental factors can cause distractions, discomfort and demotivation. Considering that, often self-report questions involve the participant's pride, self-esteem and self-image, prestige bias constantly poses a threat and participants might feel tempted to choose answers that would heighten this image (Foxcroft & Roodt, 2001; Rosnow & Rosenthal, 1996). Various other response biases (especially social desirability bias, central tendency bias, acquiescence bias, threat bias and apathy bias) commonly occur and have the ever-present potential of contaminating data (Foxcroft & Roodt, 2001; Neuman, 1997).

As mentioned in the previous chapter, a Human Resource manager stated that employees often expressed fears that opting for counselling might hold a bad reflection on them and their work record. Such fears might also have impacted upon participation. In the face of job scarcities in South Africa, participants might have felt that disclosing deeper levels of trauma might jeopardise their positions.

Next, the supervised onsite data collection activities were far better planned and executed. It seemed clear from the preliminary meetings with the various

managers, that instantaneous onsite data collection procedures would be the preferred method. It was their unanimous feeling that this method would be less disruptive and tedious. Based on what was decided by the first two participating companies, it was assumed that the third participant would follow suit in agreeing to a once-off onsite collection. However, on arrival the third participating company requested that the test packages be left with them for later distribution and collection. There was subsequently no opportunity afforded to negotiate and implement measures that would have resulted in greater participation. For example, at the outset of the study it was thought that leaving a sealed container in a very unobtrusive place would increase the level of comfort in participating.

Considering that no-one, not even colleagues, would have knowledge of who participated and who not, it was thought that this might have a desirable impact on response rates. As the research student was not granted the opportunity of a face-to-face meeting with the Human Resources manager to negotiate the provision of an unobtrusive location for the sealed container, this never came to fruition. Participants now had to hand the forms to a designated manager which might have been a fairly uncomfortable exercise and might have dissuaded others to participate. Another problem that arose from this arrangement was that, although the research student kindly requested that all unused test packages be returned, this unfortunately did not happen. In a case where all participants had to return test packages, used or unused, this action would have obscured who participated and who not and might have been experienced as less uncomfortable.

Although the study hypotheses were not unequivocally confirmed, the study was nevertheless a valuable exercise. It firstly supported existing studies in acknowledging and confirming the potentially deleterious nature of engaging with traumatised clients. It also supports and acknowledges the harmful effects of engaging with those who choose insulting behaviours such as bullying, which is on the increase. Statistical analysis revealed elevated secondary traumatic stress scores, which was the actual measure of trauma and vicarious trauma. As much as 44% of the entire sample presented with disquieting levels of secondary traumatic stress, whereas the remaining 56% of participants, exhibited lower, more benign levels. Other test scores (for compassion satisfaction burnout, self-esteem and optimism/pessimism) were average.

On the one hand, these results were believed to be encouraging. It was possible that the effects of the levels of the trauma and vicarious trauma incurred were not sufficient to have seriously adverse effects. On the other hand, these average, neutral scores might be indicative of emotional detachment, apathy and indifference which are often associated with trauma, vicarious trauma and posttraumatic stress disorder. A two-way ANOVA revealed interesting interaction effects. High levels of burnout were found to be dependent upon group (claims workers and underwriting clerks) as well as mode of interaction (telephonic interaction and face-to-face and telephonic interaction). The same was discovered in terms of high levels of secondary traumatic stress.

In conclusion, it was suggested that, while the impact on underwriting clerks and specifically claims workers is inevitable and unintentional, it can be easily ameliorated by identifying, developing and eventually putting proactive strategies into operation. As explained, improved psychometric screening, developing of a multidimensional assessment approach, improved social support and including more inoculating factors as part of the assessment process, could result in more desirable outcomes for employer and employee. A more proactive stance, involving intervention before secondary traumatic stress levels reach more serious levels, is believed to be a more sensible option. All of the aforesaid, however, can only take place once the phenomena of trauma and vicarious trauma, and how they manifest within the context of the short-term insurance industry, are better understood.

It also requires that the stressors responsible for these phenomena be examined more adequately. This study was the first step of many needed in order to address the unique, challenging and inadvertent, but unfortunate working conditions of these workers. Perhaps also including qualitative data in future studies might shed more valuable and much needed light on the actual nature of trauma and vicarious trauma incurred by these workers. It could also give one a greater understanding of what it is like to deal with traumatised clients within this context, which is so different from that of health - and mental health workers. The precise nature of bullying and the feelings that this phenomenon invokes in the recipient would be very interesting to explore.

Despite the limitations highlighted earlier, the study results nonetheless served to emphasise the complex nature of posttraumatic responses within this particular organisational setting. Mounting research on this and other similar populations of workers could result in the development of greater preventative leverage. Finally, more information on optimal healing processes could be generated for these less obvious, previously overlooked and less clearly affected groups of workers. They are, after all, exposed to trauma and vicarious trauma in providing an important service to many of us, in alleviating our losses and adversities.

7 REFERENCES

Allen, S. (1998). A qualitative analysis of the process, mediating variables and impact of traumatic childbirth. *Journal of Reproductive and Infant Psychology, 16,* 107-131.

Anderson, J. (2004). Vicarious trauma and its impact on advocates, therapists and friends. *Research and Advocacy Digest, 6,* 1-16.

Annschuetz, B. (1999). The high cost of caring…coping with workplace stress. O*ACAS Journal, 43,* 17-21.

AtHealth (2003). *Effects of traumatic experiences.* Retrieved August 06, 2005, from http://www.athealth.com/Consumer/disorders/traumaeffects.html

Barlow, D.H. & Durand, V.M. (2001). *Abnormal psychology: an integrated approach.* (2nd ed.). Belmont: Wadsworth/Thomson Learning.

Barsade, S.G. (2002). The ripple effect: emotional contagion and its influence on group behaviour. *Administrative Science Quarterly,* retrieved November 10, 2005, from http://www.findarticles.com/p/articles/mi_m4035/is_4_47/ai_107762239.

BBC News (2002). World: Africa. *Living in SA's crime capital*, retrieved April 13, 2006, from http://news.bbc.co.uk/1/hi/world/africa/1916969.stm.

Becker, D.F., Daley, M., Gadpaille, W.J. & Green, M. (2003). Trauma and adolescence I: the nature and scope of trauma. *Adolescent Psychiatry*, retrieved May 07, 2005, from http://www.findarticles.com/p/articles/mi_qa3882/is_200301/ai_n9209923.

Bell, H., Kulkarni, S. & Dalton, L. (2003). Organizational prevention of vicarious trauma. *Families in Society, 84,* 463-470.

Bergh, Z.C. & Theron, A.L. (2003). *Psychology in the work context*. (2nd ed.). Cape Town: Oxford University Press Southern Africa.

Centre for Healthy Ageing (2005). Expert non-commercial information on mental health and lifelong wellness. *Emotional and psychological trauma: causes, symptoms, effects and treatment.* Retrieved April 22, 2005, from http://www.helpguide.org/mental/emotional_psychological_trauma.htm.

Damousi, J. (2001). *Living with the aftermath: trauma, nostalgia and grief in post-war Australia*. New York: Cambridge University Press.

Dheer, A., Jaiprakash, L.C., Sharma, H.K., Singh, J. (2003). Evolving medical strategies for low intensity conflicts - a necessity. *MJAFI, 59,* 96-99.

Dohrenwend, B. P. (2000). The role of adversity and stress in psychopathology: some evidence and it's implications for theory and research. *Journal of Health and Social Behavior, 41,* 1-19.

Falsetti, S.A., Resick, P.A. & Davis, J.L. (2003). Changes in religious beliefs following trauma. *Journal of Traumatic Stress, 16,* 391-398.

Figley, C. R. (2001). Compassion fatigue: an introduction. *The Green Cross Foundation,* retrieved November 01, 2005, from http://www.giftfromwithin .org/html/cmpfatig.html

Foxcroft, C. & Roodt, G. (2001). *An introduction to psychological assessment in the South African context.* Cape Town: Oxford University Press.

Gil, T., Calev, A., Greenberg, D., Kugelmass, S & Lerer, B. (1990). Cognitive functioning in post-traumatic stress disorder. *Journal of Traumatic Stress, 3,* 29-45.

Goldenberg, J. (2002). The impact on the interviewer of Holocaust survivor narratives: vicarious traumatization or transformation? *Traumatology, 8,* 215-231.

Harrison, C.A & Kinner, S.A. (1998). Correlates of psychological distress following armed robbery. *Journal of Traumatic Stress, 11,* 787-798.

Hesse, A.R. (2002). Secondary trauma: how working with trauma survivors affects therapists. *Clinical Social Work Journal, 30,* 293-309.

Insweb Learning Center Insurance Glossary (n.d.), retrieved on May 09, 2005, from http://www.insweb.com/learningcenter/glossary/general-a.htm.

Jordan, K. (2001). Working with trauma survivors with PTSD: An overview of assessment, diagnosis, and treatment. *Counseling and Human Development, 9,* 24.51.

Joseph, S., Williams, R., & Yule, W. (1993). Changes in outlook following disaster: The preliminary development of a measure to assess positive and negative responses. *Journal of Traumatic Stress, 6,* 271-279.

Levin, A.P. & Greisberg, S. (2003). *Vicarious trauma in attorneys.* Paper presented at the Second Annual Pace Women's Justice Center Domestic Violence Think Tank, Pace Law School, White Plains, New York.

Lev-Wiesel, R. & Amir, M. (2001). Secondary traumatic stress, psychological distress, sharing of traumatic reminisces and marital quality among spouses

of holocaust child survivors. *Journal of Marital and Family Therapy, 27,* 433-444.

Linley, P.A. & Joseph, S. (2004a). *Positive and negative vicarious reactions to trauma*, retrieved March 25, 2005 from http://www.traumatologyacademy.org/journal/ documents/positiveandnegativevicarions_blind.pdf.

Linley, P.A. & Joseph, S. (2004b). Positive change following trauma and adversity: a review. *Journal of Traumatic Stress, 17,* 11-21.

Lynott, W.J. (2005). Is workplace stress hurting your practice? It could be hurting you even more…. *Podiatry Management*, retrieved March 30, 2005, from http://www.findarticles.com/p/articles/mi_mOLMB/is_1_24.

McCalla, R. & Ezingeard, J.N. (2005). Examining the linkage between technology use, emotional expression and service quality perceptions. *Research-in-progress,* Henley Management College, Greenlands, UK.

McCann, L. & Pearlman, L.A. (1990). Vicarious traumatisation: a framework for understanding the psychological effects of working with victims. *Journal of Traumatic stress, 3,* 131-149.

McFarlane, A.C., Atchison, M., Rafalowicz, E. & Papay, P. (1994). Physical symptoms in post-traumatic stress disorder. *Journal of Psychosomatic Research, 38,* 715-716.

McNally, R.J. (2003). Progress and controversy in the study of posttraumatic stress disorder. *Annual Review of Psychology, 54,* 229-252.

Mehrabian, A. (1998). *Manual for the self-esteem and optimism/pessimism scales.* Retrieved on August 06, 2005 from http://www.kaaj.com/psych/scales/esteem.html.

Murphy, L.R. (1996). Stress management in work settings: A critical review of the health effects. *American Journal of Health Promotions, 11*, 112 - 135.

National Center for State Courts (1998). *Through the eyes of the Juror: a manual for addressing juror stress.* State Justice Institute: NCSC Publication.

Newman, E. & Kaloupek, D.G. (2004). The risks and benefits of participating in trauma-focused research studies, *Journal of Traumatic Stress, 17*, 383-394.

Neuman, W.L. (1997). *Social research methods: qualitative and quantitative approaches. Needham Heights:* Allyn & Bacon.

Perry, D.B. (2003). The cost of caring: secondary traumatic stress and the impact of working with high risk children and families. *The Child Trauma Academy Booklet*, retrieved March 25, 2005, from http://www. childtrauma.org/ctamaterials/secTrma2_03_v2.pdf.

Pyevich, C.M., Newman, E. & Daleiden, E. (2003). The relationship among cognitive schemas, job-related traumatic exposure and posttraumatic stress disorder in journalists. *Journal of Traumatic Stress, 16*, 325-328.

Pieper, M.H. (1999). The privilege of being a therapist: a fresh perspective from intrapsychic humanism on caregiving, intimacy and the development of the professional self. *Families in Society, 80*, 479-487.

PTSD Alliance (2003). *Posttraumatic Stress Disorder Facts Sheet*, retrieved August 06, 2005, from http://www.sidran.org/ptsdfacts.html.

Quine L. (1999). Workplace bullying in NHS community trust: staff questionnaire survey. *BMJ, 318*, 228-232.

Rae Jenkins, S. & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: a validation study. *Journal of Traumatic Stress, 15*, 423-432.

Raynes, B.L. (2001). Predicting difficult employees: the relationship between vocational interests, self-esteem, and problem communication styles. *Applied H.R.M Research, 6,* 33-66.

Reber, A.S. (1985). *The penguin dictionary of psychology.* Harmondsworth: Penguin Books.

Reibel, D.K., Greeson, J.M., Brainard, G.C. & Rosenzweig, S. (2001). Mindfulness-based stress reduction and health-related quality of life in a heterogeneous patient population. *General Hospital Psychiatry, 23*, 183-192.

Rosnow, R.L. & Rosenthal, R. (1996). *Beginning behavioral research: a conceptual primer.* New Jersey: Prentice-Hall.

Sabin-Farrell, R. & Turpin, G. (2003). Vicarious traumatization: implications for the mental health of health workers? *Clinical Psychology Review, 23,* 449-480.

Schützwohl, M. & Maercker, A. (1999). Effects of varying diagnostic criteria for posttraumatic stress disorder are endorsing the concepts of partial PTSD. *Journal of Traumatic Stress, 12*, 155-165.

Schwartz, L.S. (1990). A Biopsychosocial treatment approach to post-traumatic stress disorder. *Journal of Traumatic Stress, 3,* 221-237.

Sexton, L. (1999). Vicarious traumatisation of counsellors and effects on their workplaces. *British Journal of Guidance, 27,* 393-403.

Sierra Pacific Network (2001). *Self-esteem,* retrieved August 06, 2005, from http://mirecc.stanford.edu/content/ptsd/self_esteem.htm.

Stamm, B.H. (1997). Work-related secondary traumatic stress. *PTSD Research Quarterly, 8,* 1-8.

Stamm, B.H. (2003). The professional quality of life scale: compassion satisfaction, burnout and compassion fatigue/secondary trauma scales. *The ProQOL Manual,* retrieved March 27, 2005, from http://www.isu.edu/irh/documents/ proqol/ProQOL_Manual.pdf. Psychometric information on test retrieved from http://www.isu.edu/~bhstamm/tests.htm.

Stamm, B.H., Varra, E.M., Pearlman, L.A & Giller, E. (2002). *The helper's power to heal and to be hurt - or helped - by trying.* Washington, DC: Register Report: A publication of the National Register of Health Service Providers in Psychology.

Steed, L.G. & Downing, R. (1998). Vicarious traumatisation amongst psychologists and professional counsellors working in the field of sexual abuse/assault. *The Australasian Journal of Disaster and Trauma Studies, 2,* retrieved March 26, 2005, from http://www.massey.ac.nz/~trauma/issues/1998-2/steed.htm.

Sue, D., Sue, D. & Sue, S. (1994). *Understanding abnormal behavior*. (4th ed.). Boston: Houghton Mifflin.

Tracy, L. C. (2002). Posttraumatic stress disorder and heavy alcohol use among Chinese Americans: The salience of trauma. *Humanities and Social Sciences, 62,* 25-74.

The Field Foundation (2005). *Stress, injury to health and PTSD: How bullying, harassment and abuse damage health and cause trauma,* retrieved November 15, 2005 from http://www.bullyonline.org/stress/ptsd.htm.

Van der Kolk, B.A., McFarlane, A.C., Weisaeth L. (1996). *Traumatic stress: the effects of overwhelming experience on mind, body, and society*. New York: Guilford Press.

Van Dijk, J.A., Schoutrop, M.J.A. & Spinhoven, P. (2003). Testimony therapy: treatment method for traumatized victims of organized violence. *American Journal of Psychology, 57,* 361-373.

Van Emmerik, A.A., Kamphuis, J.H., Hulsbosch, A.M. & Emmelkamp, P.M.G. (2002). Single session debriefing after psychological trauma: a meta-analysis. *The Lancet, 360,* 766-771.

Varner, J.M. (2004). ASNA independent study activity - compassion fatigue. *Alabama nurse, 3,* retrieved March 25, 2005, from http://www.findarticles .com/p/articles/mi_qa4090/is_200403.

Verbeke, W. (1997). Individual differences in emotional contagion of salespersons: its effects on performance and burnout. *Psychology & Marketing, 14,* 617-637.

Waysman, M., Schwarzwald, J. & Solomon, Z. (2001). Hardiness: an examination of its relationship with positive and negative long term changes following trauma. *Journal of Traumatic Stress, 14,* 531-548.

Worktrauma.org (2005). About workplace bullying, violence and people problems: a resource educational self-help site for managers, academics and victims. *Definitions adopted by the Work Trauma Foundation,* retrieved April 22, 2005, from http://www.worktrauma.org/change/definitions.htm.

Zempetakis, H. (2004). The show must go on. *Australian Graduate School of Management, 3,* 1-3

Zilberman-Ziklik, L. (2004). *Exceeding customer expectations in telephone service.* Unpublished paper, Israel institute of Technology, Israel.

8 BIBLIOGRAPHY

Henning, H.V.G., Gravett, S. & van Rensburg, W. (2002). *Finding your way in academic writing*. Pretoria: Van Schaik.

Mouton, J. (2001). *How to succeed in your master's and doctoral studies.* Pretoria: Van Schaik.

School of Human and Community Development Discipline of Psychology (2005). *Master of arts in psychology by coursework and research report: information booklet 2005.* Johannesburg: University of Witwatersrand.

Smith, M. (1995). *Style Guide for the writing of theses and dissertations.* Johannesburg: University of the Witwatersrand: The Library, 1995, occasional publications no. 13.

9 APPENDICES

Appendix A

DSM-IV CRITERIA: POSTTRAUMATIC STRESS DISORDER

POSTTRAUMATIC STRESS DISORDER

A. The person has been exposed to a traumatic event in which both of the following were present:
   1. The person experienced, witnessed, or was confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of himself /herself or others
   2. The person's response involved intense fear, helplessness, or horror

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
   1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions
   2. Recurrent distressing dreams of the event
   3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated)
   4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
   5. Physiologic reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
   1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma
   2. Efforts to avoid activities, places, or people that arouse recollections of the trauma
   3. Inability to recall an important aspect of the trauma
   4. Markedly diminished interest or participation in significant activities
   5. Feeling of detachment or estrangement from others
   6. Restricted range of affect (e.g., unable to have loving feelings)
   7. Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before trauma), as indicated by two (or more) of the following:
   1. Difficulty falling or staying asleep
   2. Irritability or outburst of anger
   3. Difficulty concentrating
   4. Hypervigilance
   5. Exaggerated startle response

E. Duration of the disturbance (symptoms in B, C, and D) is more than one month.

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

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor

Table 1*: The DSM-IV Criteria for Posttraumatic Stress Disorder (Barlow & Durand, 2001, p. A-6 Appendix A).*

Appendix B

LETTER TO INSURERS

Date 2005

Insurer Name
Human Resources Department
Telefax: (011)

Attention: Name

Dear (Name)

RE: PROPOSED RESEARCH PROJECT

At present I am doing a Masters by Research degree at the University of Witwatersrand, part of which involves a supervised research project.

I proposed research in the short-term insurance industry as it strongly relates to my work background, experiences and interests. The rationale of the study is that there is very little data on claims workers and underwriting clerks and that their experiences are largely unknown and misunderstood. There is also a strong impression that they could be at risk of direct or indirect traumatisation as previous studies conducted with similar groups have indicated this. Many different events are believed to cause emotional trauma and more recent studies have uncovered the very distressing fact that a traumatic event does not even have to be experienced directly for traumatisation to occur. During negotiations these workers are inevitably exposed to the client's trauma or distress. **Employers are not believed to play any active part in this cycle of traumatisation and do not intentionally place their workers at risk.**

It is our aim to culminate a deeper understanding of the working conditions of these workers and we hope to create a platform for the identification of inoculating effects and possible risk factors. This, in turn, might lead to the formulation of practical strategies to shield these workers from the effects of trauma and indirect trauma. **Insurers stand to gain substantially from more effective, healthy and satisfied workers, reduced staff fallout, curbed absenteeism and especially enhanced productivity.** We extend our invitation to you to partake in the forthcoming study. The study will entail that about 10 claims workers, with at least 2 years experience within the industry, complete the ProQOL-RIII Scales (Stamm, 2003), the MSE and MOP Scales (Mehrabian, 1998) on a voluntary basis. The same amount of underwriting clerks with the same level of experience will be asked to complete the scales on a voluntary basis to act as a comparison group. Each participating worker will also be required to complete a very basic biographical form (with reference to age, gender, which department the person is working in, years experience and to identify the most frequent mode of interaction with clients - telephonically, face-to-face or both). Completion of the actual scales should take no more that 30 minutes. An additional 15 minutes will be required for preparations and test instructions. Several major insurers, including yourselves, have been approached for participation.

The ethical standards of the University of the Witwatersrand will be strictly adhered to by which the identity of all participants/insurers will be protected by strict confidentiality and anonymity. All materials will be treated with integrity, respect and responsibility. Participants will be assured that their participation will not have any bearing or pose any risk to their positions at their place of employment. Participating insurers will not run any risk of being singled out, portrayed negatively, or being identified in any way. Amalgamated scores will be used during data analyses to further protect the identity of participants.

Clearly, insurers are not to blame for the unique challenges within their domain of operation and the industry will be portrayed fairly, respectfully and with integrity. Items of the proposed scale have been devised with great care by skilled researchers as to not be harmful, insulting or intrusive. Should

any participant wish to obtain professional counselling, arrangements will be made with the Centre for the Study of Violence and Reconciliation for such counselling. All research data will be destroyed on completion of the project and no identifying information will be used in the final report.

We await your earliest response.

Yours sincerely

Marné Ludick	Dr Daleen Alexander
Research Student	Research Supervisor

Appendix C

SUBJECT INFORMATION SHEET

Dear Claims Worker/Underwriting Clerk,

My name is Marné Ludick and I am a Research Psychology Masters student at the University of Witwatersrand. As part of my degree I am conducting a research study into the typical work related experiences of claims workers compared to that of underwriting clerks and vice versa. The central aim of this study is to capture your perceptions about your work, especially when dealing with clients. The experiences, feelings and thoughts generated by dealings with clients will be looked into intensively to elucidate the nature of the typical day to day encounters and its effects on you as workers.

I wish to invite you to participate in this study. Please note that your participation is voluntary and that non-participation will not have any negative consequences. Should you decide to participate in the study you will be required to complete a Professional Quality of Life Scale consisting of 30 items which will take approximately 15 minutes to answer and a Self-esteem/ Optimism-Pessimism scale, which will take approximately 10 minutes to answer.

Please note that you reserve the right to withdraw from the study at any time or for whatever reason. Questions contained in the scale have been formulated with great care so as not to be harmful, insulting or unnecessarily intrusive. The particulars of a qualified trauma counsellor at the Centre for the Study of Violence and Reconciliation will be made available to all participants, should any of you wish

to seek professional counselling. All information that I will obtain in this study will be treated as strictly confidential. Under no circumstances will anyone other than my research supervisor and I have access to this information. The data collected during the study will be destroyed upon completion of this study. No identifying information will be included in the final report and your anonymity will be assured at all times. Please be aware that your participation will not have any bearing or pose any risk to your position at your place of employment.

Should you choose to participate in this study, please also remember to complete the attached Consent Form. Depending on what is more acceptable to your employer, all the relevant forms and the test scales will either be collected by me personally on a day that will be set aside for their completion or alternatively, arrangements will be made with your employer to install a sealed container in your office for you to deposit the forms in after completion. Through this study I hope to contribute in the culmination of a deeper understanding of the day to day experiences and working conditions of insurance workers and also trust that some awareness will be initiated by placing these experiences on the forefront.

The results of the study will be made available to you at your request. Should you have any queries pertaining to the proposed study, please feel free to contact the researcher (as per contact details stipulated below).

Yours sincerely

Marné Ludick (Researcher)
Cell number 083 575 5932
marne@alug.za.org

Dr Daleen Alexander (Research Supervisor)

Appendix D

INFORMED CONSENT FORM

I (please state your name…….……) have read the Subject Information Sheet about the study entitled *"Direct and indirect exposure to trauma: experiences of claims workers and underwriting clerks in the short-term insurance industry"* to be conducted by Marné Ludick, and I agree to take part in the study on the following conditions:

That my participation is voluntary and that I reserve the right to withdraw from the study at any time.

I may choose not to answer any questions I might feel uncomfortable answering.

I understand that no information that may identify me will be included in the research report and that I will remain anonymous and my responses confidential.

The particulars of a qualified trauma counsellor at the Centre for the Study of Violence and Reconciliation will be made available to me should I wish to seek professional counselling.

……. …….

Signature Date

Appendix E

BIOGRAPHIC DETAILS AND TEST INSTRUCTIONS

Dear Claims Worker/Underwriting Clerk,

PLEASE TAKE NOTE THAT, IN ORDER TO QUALIFY FOR PARTICIPATION, YOU HAVE TO FALL WITHIN THE AGE GROUP OF 21 - 45 YEARS AND NEED TO HAVE AT LEAST 2 YEARS WORKING EXPERIENCE IN THE INSURANCE INDUSTRY.

Please mark the applicable boxes with an "X":

Which department do you work in?: ☐ Underwriting ☐ Claims

Which age group do you belong to?: ☐ 25-30 ☐ 31-35 ☐ 36-40 ☐ 41-45

Please mark the appropriate gender group: ☐ male ☐ female

How many years have you worked in **this** department?: ☐ 2-4yrs ☐ 5-8yrs ☐ 9-12yrs ☐ 13-16yrs ☐ 17+yrs

How do you **mostly** deal with clients?: ☐ Telephonic ☐ Face-to-face ☐ Both telephonic and face-to-face

Test instructions:

Scale 1 (ProQOL-R III): When answering the questions of the first scale, please think of your experiences in terms of helping clients with underwriting queries (in the case of underwriting clerks) or claims queries (in the case of claims workers). When reference is made to "my work as a helper", think in terms of you helping a client within of your position as underwriting clerk or claims worker. When reference is made to "traumatised clients" think specifically in terms of when you are helping a client who has suffered a loss or who had been the victim of an accident/crime and is lodging a claim. If you are an underwriting clerk, you probably do not deal with traumatised clients whereby you could just answer accordingly.

Scale 2 (MSE and MOP Scales): When answering these questions, also think in terms of how you feel about yourself in general and within the context of your work as an underwriting clerk or claims worker.

NB: PLEASE MAKE SURE THAT YOU ANSWER ALL THE QUESTIONS THAT YOU FEEL COMFORTABLE ANSWERING AND THAT YOU DO NOT *ACCIDENTALLY* SKIP ANY QUESTIONS OR LEAVE ANY BLANK SPACES. SHOULD YOU FEEL UNCOMFORTABLE ANSWERING A PARTICULAR QUESTION, PLEASE JUST DRAW A LINE THROUGH IT. REMEMBER THAT THE TEST IS CONFIDENTIAL AND THAT YOUR IDENTITY WILL NOT BE MADE KNOWN IN ANY WAY.

Appendix F

ProQOL - R III

PROFESSIONAL QUALITY OF LIFE

Compassion Satisfaction and Fatigue Subscales - Revision III

Helping others puts you in direct contact with other people's lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative. Consider each of the following questions about you and your current situation. Write the number that honestly shows how often the statement has been true for you in the last 30 days.

0=Never	1=Rarely	2=Few Times	3=Somewhat Often	4=Often	5=Very Often

_____1. I am happy.

_____2. I am preoccupied with more than one person I help.

_____3. I get satisfaction from being able to help people.

_____4. I feel connected to others.

_____5. I jump or am startled by unexpected sounds.

_____6. I have more energy after working with those I help.

_____7. I find it difficult to separate my private life from my life as a helper.

_____8. I am losing sleep over a person I help's traumatic experiences.

_____9. I think that I might have been "infected" by the traumatic stress of those I help.

_____10. I feel trapped by my work as a helper.

_____11. Because of my helping, I feel "on edge" about various things.

_____12. I like my work as a helper.

_____13. I feel depressed as a result of my work as a helper.

_____14. I feel as though I am experiencing the trauma of someone I have helped.

_____15. I have beliefs that sustain me.

_____16. I am pleased with how I am able to keep up with helping techniques and protocols.

_____17. I am the person I always wanted to be.

_____18. My work makes me feel satisfied.

_____19. Because of my work as a helper, I feel exhausted.

_____20. I have happy thoughts about those I help and how I can help them.

_____21. I feel overwhelmed by the amount of work or the size of my caseload I have to deal with.

_____22. I believe I can make a difference through my work.

_____23. I avoid certain activities/situations as they remind me of frightening experiences of people I help.

_____24. I plan to be in this profession for a long time.

_____25. As a result of my work, I have sudden, unwanted frightening thoughts.

_____26. I feel bogged down by the system.

_____27. I have thoughts that I am a "success" as a helper.

_____28. I can't remember important parts of my work with trauma victims.

_____29. I am an unduly sensitive person.

_____30. I am happy that I chose to do this work.

Appendix G

The Mehrabian MSE and MOP Scales

Self-Esteem (MSE) and Optimism-Pessimism (MOP) Scales

Please use the following scale to indicate the degree of your agreement or disagreement with each of the statements below. Record your numerical answer to each of the statements below. Record your numerical answer to each statement in the space provided preceding the statement. Try to describe yourself accurately and in terms of how you are generally (that is, the average of the way you are in most situations -- not the way you are in specific situations or the way you would hope to be).

+4 = very strong agreement
+3 = strong agreement
+2 = moderate agreement
+1 = slight agreement
0 = neither agreement nor disagreement
-1 = slight disagreement
-2 = moderate disagreement
-3 = strong disagreement
-4 = very strong disagreement

MSE SCALE

_____1. I am not shy.

_____2. Others seek my friendship.

_____3. I don't like the way I look.

_____4. I will be a success in my life.

_____5. I am not clever.

_____6. Once I decide to do something difficult, I can do it.

_____7. I wish I were a completely different person.

_____8. I lack confidence.

_____9. There are many things I do well.

_____10. People avoid me.

_____11. I like myself.

MOP SCALE

_____1. I am optimistic about my work career

_____2. I am haunted by bad luck.

_____3. I usually see things in a positive light.

_____4. I avoid disappointment by expecting the worst.

_____5. When things can go wrong for me, they do.

_____6. I believe there is a benefit to be gained from every misfortune.

_____7. I am more optimistic than pessimistic in nature.

_____8. My future looks gloomy.