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ANALYSES OF EXPERIENCES OF VICARIOUS TRAUMATISATION IN SHORT-TERM INSURANCE CLAIMS WORKERS

Marné Ludick

A thesis submitted to the Faculty of Humanities, University of the Witwatersrand, Johannesburg, in fulfilment of the requirements for the degree of Doctor of Philosophy (Psychology).

University of the Witwatersrand, July 2013

DECLARATION

I hereby declare that this thesis is my own, unaided work. It is submitted for the degree of Doctor of Philosophy in Psychology (PhD) at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any other degree or examination at any other university.



_____

Marné Ludick (Mrs)

Date: 22 July 2013

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ABSTRACT

The research entailed a comprehensive study of vicarious trauma in short-term insurance claims workers, compared to trauma counsellors and a control group of holiday booking consultants. A well-known, comprehensive model of compassion fatigue/secondary traumatic stress, developed for therapists formed the basis of the study. The research attempted to determine whether this model can be applied more widely to include administrative populations exposed to traumatised clients on a regular basis. To this end, the model was deconstructed into its eleven constituent parts and each element was investigated in addition to other variables of interest to the study. This was done to determine the importance and applicability of each model element and other selected variables to the administrative context.

A mixed methods approach was utilised, which combined quantitative and qualitative data. The results yielded by the study were collectively utilised to construct an etic and an emic voice from the research. At the same time, effects from vicarious trauma were considered from an overarching bio-psychosocial stance, systematically gauging effects on various levels of functioning. Scores from quantitative measures on secondary traumatic stress, negative cognitive schemas, empathy, social support and compassion satisfaction were statistically analysed, which revealed significant differences between the worker groups. Widely accepted relationships between the study variables were tested and found to hold true within and across groups. Regression analysis determined the roles of empathy, social support and compassion satisfaction in vicarious trauma, as measured by secondary traumatic stress and negative cognitive schemas. In addition, constructivist self-development theory was employed to interpret the negative cognitive effects from vicarious traumatisation.

Qualitative data were utilised to further elucidate the role and nature of vicarious trauma in each of the worker groups. The themes of exposure to client suffering, detachment, level of empathic engagement, personal trauma history and difficult life demands were unearthed from the qualitative data, which illuminated the importance and role of each of these elements to claims workers. Other areas of interest, being utilisation of sick-leave as a means to cope, work-related illness, attitudes towards professional counselling, feelings evoked by traumatised clients, and the language utilised by workers in response to client traumata were investigated. Further effects on participants as well

as effects that reach beyond the person were identified and examined. Effects on the social and work contexts were also elucidated.

Finally, interesting themes that emerged spontaneously from the data were considered. The consideration of the various model elements and other areas of interest systematically revealed that administrative workers dealing with traumatised clients are also affected by the process of vicarious trauma. Furthermore, the model was found to be largely suitable to the context of claims workers. However, the model was expanded to augment its usability within the more general administrative domain. Finally, the overarching aim was to enrich, contextualise and elaborate on the experiences of claims workers within their unique work context, to facilitate insight and a deeper understanding of vicarious trauma in more administrative populations that have largely been overlooked in research.

Keywords:

Trauma; vicarious trauma; Figley's model of compassion fatigue; secondary traumatic stress; compassion fatigue; post-traumatic stress disorder; negative cognitive schemas; empathy; social support; compassion satisfaction; short-term insurance claims workers; trauma counsellors; holiday booking consultants; emotional contagion; call centres; mixed methods research; bio-psychosocial model; constructivist self-development theory.

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"*As we struggle to make sense of things, life looks on in repose*" (Author unknown).

CHAPTER ONE: INTRODUCTION
Overview, Purpose and Explanation

1 Trauma and Vicarious Trauma – A Silent Epidemic

No-one can escape the unpredictable adversities of living. Traumatic events occur indiscriminately across all sectors of the human race (Bedard, Greif & Buckley, 2004). In recent years, the world has witnessed trauma on large scales that claimed lives and caused previously unimaginable losses. The persistent Middle Eastern war as well as seismic and volcanic activities, tsunamis and weather extremes struck across the globe, causing indeterminable trauma.

Each of these mass traumas sparked swells of research and a renewed focus on the effects of traumatic events. In fact, trauma has been at the centre of research interest for more than a decade (Figley, 2003). The term 'trauma' has a dual meaning: It refers to injury at a physical and psychological level, and includes the conception of an external event leading to an inner response (Becker, Daley, Gadpaille & Green, 2003). The physiological and psychological consequences following trauma have been documented extensively (McNally, 2003). With the groundswell in research has also been a heightened need for traumatic stress research from all cultures and societies (Bedard *et al*., 2004). The present and future direction of trauma research suggests an urgent need for continued efforts, increased focus, a multidisciplinary approach and international scope (Schnurr, 2006).

In addition to the natural disasters that have wreaked havoc internationally, there are also life's accidents, crime, violence, abuse, neglect and losses that add to everyday traumas. To reiterate, these are simply harsh and inescapable realities of living and no-one is immune to the effects. In South Africa in particular violent crime is contributing significantly to traumatic stress (Centre for the Study of Violence and Reconciliation [CSVR], 2007). The present high levels of crime and violence have prompted some academics to suggest that South Africa has a culture of violence. Our society seems to view violence as an acceptable means to resolve problems and conflicts as well as to achieve goals (CSVR, 2009; Hamber & Lewis, 1997). Because of this reasoning, violent crime and trauma are at present normative throughout South Africa (Hamber & Lewis, 1997).

Official statistics largely support the belief that South Africa is tremendously violent (CSVR, 2009). According to the South African Police Service (SAPS), 2.1 million cases of serious crime were reported between 2011 and 2012, of which 29.9% involved "*contact crime*" (SAPS Strategic Management, 2012, p. 3). Contact crime refers to the most serious of cases such as murder, attempted murder, sexual offences, assault and armed robbery. In preceding years, spanning 2009 to the present, between 2.1 to 2.2 million serious cases were registered annually, with persistently high levels of contact crimes ranging from 31.9% to 30.8% (SAPS, 2009/2010; SAPS Strategic Management, 2010/2011; SAPS Strategic Management, 2011/2012). These statistics have led to South Africa becoming labelled as the crime capital of the world (Independent Online, 2007). Sadly, over the previous century, South Africa has been distinguished internationally by its high levels of violence and crime (CSVR, 2009).

As unsettling as the official South African crime reports may be, various local authors warn that the SAPS statistics are seriously underestimating the real incidence of violence and crime (CSVR, 2009; Hamber & Lewis, 1997). It has been found that these offences are generally gravely under-reported in South Africa, and that the SAPS statistics more likely reflect the patterns of reporting than the actual incidence of crime (Hamber & Lewis, 1997). To add to the problem of under-reporting, the available statistics are often strongly disputed.

In the wake of the many tribulations of living, we all experience trauma at one time or another. For the past two decades there has been emergent research evidence indicating that a traumatic event need not be experienced *directly* for traumatisation to occur (Hesse, 2002; Sabin-Farrell & Turpin, 2003). One can be traumatised simply by learning about a distressing event (McCann & Pearlman, 1990). Therefore, listening to someone's relaying of an event or being exposed to a traumatised individual can in itself be traumatising. This phenomenon is referred to as indirect, secondary or vicarious trauma.

Typically, following a crime, accident or disaster, a chain of events is set in motion and a whole host of services called into action – for instance, rescue, emergency and law-enforcement services are usually first on the scene. Healthcare workers are called upon next to come to the aid of trauma survivors. Family and friends offer support in the aftermath and some trauma survivors turn to mental healthcare professionals for assistance. These various caregivers each has the potential to experience secondary trauma (Sexton, 1999; Stamm, 1997; Steed & Downing, 1998; Varner, 2004).

The largest part of academic research into vicarious trauma has focussed on groups more obviously associated with its risks (Hesse, 2002; Sabin-Farrell & Turpin, 2003). These include the groups of rescue, emergency, law-enforcement and healthcare professionals outlined in the previous paragraph. Naturally, the vast majority of existing vicarious trauma literature pertains to these same groups. There are, however, groups that are less strongly associated with vicarious trauma, that are often-times overlooked by researchers. Funeral directors, advocates, attorneys and other court workers, including clerks, jurors, interpreters and transcribers, have also been found to be affected (Anderson, 2004; Linley & Joseph, 2004a). Journalists and trauma researchers are further examples (Goldenberg, 2002; Simpson & Boggs, 1999).

Moreover, the high levels of violence in South Africa are now even reaching administrative workers not normally associated with vicarious traumatisation, such as life insurance and short-term insurance claims workers. Concomitant with the high crime rates in South Africa, there has indeed been an increase in expenditure on insurance (Bowman, Seedat & Matzopoulos, 2007). One can argue that the more insurance policies are sold, coupled with the high crime rate, the more claims will be lodged. The more insurance claims, the greater the likelihood that insurance claims workers will encounter traumatised clients.

These different groups of insurance claims workers are in occupational settings, and their exposure to traumatised clients is inadvertent, incidental, and for administrative rather than remedial purposes. The conveying of empathy to trauma survivors is not their primary role, but again incidental to, or a by-product of, their primary job functions. These groups also largely lack training and skills in dealing with the trauma exhibited by clients. Moreover, they mostly do not have access to the same resources generally associated with more obviously affected groups, such as mental healthcare workers, which renders them quite vulnerable.

It is also unlikely that there would be supervision or a dialogue within the insurance industry about the difficulties and negative effects associated with vicarious trauma. These administrative workers have largely been excluded from the conceptual anthology of vicarious trauma reactions. An extensive literature search revealed a dearth of published material on vicarious trauma in administrative workers in general, not to mention short-term insurance claims workers. For these reasons, short-term insurance claims workers were chosen as the focus of the present study to represent those populations of unconsidered administrative workers dealing with traumatised clients.

The phenomenon of vicarious trauma is at the core of the present research. To begin with, direct trauma is incurred by short-term insurance clients. They claim for losses suffered, often following traumatic events. The loss of property due to accidents, theft, robbery, vandalism and natural disasters can indeed be distressing. This is especially so where possessions are lost at the hands of criminals, bearing in mind how violent these encounters often are. Also, with the greater prevalence in violent crime comes the greater frequency of having to deal with severely traumatised clients.

Within the course of their duties, short-term insurance claims workers are inadvertently confronted by the trauma of their clients. Inevitably, they listen to detailed recollections of traumatic events or losses, or bear witness to clients' trauma. More importantly, individuals are particularly at risk of negative outcomes if the trauma they are exposed to is ongoing, as is the case when it is part of everyday work experiences (Jordan, 2001). Inadvertently, a growing number of these claims workers might be vicariously traumatised from having to contend with high levels of trauma from clients on a daily basis. It is this state of affairs that has led to the interest in conducting the proposed research within the current South African context.

2 Central Aims

In the present research a comprehensive examination of vicarious trauma was undertaken in an attempt to assess and demonstrate the wide range of effects on participants. The central aim has been to contribute unique information to the existing body of knowledge on vicarious trauma and to expand the application of the construct into less familiar territory by focusing on a group that is less known in terms of vicarious trauma. For this purpose, a mixed methods research design was utilised.

The primary focus falls on short-term insurance claims workers, in representation of the more overlooked administrative populations exposed to client traumata. Data from the group of claims workers were compared to data from a group more generally associated with vicarious trauma, being trauma counsellors. Trauma counsellors indeed fall within the realm of well-researched groups in relation to vicarious trauma, making them an ideal comparison group. A group of administrative workers, holiday booking consultants, who are not expected to deal with traumatised clients, served as a control group. To control for extraneous variables, all participants, across the three worker groups, were sourced from call centres.

The study attempts to describe the levels of vicarious trauma and to create a complete representation of this phenomenon, including its prevalence, extent and nature specific to each of the worker groups. Searching for significant differences as well as similarities between the groups on each of the study variables was central to the study. Relationships between key variables associated with vicarious trauma, which have been reported consistently, were tested within and across the worker groups to establish whether these widely accepted relationships also hold true for them.

Through analyses of quantitative and qualitative data, it is hoped that the nature of vicarious trauma in claims workers has been adequately captured and illuminated. Of interest also is exactly how these worker groups are affected in relation to one another and this was examined from a bio-psychosocial perspective, which considers effects at the psychological, physiological and social levels of functioning. Secondary traumatic stress and negative cognitive schemas were the two measures utilised to gauge vicarious trauma. The role of perceived social support as well as its impact upon the prevalence and extent of vicarious trauma, was also explored. Levels of empathy were evaluated, also in relation to the vicarious trauma measures, to also establish its impact on the levels of vicarious trauma. Levels of compassion satisfaction were investigated and considered, again in relation to vicarious trauma, to ascertain whether compassion satisfaction has an ameliorative effect on vicarious trauma.

Through all the above-mentioned actions, and by focusing on claims workers, a well-known, comprehensive model depicting the process of vicarious trauma in therapists was looked into. The suitability of this model within the context of administrative workers is argued. Firstly, the model was deconstructed into its constituent parts, after which data, either qualitative, quantitative or both, were collected on each model component and other selected variables. This was done to determine whether these elements are relevant to claims workers and to establish whether the model, intended for therapists, can be applied in a wider context to include administrative populations dealing with traumatised clients. Even though the model was not tested, the study argues its suitability and ways in which the model can be adapted or expanded upon to better fit the context of claims workers. Finally, the overarching aim was to enrich, contextualise and elaborate on the experiences of claims workers within their unique work setting, to facilitate insight and a deeper understanding of the nature and challenges of vicarious trauma within the administrative context.

3 Rationale

Due to urbanisation, increased trade as well as industrial growth, the insurance industry has boomed globally over the past century, including in South Africa (Coetzer & Rothman, 2006). The high crime rate, levels of violence and the current breakdown in social order outlined earlier all make South Africa a leading site for conducting trauma studies. Researching vicarious trauma is equally relevant, not only to South Africa, but also to current international research needs and trends (Bedard *et al*., 2004).

Furthermore, a previous exploratory study undertaken by the author into the trauma-related experiences of claims workers revealed that as much as 43% of the sample expressed disturbing levels of secondary traumatic stress (Ludick, 2006). The magnitude of some of the scores indicated serious levels of vicarious trauma and a need for intervention. Of the sample presented, nine percent exhibited a combination of elevated scores that place them at a particularly high risk of losing their employment, developing depression or even post-traumatic stress disorder. It was believed that these findings warranted further investigation.

Additionally, as stated earlier, the majority of academic studies and literature are focused on healthcare workers and the array of groups mentioned earlier. Even within these diligently researched populations, vicarious trauma findings are mixed and plagued by ambiguity (Elwood Mott, Lohr & Galovski, 2011). For instance, there is a clear paucity of studies that compare different clinicians and healthcare worker groups, not to mention other less obviously associated groups. Moreover, a prominent figure in vicarious trauma studies, Charles R. Figley, has emphasised a tremendous need for further research in more diverse populations, and not to only focus on clinicians (2003).

Figley argues that looking at more diverse groups is crucial as this will promote greater understanding of this ever-mounting, worrying phenomenon. He also suggests that investigating the usefulness of the well-recognised model developed by him, could possibly be a very useful line of research. Both these aforesaid challenges were met, amongst others, by the present research and his model formed a cornerstone of the study. The present research aimed to build on the preceding exploratory study by making intergroup comparisons between claims workers, trauma counsellors and holiday booking consultants in call-centre environments. As indicated earlier, the study also introduced qualitative data to complement and build on the quantitative findings, so as to generate more in-depth information on vicarious trauma within a group relatively unfamiliar in vicarious

trauma research terms.

If the negative results of vicarious trauma are not dealt with timeously and appropriately, they can have serious effects on the worker at the intrapersonal and interpersonal levels (McCann & Pearlman, 1990). However, vicarious trauma is generally viewed to be a completely preventable process (Clemans, 2006). It has been shown that much secondary traumatic stress can be alleviated and prevented if the worker commits to certain activities, such as increasing a sense of work satisfaction, effectively detaching from client traumata and maintaining social contact as well as self-care (Salston & Figley, 2003).

The relevance of this study further extends to the fact that vicarious trauma is inevitably taking a toll on some administrative populations, including claims workers. Their quandary needs to be illuminated and, in time, perhaps addressed. It is important for the industry to take heed of vicarious trauma and the ramifications it might have for workers. It is also important for employers to realise the costs of secondary traumatic stress on their organisations as it continuously erodes the morale of workers, affects their loyalty, attendance, productivity and eventual company profits (Lynott, 2005).

Furthermore, valuable information was gained on vicarious trauma within the call-centre environment, which added further worth to the study. At the outset, it was realised that, even though research information on vicarious trauma is prolific, data on this phenomenon within telephonic set-ups are sparse and this context has also largely been overlooked (Dunkley & Whelan, 2006a). Data on call-centre based trauma counsellors are equally sparse. Even though the group of call-centre trauma counsellors served mainly as a comparison group, the study nonetheless presented data on vicarious trauma in a group of trauma counsellors who are less often considered, but who perform a crucial, invaluable modern-day trauma service.

It is also important for South African studies not to fall short in terms of the latest trends and developments in the international research community. Mixed methods research is a fairly new-found method that has gained in popularity over the years. The rationale for opting for mixed methods research is that this approach has merits of its own. For instance, Barnes (2012) reported a clear dearth of mixed methods studies within the South African context. As little as three percent of the articles published by the *South African Journal of Psychology* between 2005 and 2010 utilised a mixed methods design. Barnes (2012) concluded that these findings express a clear need for more mixed method studies to be performed on home soil in order to further develop this paradigm for

South African use.

Furthermore, utilising the two main research methods side-by-side is believed to offer a creative, eclectic and expansive form of research capable of broadening the understanding of a phenomenon beyond what a single method can accomplish (Johnson & Onwuegbuzie, 2004). Mixed methods research is extolled for holding tremendous promise in the research world, as its techniques more closely resemble what researchers really do in practice (Johnson & Onwuegbuzie, 2004). In the study, the two research methods are used in a complementary way to investigate various aspects of vicarious trauma and related variables in different ways in order to enrich and elaborate understanding. A mixed methods design enabled the expansion of the scope of the study and the existing way of thinking about vicarious trauma, whilst also initiating new lines of enquiry in the field.

Finally, much more academic information, both qualitative and quantitative, is essential in order to understand vicarious trauma and its amelioration – even more so for the many overlooked groups. It might be that vicarious trauma need not only be addressed in the obviously affected groups but perhaps also within the more overlooked industries. Bringing short-term insurers into contact with the rich diversity of existing strategies and interventions employed successfully by other more well-researched groups could hold future benefits for claims workers. Providing a basis from which ameliorating strategies could be developed might not only be advantageous to claims workers, but also other populations that have more in common with them than with the traditionally researched groups.

4 Chapter Outline

The next chapter contextualises and demarcates vicarious trauma by introducing closely associated concepts and punctuating some of the theoretical developments within this field. A host of complexities that influence and inform vicarious trauma research are explored and the chapter concludes with a brief look at the status of vicarious trauma studies in South Africa. *Chapter three* considers the wide-spread effects of vicarious trauma from a bio-psychosocial stance and discusses the difficulties surrounding amelioration. The theoretical framework within which the study is embedded as well as the theory behind the mixed methods approach adopted by the study is outlined by *Chapter four*.

Chapter five delineates the research method, starting with the research design and the steps taken to increase the quality of the research. The research questions that drive the study are presented as

well as the data collection and analysis strategies, concluding with the ethical considerations of the research. *Chapter six* outlines and tabulates the statistical analytical results from the quantitative measures, whereas *chapter seven* focuses on the results yielded by the different levels of content analyses employed, structured around the etic and emic voices. The research results are further developed and discussed in *Chapter eight*, structured around Figley's (2002a) model, other variables of importance and in line with a bio-psychosocial perspective. The thesis is concluded by *Chapter nine* which presents the recommendations, limitations and future research direction gleaned from the study.

*"That which is to give light must endure burning" (*Victor Frankl*,* 1963).

CHAPTER TWO: THE CONCEPT OF VICARIOUS TRAUMA

Contextualising and Demarcating the Phenomenon of Vicarious Trauma

This chapter defines and considers vicarious trauma alongside other closely related concepts. Some of the most prominent theories and most salient historical developments within this domain are highlighted. Other possible correlates of vicarious traumatisation are considered and demarcated for the present study. The ambiguities and complexities surrounding vicarious traumatisation are expounded and the discussion then indicates how the concept is viewed by the present study. The chapter concludes by reviewing some South African studies.

1 Vicarious Trauma and Related Concepts

1.1 Vicarious trauma, secondary traumatic stress, compassion fatigue and burnout.

Vicarious trauma is defined as a cumulative process of continued exposure to traumatic materials and images from traumatised individuals, which results in negatively transformed inner experiences (McCann & Pearlman, 1990). It refers to the damaging changes that occur in how persons view themselves, others, and the world (McCann & Pearlman, 1990). These negative changes in the person's belief system can result in reduced motivation, decreased efficiency and diminished empathy (Baird & Kracen, 2006). Therefore, vicarious trauma holds the potential to affect the person's feelings, relationships and their entire lives (McCann & Pearlman, 1990).

A primary aspect and consequence of vicarious trauma is the amount of stress it causes (McCann & Pearlman, 1990). Optimal stress generates motivation, heightened spirits, alertness, mental acuity and high energy needed for optimum functioning (Craig & Sprang, 2010). In essence, stress refers to a specific relationship between the person and the environment. Craig and Sprang (2010) point out that the levels of stress often become excessive and threaten to overpower the person's efficiency and resources, placing the person's health and psychological well-being in jeopardy. For those persons or professionals dealing with traumatised individuals, these inordinate levels of stress may manifest as secondary traumatic stress (Stamm, 2005a). This phenomenon is especially deleterious when exposure is ongoing (Jordan, 2001; Steed & Downing, 1998). It has the potential to result in serious and persistent emotional and behavioural problems and lasting cognitive changes (McCann & Pearlman, 1990). However, vicarious traumatisation in those exposed to the trauma of

others is completely normal, expected and mostly inevitable (Salston & Figley, 2003).

Key figures writing on vicarious trauma have for many years devoted much time and effort to clarify and understand this phenomenon (Figley, 2003; McCann & Pearlman, 1990; Stamm, 1997). For instance, Figley explained in a recent interview that his interest in vicarious trauma, or what he refers to as the toxicity of dealing with traumatised individuals, dates back as far as the late 1980s (Gould, 2005). When theorising about vicarious trauma, it is important to be cognisant of other closely related terms, such as **secondary traumatic stress, compassion fatigue** and **burnout** (Figley, 2003; McCann & Pearlman, 1990; Stamm, 1997).

It is also important to note that there is considerable overlap between vicarious trauma and these concepts. Due to this overlap, there has been much indecisiveness about their application. Over the years, several authors have attempted to disentangle and clarify them (*e.g*. Elwood *et al*., 2011; Jenkins & Baird, 2002; Linley & Joseph, 2004). Sabin-Farrell and Turpin (2003) conducted a comprehensive review of how the above concepts have been used by researchers over the years. They argue that inconsistencies in the application of the various terms have further intensified their indistinctness.

For instance, the term vicarious trauma focuses on a process of negative cognitive changes (McCann & Pearlman, 1990). Secondary traumatic stress and compassion fatigue focus on emotional responses and symptoms (Sabin-Farrell & Turpin, 2003). Yet these authors listed several vicarious trauma studies where the focus was on symptoms and emotional changes. Likewise, they found secondary traumatic stress and compassion fatigue studies where the main focus centred on negative cognitive changes. To add to the confusion, some authors argue that vicarious trauma, secondary traumatic stress and compassion fatigue are interchangeable, whereas others claim that they are distinctly different (Sabin-Farrell & Turpin, 2003).

These authors eventually posed the frustrated question as to whether we really need another construct – vicarious trauma – to refer to indirect traumatisation, about which evidence is already so clouded and meagre? They fear that we may be demonising normal psychological distress from hearing traumatic stories. However, Elwood *et al*. (2011) concluded that, in the quest to identify and respond to occupational hazards, including those from trauma exposure, it would be irresponsible to disregard these potentially detrimental effects. Instead, they call for more systematic research aimed at examining these various concepts and addressing the current weaknesses.

Bride, Radey and Figley (2007) as well as Elwood *et al*. (2011) add that, in spite of this confusion and overlap between the concepts, there are nonetheless subtle differences in terms of symptom focus and theoretical origin, and that all three terms refer to the harmful negative impact from working with traumatised clients. According to Linley and Joseph (2004), **secondary traumatic stress** originally referred to the emotional duress experienced when dealing with traumatised clients. Figley describes secondary traumatic stress as tension and fixation with the suffering of those being helped, to an extent that it traumatises the helper (Gould, 2005).

Secondary traumatic stress is believed to be a phenomenon almost parallel to post-traumatic stress disorder (Hesse, 2002; McNally, 2003; Sexton, 1999). The difference in the case of secondary traumatic stress is that exposure is indirect, whereas post-traumatic stress disorder results from direct traumatic experiences (Linley & Joseph, 2004). Figley (2003, p.2) summarizes secondary traumatic stress as the *"cost of caring"* from which symptoms similar to post-traumatic stress disorder emanates. Many of the symptoms of secondary traumatic stress mirror the effects that victims experience, such as fear, anger, dissociation, flashbacks, nightmares, and an incapability to trust (Clemans, 2004; Dunkley & Whelan, 2006b). Avoidance of recollections of the event, numbing in affect and functioning, as well as continuous arousal has also been reported (Levin & Greisberg, 2003). Due to these assertions, the development of secondary traumatic stress has centred on post-traumatic stress disorder symptoms, which distinguishes secondary traumatic stress from vicarious trauma and burnout (Elwood *et al*., 2011).

Secondary traumatic stress was later renamed **compassion fatigue**, as the latter term was believed to be less stigmatising (Figley, 2003). However, Sabin-Farrell and Turpin (2003) have cited various studies where secondary traumatic stress and compassion fatigue are referred to as distinctly different phenomena. Figley, who coined the term compassion fatigue, has repeatedly suggested that secondary traumatic stress can be operationalised as compassion fatigue and that they are one and the same (Dunkley & Whelan, 2006b). As a result, these terms are mainly used interchangeably and both are believed to refer to the same emotional and behavioural responses to the trauma of others (Figley, 2003).

To date, both secondary traumatic stress and compassion fatigue have been viewed as phenomena specific to those who deal with traumatised clients (Sabin-Farrell & Turpin, 2003). More recently it has been suggested that secondary traumatic stress can be applied across many diverse populations, whereas compassion fatigue is limited to helping professions, such as healthcare, mental healthcare,

emergency and rescue workers (Elwood *et al*, 2011). The definitions for both these concepts are embedded in the clinical view of post-traumatic stress disorder as expounded by the Diagnostic Statistical Manual of Mental Disorders-IV. For this reason, both definitions are largely symptom-based and the view that secondary traumatic stress or compassion fatigue is similar to post-traumatic stress disorder has been further consolidated.

The final closely related concept is **burnout**. In contrast to secondary traumatic stress or compassion fatigue, burnout is more non-specific. Research suggests that burnout is more a function of factors such as job-related stress, workload and interpersonal conflict with co-workers (Elwood *et al*., 2011). Other factors reported to play a role include role ambiguity, role conflict, control, autonomy, immediate work community, reward, recognition and institutional power dynamics (Moultrie, 2004). Burnout, therefore, is not limited to working with traumatised clients as is the case with secondary traumatic stress or compassion fatigue (Elwood *et al*., 2011). Burnout can be experienced in *any* client-centred profession, especially when working with difficult populations (McCann & Pearlman, 1990). It is believed to be more related to chronic tedium in the workplace rather than exposure to trauma or any other specific types of client problems (Jenkins & Baird, 2003).

The short-term insurance industry, as demarcated by the present study, is indeed a very problem-laden, client-centred industry which makes burnout a term to be aware of. It can be defined as *"a state of physical, emotional and mental exhaustion caused by long-term involvement in emotionally demanding situations"* (Hesse, 2002, p. 297). It is understood as the body's way of responding to continuous occupational exposure to psychologically taxing interpersonal situations (Annschuetz, 1999). This includes dealing with clients who are upset, in emotional pain and having to continuously convey empathy to them. Interpersonal conflict is also believed to be a contributing factor and burnout generally entails the presence of feeling emotionally drained and disconnected from others (Elwood *et al*., 2011).

Elwood *et al*. (2011) also point out that burnout is associated with a decline in feelings of accomplishment which stem from the person's work. Finally, the definition of burnout is also symptom-based, encapsulating feelings of exhaustion, depression, reduced feelings of efficacy and a sense of depersonalisation (Sabin-Farrell & Turpin, 2003). Symptoms reported by McCann and Pearlman (1990) include cynicism, boredom, loss of compassion and discouragement. As can be seen, the concept of burnout clearly overlaps with secondary traumatic stress/compassion fatigue,

but it does not specifically denote the exposure to trauma that is central to the latter two terms (Basedau, 2004).

While secondary traumatic stress, compassion fatigue and burnout are equally important when learning about vicarious trauma, the present study focused on secondary traumatic stress or compassion fatigue. Exploratory research which preceded the present study (Ludick, 2006) revealed that burnout is not of particular concern in short-term insurance claims workers. Despite their considerable workload, the levels of burnout were found to be surprisingly low and only 2.66% of the sample presented with high levels. This was an important finding as the vicarious trauma experienced by short-term insurance claims workers does not seem to centre much upon their workload.

Consequently, burnout was omitted from the present research and secondary traumatic stress or compassion fatigue took centre stage. Bearing in mind that the two terms are interchangeable, secondary traumatic stress is the term and measure of choice for the present study. Seeing that conveying compassion is not the primary function of claims workers, the term compassion fatigue seems less accurate, whereas secondary traumatic stress is believed to be more descriptive of their unique work experiences. The next section covers some of the developments in the field of vicarious trauma.

2 Theoretical Developments

Alongside the development of the concepts outlined above, several academic advancements were made in the field of vicarious trauma, of which some of the most prominent ideas are considered next. For instance, various authors have developed theoretical models which explain the nature and progression of secondary traumatic stress in therapists. In 1995, Figley proposed an etiological model of compassion fatigue (Figley, 2002a). Later in 1995, Dutton and Rubinstein proposed a four-component model for understanding secondary traumatic stress. The four parts of the model relate to the traumatic event which the therapist has been exposed to, the therapist's post-traumatic stress reactions, the therapist's coping strategies, and the personal and environmental factors that mediate the secondary traumatic stress reactions (Sanchez, 2010). This model is presented as an ecological framework for secondary trauma which integrates certain aspects of Figley's model (MacRitchie, 2006). This model, however, focuses more on aspects *relating* to secondary traumatic stress, as opposed to Figley's focus on the *progression and transmission* of compassion fatigue (Figley, 2002a).

Around the same time, Beaton and Murphy proposed a similar model which takes into account organisational factors, including role conflict, size of the organisation and cultural norms (Sanchez, 2010). Their model, however, focuses more on crisis workers (Ortlepp & Friedman, 2001). In addition, they also look at mediating factors such as the therapist's training, social support and experience. Still in 1995, Yassen proposed another ecological model that centres on the prevention of compassion fatigue and incorporates specific suggestions in certain areas of the person's life and the environment (Salston & Figley, 2003). The model provides ways to evaluate the worker's present life, to diminish stress and to add joy.

In 1998, Gentry and Baranowsky were commissioned to devise a model for understanding the multiple causes of compassion fatigue formulated from their Accelerated Treatment Programme, which is a collection of potent techniques and experiences aimed at ameliorating compassion fatigue (Gentry, 2002). More recently, Radey and Figley (2007) introduced a new model conceptualising the pathways to either compassion fatigue or compassion satisfaction, according to which a person would either thrive or dwindle.

In South Africa, the Wits Trauma Model was developed and employed in the early 1990s by Eagle, Friedman and Shumkler for use in urban South Africa (Bean, 2008). Bean explains that this model was birthed from a blend of theoretical approaches, clinical experiences and draws upon clinical feedback. Also within the South African context, Friedman formulated a twin peaks model of secondary traumatic stress (MacRithcie, 2006). Ortlepp and Friedman (2001) later joined forces to propose a model that draws upon the work of Beaton and Murphy, Figley, as well as that of Dutton and Rubinstein mentioned earlier. Ortlepp and Friedman describe their model as "*eclectic*" (2001, p. 38). The models discussed thus far broadly outline some of the developments in the field and is by no means an exhaustive review.

Another prominent development is Figley's long history of the use of psychoanalytic theory of countertransference to aid in the understanding of vicarious trauma (Figley, 2003). It has since been developed into the more contemporary concept of traumatic countertransference. To date, it has been one of the most commonly used explanations for the process of vicarious trauma (Sabin-Farrell & Turpin, 2003). The concept, as with vicarious trauma research and theories in general, centres mainly on therapists and the therapeutic context. Traumatic countertransference focuses on the conscious and unconscious responses elicited in the therapist in reaction to information and traumata from the client (Sabin-Farrell & Turpin, 2003). Traumatic countertransference also

consists of a range of emotional responses, such as identifying with the client's powerlessness, pain, personal vulnerability and rage.

Unless these reactions are understood and contained, they could cause harm to the therapist (Sabin-Farrell & Turpin, 2003). Countertransference also places emphasis on how traumatic experiences can touch on the personal history of the listener, which can result in emotional numbing, over-promotion of non-constructive coping strategies, avoidance behaviours or engaging in identification (Salston & Figley, 2003).

When looking at countertransference in relation to vicarious traumatisation, it is believed that the two processes are different but interactive (Sabin-Farrell & Turpin, 2003). These authors point out that countertransference is more descriptive of experiences within a therapeutic relationship, whereas vicarious trauma refers to the process with its wide array of resultant changes and affects that permeate the therapist or listener's entire life. It is generally believed that this reference point has led to a fuller, more sophisticated understanding of vicarious trauma. Around the same time, Figley (2003) revised his earlier causal model for compassion fatigue into its current form. As this model will play a central part in the proposed study, it will be returned to in the theory section.

Another important advancement in the understanding of vicarious traumatisation entailed the introduction of the theory of emotional contagion (Sabin-Farrell & Turpin, 2003). Emotional contagion is defined as:

> *The tendency to automatically mimic and synchronize expressions, vocalizations, postures and movements with those of another person's and, consequently, to converge emotionally.* (Hatfield, Caccioppo & Rapson, 1993, p. 5)

This theory postulates that a person observing the emotional expressions of others will experience emotions parallel to what the other persons are exhibiting (Sabin-Farrell & Turpin, 2003). These authors have suggested that emotional contagion is linked to the empathic process between therapist and client and is therefore believed to be most relevant to therapeutic relationships. However, emotional contagion theory goes much deeper than this. In a broader sense, it is believed to involve the transmission of emotions, affect, attitude and behaviour from one person, or the initiator, to the other, who is the recipient (Belkin, 2009). This theory postulates that emotions, including distress and trauma, are transmitted from person to person, almost like a contagious virus. Sexton (1999)

suggests that there are powerful unconscious processes that constantly operate in human groupings, including service organisations. Emotional contagion is believed to be an automatic, lightning-fast, continuous, subconscious and primitive process of emotional transference from one person to another.

Barsade (2002) explains that, through human contact, we unconsciously, automatically and spontaneously mimic one another's facial expressions and body language, posture, movement and vocalisations, such as speech patterns and vocal tones. Through this mimicking and posturing, automatic afferent feedback is received from the body (Hatfield *et al*., 1993). One begins to experience the emotion itself brought about by the physiological feedback from the muscular, visceral, and glandular systems (Barsade, 2002). Barsade believes this emotional mimicry to be an innate human trait even observed in day-old infants. One ultimately becomes aware of experiencing the particular emotion, but the initial processes that lead to it are subliminal and involuntary (Barsade, 2002).

Emotional contagion is also possible within a telephonic or electronic set-up (Hatfield *et al*., 1993). Where contact is telephonic, speech patterns and vocal tones that relay emotion are responded to (Barsade, 2002). This phenomenon is known as "v*oice-to-voice*" contagion (McCalla & Ezingeard, 2005, p. 1). Some authors argue that facial feedback is necessary for emotional contagion to occur (Barsade, 2002). However, others have shown that emotional contagion is possible through purely vocal feedback such as patterns of intonation, voice quality, tone, rhythm, and pausing (Hatfield *et al*., 1993). The latter authors conducted research that confirmed the vocal feedback hypothesis. Subjects listened to cassettes containing the distinct sound patterns of various emotions. Their study clearly showed that it is still possible to "catch" the distress of others, even if the contact is telephonic.

Furthermore, general findings on emotional contagion point to negative emotions being more readily transmitted than positive ones (Belkin, 2009). Research reviewed by this author has illustrated that, due to selective memory bias, people tend to pay more attention to negative information. It is hypothesised that there is a universal tendency, based on our innate predispositions and our experience, to give greater weight and attention to negative events and information (Rozin & Royzman, 2001). This negative dominance also extends to learning as well as to our memory systems.

One explanation is that, in the extreme, negative events tend to be more threatening than positive events are beneficial (Rozin & Royzman, 2001). Another viewpoint is that negative events often unfold more rapidly, requiring a swifter response. In view of the predator-threat situation, there is no time for trial and error and things have to happen very quickly for survival (Rozin & Royzman, 2001). For these reasons, negative information seems to command more attention. We also seem to process negative events, information and reinforcements more quickly and deeply and it creates learning that is more resistant to extinction (Rozin & Royzman, 2001). This becomes more evident when considering that there are a greater number of negative emotions and responses than positive ones. Even the language utilised to describe the nature of physical pain is far greater and richer than the vocabulary available to depict pleasure (Rozin & Royzman, 2001). This research further suggests that the cognitive structures dedicated to the processing of negative events and information are more complex, comprehensive and more finely tuned.

The next important advancement in vicarious trauma theory was the formulation of constructivist self-development theory (CSDT). CSDT was developed in the early 1990s by McCann and Pearlman as a comprehensive model for understanding the impact of psychological trauma. Pearlman and Mac Ian (1995) describe CSDT as a unification of contemporary psychoanalytic theories, such as self-psychology and object-relations theory, with social cognition theories as the underpinning developmental framework. The theory was mainly developed for the understanding of direct experiences of trauma and was later extended to include vicarious trauma responses (Pearlman & Mac Ian, 1995). With reference to vicarious trauma, CSDT highlights two main psychological manifestations: transformed cognitive schemas and intrusive trauma. Regarding the latter, the therapist or listener internalises intrusive traumatic memories or images described by traumatised clients (McCann & Pearlman, 1990). These memories or images then repeatedly return as painful or frightening fragments.

These fragments may take on the form of flashbacks, nightmares or intrusive thoughts, comparable to one of the hallmarks of post-traumatic stress disorder (McCann & Pearlman, 1990). These intrusive fragments may be triggered by previously neutral stimuli, which the therapist or listener might have come to associate with the clients' trauma (McCann & Pearlman, 1990). From CSDT, vicarious traumatisation was birthed, a term coined by McCann and Pearlman (Stamm, 1997). This concept came in response to their questioning of the adequacy of countertransference which failed to explain the process and outcomes of indirect trauma exposure. McCann and Pearlman (1990) found the concept of countertransference too narrow and unable to account for the pervasive and

lasting alterations to cognitive schemas. It was at this point in time that they suggested the process be termed vicarious traumatisation, a concept more capable of also contending with the wide array of negative cognitive schemata and behavioural changes in therapists (Stamm, 1997). As CSDT is also central to the proposed research, it will be discussed further under the theory section.

Furthermore, those who are traditionally thought of as at risk are also important to consider. Traditionally, the "*significant others*" of the primary trauma victim, such as family, friends, neighbours or colleagues were believed to be most at risk for vicarious trauma (Ortlepp & Friedman, 2002, p. 213). However, certain professions have been shown to also possess the nature and structures that are conducive to psychological stress (Chan, Lai, Ko & Boey, 2000). The term psychological stress would also include secondary traumatic stress/compassion fatigue, as it is a form of psychological stress that emanates from the work context, in this case, that of trauma work. The field of traumatology has expanded greatly to incorporate these secondary effects and to broaden the view of who is typically affected (Steed & Downing, 1998). As previously indicated, rescue workers, health and mental health workers come to the aid of trauma survivors. Often, attorneys and advocates represent trauma survivors, and journalists as well as trauma researchers report on such incidents.

All of these workers have been shown, to varying degrees, to be at risk for vicarious traumatisation (Anderson, 2004; Annschuetz, 1999). As more studies focus on populations less obviously associated with vicarious trauma, such as the short-term insurance claims workers at the centre of the present study, it is expected that the view of those typically affected will widen even further in time to come. Apart from the concepts discussed thus far, there is also a wide array of concepts that are believed to bear a reciprocal relation to vicarious trauma, referred to as correlates. The next section looks at some of these correlates, focusing on those that were selected for the present research.

3 Correlates of Vicarious Trauma

Correlates of vicarious trauma often referred to are personal trauma history, frequency of exposure or caseload, coping style and level of experience (*e.g*. Baird & Kracen, 2006; Dunkley & Whelan, 2006b; McCann & Pearlman, 1990; Ortlepp & Friedman, 2002; Salston & Figley, 2003; Schauben & Frazier, 1995). The importance of social support has also long been indicated in the prevention or diminution of vicarious trauma outcomes (Figley, 2002a). Empathy is another concept that often appears in literature in relation to vicarious trauma (Figley, 2003). For these reasons, social support

and empathy were earmarked as variables of importance to the present study.

Finally, many positive experiences from ongoing work with traumatised individuals have been reported consistently. Positive growth, spiritual connection and respect for human resiliency and hope are a few affirmative experiences that have been described (Linley & Joseph, 2004; McCann & Pearlman, 1990). In order to give a balanced view of vicarious trauma, the positive aspects from working with traumatised individuals also need to be considered. For this purpose, the positive concept of compassion satisfaction was selected for investigation. After the discussion of the selected correlates, a few others are also briefly considered.

3.1 Empathy and vicarious trauma.

Until the end of the 19th century, empathy was understood to be purely a philosophical aesthetic (Stanford Encyclopaedia of Philosophy, 2008). In 1909 the term empathy was coined by psychologist Edward Titchener, who translated it from the German term "*Einfühlung*" or "*feeling into*", however, it was Theodor Lipps' work that transformed empathy into an important concept in social and human sciences (Stanford Encyclopaedia of Philosophy, 2008, p. 2)

Ashraf (2004), who traced back the historical and theoretical development of the concept of empathy, noticed that Sigmund Freud also adopted the notion of *Einfühlung* in his work. According to Ashraf, Freud comprehended empathy to be one person adopting the producing person's internal state and comparing it to their own internal state and experiences. Ashraf furthermore remarked that Allport believed empathy to stand midway between inference and intuition.

Growing from Lipps' conception, empathy nowadays refers to feeling what another person is experiencing, and the capacity to recognise the emotions of others (Ashraf, 2004). Empathy is also the realisation that we are separate, diverse beings who are tethered to one another by similar experiences and the ability to feel the emotions and needs of others without losing our separate identities (Ashraf, 2004). Empathy is believed to be the very element which promotes pro-social and culturally valued behaviours, such as extending help to others (Ashraf, 2004). For instance, Ashraf points out that empathy is often lacking in highly aggressive individuals, antisocial persons, psychopaths, child molesters and rapists.

The nature of empathy is paradoxical, because it is the person's capacity and desire to empathise that draw them to a helping profession or situation, but it is also the very pathway through which

vicarious traumatisation takes place (Salston & Figley, 2003). Succinctly, it is both the keystone to helping others as well as rendering one susceptible to the *"cost of caring"* (Figley, 2002a p. 1436). It seems that the greater a person's capacity for empathy, the greater the risk of vicarious traumatisation. Stebnicki (2007) explains that in traditional Native American teaching, it is said that every time you reach out to someone, you give away a piece of yourself until, at some point, you require healing yourself. McCann and Pearlman (1990) bring the same point across in stating that repeated empathic connections with clients leave the therapist or helper emotionally impaired and depleted due to an accumulation of traumatic stories they have to contend with emotionally. According to Figley (2002a, p. 1434) empathy is one of the tools that is provided in the *"art of human therapy"*. If empathy is not present, it is unlikely that therapeutic change or help in whatever form will transpire.

It is believed that the degree of help or therapeutic change effected is directly linked to the degree of empathy expressed by the therapist or helping person (Figley, 2002a). Insight into the behaviours, thoughts and feelings of the other person is accomplished by projecting oneself into their position. In doing so, the therapist or helper might experience feelings parallel to those of the other person, such as fear, hurt, anger or emotional tumult (Figley, 2002a). It is in this sense that empathy becomes both a benefit and a cost in a therapeutic relationship. However, this experience of emotional projection is not limited to therapeutic relationships only. Seeing that empathy is an innate human tendency, it would quite likely extend to *any* relationship where individuals emotionally connect – for whatever reason – around a stressful, traumatic, or life-changing event.

Furthermore, empathy is seen as a multidimensional, complex concept that has many definitions (Ashraf, 2004). D'Ambrosio, Olivier, Didon and Besche (2009) point out that, in recent years, some consensus has been reached on the two main dimensions of empathy. The first is cognitive empathy, which relates to the intellectual understanding of what another person is feeling. The second is affective empathy, which refers to the possession of an appropriate emotional response to the attributed mental state of the other person.

Because of the wide use of the concept of empathy across many strata of social and psychological thinking, it has always been somewhat vague, speculative and confusing (Ashraf, 2004). Empathy varies and has different meanings in different branches of psychology and social studies (Ashraf, 2004). Although there is literature on empathy in relation to vicarious trauma and secondary traumatic stress, there is still a significant dearth in research performed on empathy itself

(MacRitchie, 2006). Furthermore, it is a concept central to modern-day psychology as well as Figley's model, which formed a cornerstone in the present study.

Finally, even though the capacity to empathise differs from person to person, it is nonetheless an innate human trait, as mentioned before. Therefore, it is not unrealistic to accept that the claims workers earmarked by the study could similarly connect to their traumatised clients around their traumatic experiences and losses. This, of course, could potentially cause psychological and emotional distress. In fact, at the outset of the study, the importance of empathy in claims workers was somewhat underestimated. The present study investigated the relationship between the level of empathy and the vicarious trauma measures utilised. It was hoped that, looking at this elusive, paradoxical concept might add much needed information to the field of traumatology in clarifying the role of empathy in the process of vicarious traumatisation. The next correlate to be considered is that of social support.

3.2 Social support and vicarious trauma.

Chronister, Johnson and Berven (2006) report that researchers from various disciplines have established a positive relationship between social support and an array of outcomes generally associated with coping, health and well-being. From this work they also report that social support has been established to be negatively correlated to stress, emotional distress and even mortality. There is rising empirical support that social bonds and support appear to be key in post-traumatic growth, recovery and better adjustment (Cook & Bickman, 1990; Flannery, 1990; MacRitchie, 2006; Mirzamani, 2006; Wilson & Boden, 2008). There is substantiation that it offers health protection and that recovery from illness is positively influenced by social support (Sarason *et al.*, 1987). It has long been accepted that social support undoubtedly lessens the effects and severity of secondary traumatic stress symptoms (Basedau, 2004; Hyman, 2004; Figley, 2002a). In a systematic review of literature spanning more than a decade, Michie and Williams (2003) found social support to be one of the key work factors related to poor psychological health and sickness-related absenteeism in a diversity of workers.

As with empathy, social support is innate and biologically programmed (Flannery, 1990). One of many definitions for social support entails the help, comfort and/or information a person receives, verbally or non-verbally, through formal or informal contact with others (Flannery, 1990). It also refers to the existence or availability of people on whom a person can rely and who makes the person feel cared for, loved and valued (Sarason, Levine, Basham & Sarason, 1983). Cohen,

Underwood and Gottlieb (2002) further elaborate that social support also includes social resources that are provided in reality by non-professionals, within the framework of informal helping relationships as well as formal support groups. However, these contacts need to be perceived as both available and helpful to qualify as social supports (Flannery, 1990). Social support available early in life allows a child to develop into a self-reliant person who then also acts as a support to others, and it bolsters one's ability to withstand difficulties and challenges (Sarason *et al*., 1983). The psychopathologies that may emerge later in life are diminished significantly where social support is present from early on (Sarason *et al.*, 1983).

Defining the term social support is no easy feat as there are numerous definitions and conceptualisations of the term, each with their own meaning and implications (Basedau, 2004). To begin with, the concept of social support is viewed to be a complex, multidimensional construct (Cook & Bickman, 1990; Flannery, 1990; Hyman, 2004). In addition, there is a clear lack of consensus that further complicates how social support should be conceptualised (Elklit *et al.*, 2001). To measure a construct as broad, vague and undecided as social support is an even more difficult task. This has been misguiding, complicating and hampering many research efforts, as the term is too vague and too unspecific for research purposes (Chronister *et al*., 2006). Basedau (2004) further suggests that subscribing to any one definition of social support could result in oversimplification of a complex meta-construct.

From the research of Cohen *et al*. (2002) it is reported that there are numerous comprehensive and complex theories and schools of thought that guide and influence the way in which social support is studied. To illustrate, whilst reviewing social support research studies, it was indeed a difficult task to navigate through the literature in search of commonalities and points of agreement. The more studies looked at, the more diversified viewpoints became and the more varied elements and definitions were. Instead of homing in on the accepted fundamentals and nature of social support, it led to an ever-widening body of literature with very few points of intersection. A best effort had to be made, within the limited scope of the present study, to extricate the most outstanding ideas, or simply those that were encountered more often.

Firstly, the way in which social support affects psychological outcomes is one scope of research (Demirtepe-Saygili & Bozo, 2011). Although advancement has been made in accepting and comprehending the potential benefits of social support, research has not yet uncovered the specific processes and mechanisms that underlie these benefits (Chronister *et al*., 2006). This debate

continues and is far from resolved (Basedau, 2004; Demirtepe-Saygili & Bozo, 2011; MacRitchie, 2006). According to Chronister *et al*. (2006) the two most widely accepted models of social support are the main-effect and the stress-buffering models.

Even though the study did not approach social support from any of the following theoretical standpoints, these are nonetheless discussed briefly to highlight some of the developments in social support literature. In the first place, the stress-buffering model proposes that social support moderates the outcomes of stresses on health and adaptability. Hence, stress is viewed to have more negative effects in the absence of social support (Chronister *et al., 2006*). Low levels of social support in themselves are not necessarily stressful, but under circumstances involving trauma or stress, those with higher levels of support will experience less negative outcomes (MacRitchie, 2006).

Conversely, the main-effect model posits that, regardless of stress levels, high levels of support will always bolster health and well-being. Whether a person is under pressure or not, social support is believed to have a generally beneficial effect on wellness as well as emotional and social development (MacRitchie, 2006). It is believed that social support directly promotes health and healthy behaviours, consequently shielding the person from negative effects. In other words, social support has a direct effect on psychological outcome variables, regardless of the person's stress levels (Demirtepe-Saygili & Bozo, 2011).

Chronister *et al*. (2006) conclude that research supports both these models, but that they merely reflect two different, distinct dimensions of social support. They explain that support for the stress-buffering model emerges where subjective evaluation of social support is measured, whereas the main-effect model receives supported where the structural dimensions of social support are measured. The latter entails exploring, for instance, people's connection to their personal networks, the size and frequency of such contacts as well as the characteristics of their social ties (Chronister *et al.*, 2006).

Two further models that have emerged are the support mobilisation and the support deterioration models (Chronister *et al*., 2006). These authors explain that the first proposes that stress is a trigger that initiates the development of a social support system. From this view, individuals are believed to have a tendency to connect with others when they are faced with adversity. The second view, in contrast, emphasises that individuals who are experiencing stress are unlikely to seek out

affiliations, and this in turn generates more negative outcomes (Chronister *et al*., 2006). Upon pondering this point, one could logically and intuitively conclude that these two different courses of action might also be a product of individual differences in personality traits. More extroverted individuals might reach out to others, or mobilise social support more readily. On the other hand, an introverted person might withdraw and become even more introverted during trying times, resulting in social support deterioration. Some researchers do, in fact, propose that the extent of social support mobilisation may very well be related to an individual characteristic; however, they refer to the person's psychological resources (Chronister *et al*., 2006). Basedau (2004) also cited literature that views social support to be regulated by the individual characteristics of willingness to access support.

In conjunction to stress being viewed as a moderator, another viewpoint is that social support interacts with the stressors, and should be seen as a *mediator* in the stressor-strain relationship (Demirtepe-Saygili & Bozo, 2011). However, another source of confusion is the imprecise use of the terms mediator and moderator as though they are interchangeable (*e.g*. Murphy, 1988). The pedagogy of the article by Baron and Kenny (1986) emphasised the importance of respecting the distinction between the two terms and to highlight the theoretical implications of the moderator-mediator distinction.

They argue that both terms are firmly based in statistics, each having very specific definitions and equally specific statistics that best represent each. Again, both the moderator and mediator hypotheses are clearly supported by research. There is ample research evidence in favour of the view that social support is a moderator (*e.g*. Kirmeyer & Dougherty, 1988; Cook & Bickman, 1990). Others offer support in terms of social support being a mediator (*e.g*. Andrews, Brewin, & Rose, 2003; Joseph *et al*., 1993). Olstad, Sexton and Søgaard (2001) concluded that empirical research on which of the two approaches is most correct has been inconclusive. Clarification is again hampered by the lack of conformity on how to define and measure the various concepts concerned.

It is important to mention here that the purpose of the present study is not to further develop any of the debates outlined here or to attempt to resolve any of the highlighted issues. These different approaches and perspectives were merely flagged as ongoing points of controversy and the most salient debates in social support research. As stated before, social support was not approached from any of the standpoints outlined here and the study merely sought to establish whether social support

is important to claims workers in relation to vicarious trauma.

Finally, on top of the various debates outlined here, it is also important to differentiate between received and perceived social support (Chronister *et al*., 2006). Sarason *et al*. (1987) suggest that it is in general more useful to measure perceived social support as this term has been found to be more related to psychological health than actual support. Demirtepe-Saygili and Bozo (2011) add that the appraisal of the support is actually more critical than the enacted support itself. Dalgleish, Joseph, Thrasher, Tranah and Yule (1996) differ on this point and propose that it is more helpful to study received support following trauma.

Measures of perceived and received support have been found to correlate weakly, signifying that received and perceived support are actually separate and dissimilar constructs (Basedau, 2004). Basedau concluded, after an extensive literature review, that the majority of research studies suggest that the perception of being supported is more important in psychological well-being than the magnitude of actual support received. In line with this finding, the present study opted for measuring perceived social support, therefore an instrument was selected that also offers some insight into the structural composition and size of support networks.

Despite the conceptual confusion about social support, the study nonetheless demarcated this variable to form part of the study. The persisting uncertainty and indecision surrounding social support studies clearly indicate a need for continued research in this area. When it comes to preventing and treating secondary traumatic stress, assessing and enhancing social support are important exercises (Figley, 2002a). Figley also strongly urges that it is imperative to enlarge the helping person's support system – not only in numbers but also in diversity of relationships to draw support from. On the other hand, Figley (2002a) warns that some relationships may be a source of tension and distress, thus it would also be necessary for the helping person to regularly re-evaluate and winnow out any toxic relationships.

In conclusion, the claims workers investigated by the present study are inadvertently in a helping role as they continuously assist clients in crisis and emergency situations. As stated before, it was assumed, though circumspectly, that the trauma counsellor participants might be better equipped to deal with vicarious traumatisation compared to the claims workers. Trauma counsellors have extensive training, superior insight into the hazards of trauma work and usually have supervision, work-based support and other helpful resources. It is believed that they might be in a less

compromised position at intrapersonal, interpersonal and social levels compared to claims workers. However, claims workers might appear to be coping well at a given moment, as with any other group serving traumatised clients, but might be teetering on the brink of becoming overwhelmed, in the face of additional pressures or a diminution in their support systems (Jordan 2001). The next section will look at a more positive construct associated with vicarious traumatisation, being compassion satisfaction.

3.3 Compassion satisfaction and vicarious trauma.

Compassion satisfaction refers to the pleasure one derives from performing a chosen job well (Stamm, 2005a). It also relates to the experience of helping others to be a pleasurable one. Furthermore, it includes mainly positive feelings toward one's colleagues and a sense that one is able to contribute to the work-setting or even to the *"greater good of society"* (Stamm, 2005a, p.5). Higher levels of compassion satisfaction signify a greater contentment related to one's ability to be an effective helper. Figley (2002a) similarly surmises that a sense of satisfaction with one's help or service is believed to alleviate secondary traumatic stress. Compared to vicarious trauma and secondary traumatic stress, compassion satisfaction is a more recently developed construct (Smit, 2006). Therefore, literature on this concept is rather scant. Compassion satisfaction has also been consistently excluded from trauma research (Craig & Sprang, 2010).

Moreover, the concept of vicarious trauma has long been criticised for focusing mainly on the negative aspects of helping traumatised persons (Collins & Long, 2009; Linley & Joseph, 2004; Steed & Downing, 1998). On the contrary, a number of research studies have revealed that some individuals report positive impacts upon their lives from doing trauma work (Goldenberg, 2002; McCann & Pearlman, 1990). This line of thought gave rise to the concept of salutogenesis which focuses on the array of factors that seem to sustain human health and well-being, even in the face of adversity and omnipresent stressors (Hlengani, 2006). Linley and Joseph (2004) refer to the phenomenon of positive adaptation to trauma and adversity as post-traumatic growth. Similarly, they refer to the growth following vicarious trauma as vicarious post-traumatic growth.

Steed and Downing (1998) examined how therapists were affected by their constant exposure to sexual assault/abuse survivors. They reported that many of the counsellors experienced positive changes in their self-identity, as well as their beliefs about the self and others. Despite the ongoing problem-laden interactions described by these studies that are sufficient grounds for vicarious traumatisation, there are nonetheless well adjusted, happy individuals who derive pleasure, esteem

and satisfaction from doing trauma work. It is important to recognise that not everyone exposed to trauma will experience a purely negative outcome and that positive reactions are anything but uncommon (Goldenberg, 2002; Joseph *et al*., 1993). In this same vein, McCann and Pearlman (1990) state that it is their firm belief that all therapists exposed to trauma survivors will experience lasting cognitive changes. They add that whether these changes are helpful or destructive will largely depend on whether the person can transform and integrate the many frightening testimonies from clients.

From their work, Steed and Downing agree that there is far less emphasis on the positive sequelae which can lead to a limited view of vicarious trauma. It has been suggested that only being cognisant of both the positive and negative effects of dealing with traumatised clients would bring about a comprehensive and holistic view of trauma work (Collins & Long, 2003).

Figley's model utilised in the study, acknowledges the importance of a sense of satisfaction as a protective factor against negative outcomes (Figley, 2002a). Stamm (2002, p. 109) suggests that it has become clear that, in order to understand the negative "*costs of caring*", it is necessary to also recognise the "*positive payments*" from care-giving. Stamm further states that this notion became even more apparent during her important work as a consultant in South Africa. She found that, amidst instability and violence in KwaZulu-Natal, counsellors and caregivers more often celebrated hope rather than retreating into anhedonia. Moreover, she reported psychometric problems which arose from presenting only negative questions. She explains that a negative, symptom-focused format could create a response bias in that negative reporting is artificially inflated. Positive questions became more and more warranted as those trauma workers who were faring well psychologically, were disconcerted by the wide array of negative questions that were not representative of their experiences (Stamm, 2002).

Furthermore, one of the most intriguing questions raised by Stamm's work is whether a person could be experiencing secondary traumatic stress or compassion fatigue and still experience high levels of compassion satisfaction. This was found to be both possible and common and, at present, the hypothesis indicates that there is usually a balance between the two. However, Stamm (2002) noted from her extensive work in various humanitarian settings that, even those believed to be suffering from compassion fatigue nonetheless often continue to enjoy their work because they feel that they are helping and making a difference. Their belief in doing the "*right thing*" sustains them and continues to propel them forward (Stamm, 2002, p. 113).

It has also been indicated that, in situations where the belief system is well maintained with positive material, a person's resiliency is enhanced (Figley, 2002a). Without the positive effects, such as a sense of satisfaction, one could easily have no energy left to sustain the vision of a benevolent world from which one could derive hope and satisfaction (Stamm, 2002). These statements emphasise the importance of positive energy as a protecting factor and also calls for more research in this under-explored area. Next, the ambiguities that plague vicarious trauma studies are considered next as well as how this phenomenon is viewed by the present research.

4 The Complexity of Vicarious Trauma Correlate Relationships

Thus far, some of the controversies surrounding the relationship between vicarious trauma and certain correlates have been highlighted. As indicated before, these relationships can often be paradoxical. It was explained how social support can alleviate as well as cause considerable distress (Figley, 2002a). The conclusion reached after an extensive review of social support and vicarious trauma literature is that the benefits of social support vary from population to population. It was also explained earlier how empathy can both heal and hurt (Figley, 2002). Ortlepp and Friedman (2002) conclude that there is neither consistency regarding the understanding of the impact of these relationships, nor the direction of such relationships. As stated before, the cursory practice of researching and writing about vicarious trauma and secondary traumatic stress as though they are one and the same has added to the lack of clarity (Baird & Kracen, 2006).

Before one can even start to theorise about the role of correlates, it is crucial to draw a clear theoretical distinction between vicarious trauma and secondary traumatic stress. Baird and Kracen (2006) can attest to the travails of performing this seemingly easy task. Their attempt to do so was soon thwarted by the vicious cycle of inconsistencies and lack of clarity. Another problem is that vicarious trauma is a relatively new concept that has not been researched for a particularly long period of time (Baird & Kracen, 2006). Literature offers conjectures about the damaging effects of vicarious traumatisation and possible ways of overcoming them, but empirical studies investigating the consequences of vicarious trauma are few (Dunkley & Whelan, 2006b).

As stated earlier, several authors have made reference to the role of personal trauma history in the development of vicarious traumatisation (*e.g*. McCann & Pearlman, 1990; Salston & Figley, 2003). However, research findings on this relationship are varied and inconsistent. Some studies demonstrate a clear relationship, whereas others do not. For instance, Pearlman and Mac Ian (1995) found that therapists with a personal trauma history showed greater prevalence of negative

cognitive schemas compared to those without such a history. In contrast, Schauben and Frazier (1995) failed to find a link between symptomatology and personal trauma history in their study. Some authors have even suggested that personal trauma history may be an advantage to therapists (MacRithcie, 2006; Schauben & Frazier, 1995). They propose that it can enable the helper to identify with or relate to the problems experienced by clients. They also believe that helpers are often in a better position to understand client responses and even model healing to trauma survivors. Some authors suggest that personal trauma history does not necessarily impact upon vicarious trauma outcomes, but that the extent to which the therapist has resolved his/her own traumas is the deciding factor (MacRitchie, 2006).

Another correlate that has enjoyed much attention is that of case-load. Case-load refers to the frequency of exposure to traumatised clients, including time spent with such clients or cumulative exposure to traumatic materials. For instance, Baird and Kracen (2006) found that higher ratios of trauma exposure significantly increased the probability of secondary traumatic stress. They also reported a relatively weak association between frequency of trauma exposure and vicarious trauma. This again verifies the notion that secondary traumatic stress and vicarious trauma are two separate constructs with different correlates.

Furthermore, Schauben and Frazier (1995) found that therapists who assisted higher volumes of trauma clients reported more disturbances in their belief systems, a greater number of post-traumatic stress symptoms, and a higher prevalence in vicarious trauma responses. However, Levin and Greisberg's (2003) study involving attorneys compared to a group of mental healthcare workers demonstrated the opposite. Despite having fewer cases involving trauma, the attorneys consistently exhibited a higher prevalence in negative effects associated with vicarious traumatisation. They attributed their findings more to lack of support and supervision than to case-load.

Furthermore, Pearlman and Mac Ian (1995) have also long alluded to a relationship between the level of experience in therapists and vicarious trauma. They suggest that newer, more inexperienced therapists reported the most negative effects. Steed and Downing's study (1998) also supported this notion. Sexton (1999) likewise made reference to several research studies that found neophyte therapists to be particularly vulnerable. Several authors have found that experienced trauma workers indeed showed less disrupted cognitive schemas and presented with significantly less trauma-related distress. (Pearlman & Mac Ian, 1995; Steed & Downing, 1998). This seems to suggest that level of experience indeed has an inoculating effect. However, this association is far

from simple. Experience comes with time, but effects resulting from repeated exposure to trauma also accumulate over time. The very definition of vicarious trauma portrays it as a cumulative process of continued exposure (McCann & Pearlman, 1990). Seeing that experience over time coincides with a greater level of exposure to trauma, it would probably also be very difficult to extricate the effects contributed by each.

Finally, there is also the conundrum that compassion satisfaction and other positive effects alluded to earlier are often reported from performing trauma work, even when all the conditions conducive to vicarious traumatisation have been met. It has perplexed many researchers as to why not all individuals continuously exposed to client traumata experience negative effects? Moreover, positive outcomes are anything but rare (Goldenberg, 2002; Linley & Joseph, 2004; Stamm, 2002; Steed & Downing, 1998).

As stated before, the persistent lack of clarity regarding these relationships clearly indicates that research in these areas is both important and necessary. Baird and Kracen (2006) conclude how imperative studies of vicarious trauma outcomes and correlates are as they have the power to highlight critical incidents or landmarks for the progression of vicarious trauma. The next section looks more closely at vicarious trauma and the conception of this construct in the present study.

5 Vicarious Trauma: Consequence or Process?

The reigning uncertainty and vagueness in the field of vicarious trauma was touched upon a number of times. Much attention was afforded to highlighting the ambiguities that persist about some of the concepts and correlates associated with vicarious trauma. However, the same consideration should be afforded to vicarious traumatisation, a term central to the present study. This chapter commenced with the introduction, definition and historic development of vicarious trauma. However, vicarious trauma is steeped in its own vagueness, ambiguities and complexities that are yet to be resolved. Naturally, before one can start researching a phenomenon, it has to be understood and considered critically.

It has to be mentioned here that continued research efforts from dedicated, sagacious researchers across the globe have greatly enriched the field of vicarious trauma. However, alongside these invaluable endeavours came a litany of inconsistencies that hinder the conceptual clarity required for uniform theory building and research (Baird & Kracen, 2006; Figley, 2003; Kadambi & Ennis, 2004). As pointed out before, vicarious trauma has been clouded by indecisiveness since its

introduction over two decades ago (Dunkley & Whelan, 2006b).

From literature in this area, there seems to be confusion about what exactly vicarious trauma is. Some view vicarious trauma, as in the case of secondary traumatic stress/compassion fatigue and post-traumatic stress disorder, as a product, outcome or reaction to dealing with traumatised clients (Dunkley & Whelan, 2006b; Jenkins and Baird, 2002; Sabin-Farrell & Turpin, 2003; Schauben & Frazier, 1995). Others maintain that it is a process (Baird & Kracen, 2006; Clemans, 2006; Kadambi & Ennis, 2004; McCann & Pearlman, 1990). In line with this thinking, Adams, Figley and Boscarino perceive vicarious trauma to be a process, while symptom-based outcomes including secondary traumatic stress or compassion fatigue are *"types of vicarious trauma*" (2008, p. 104).

McCann and Pearlman are credited for first coining the term vicarious traumatisation (*e.g*. Kadambi & Ennis, 2004; Sabin-Farrell & Turpin, 2003). It is therefore important to revisit their definition and intended use of the term. McCann and Pearlman (1990) specifically view vicarious trauma as a framework for understanding the wide array of reactions that stem from dealing with the trauma of others. They also explicitly refer to it as a "*process*" (McCann & Pearlman, 1990, p.133). Despite the confusion and controversy that has since crept into the arena, this description still proves to be the most useful. Viewing vicarious trauma as a product or outcome, seriously takes away from the concept and dramatically narrows its usefulness.

Understanding vicarious trauma as a framework allows the concept to be applied relatively widely, and makes it a very usable, tensile and accommodative term. Firstly, the concept of a framework implies a complex entity or process to be at play. It also implies the presence of several underlying structures or components that collectively contribute to its progression and understanding. McCann and Pearlman (1990) indeed often describe vicarious trauma as a complex process with several closely related concepts and outcomes.

McCann and Pearlman's definition makes provision for a whole host of outcomes. Cognitive schemas are challenged, negatively transformed or even shattered and the person's frame of reference and memory system can become disrupted. Within this framework, they also describe post-traumatic stress disorder-like symptoms that can emerge. Linking vicarious trauma to a set of symptoms is probably what led to it being understood as another symptom-based outcome or product of trauma exposure, such as secondary traumatic stress and post-traumatic stress disorder. However, as stated earlier, framing vicarious trauma as another symptom-based product seriously

detracts from its full meaning and use.

Adopting McCann and Pearlman's intended use of the term also goes beyond what has been outlined thus far. The concept of vicarious trauma integrates both internal and external influences and views the individual holistically (McCann & Pearlman, 1990). It also suggests effects on various levels of functioning, almost similar to a bio-psychosocial perspective. Although cognitive changes are the primary point of focus, behavioural consequences with interpersonal and social implications are also implied. Although sets of behavioural changes are not explicated *per se*, negative cognitive schemas hold behavioural implications.

It even suggests social implications as the affected person does not exist in a vacuum. The internal changes do not only transform how the person views and experiences the world and others, but also how the person interacts with others within this world. McCann and Pearlman (1990) sporadically interpret what behaviours are likely to emerge from negative cognitive schemas in certain needs areas. They also often describe how these behaviours typically impact on others in the affected person's life, as well as in the social domain of functioning. Therefore, vicarious trauma is a frame housing certain mechanisms which effectuates a process of internal changes accompanied by symptoms, behavioural changes as well as interpersonal and social implications.

As pointed out before, a point of criticism is that the concept of vicarious trauma is focused mainly on the negative outcomes associated with helping traumatised individuals (Collins & Long, 2009; Linley & Joseph, 2004; Steed & Downing, 1998). Positive experiences often reported do not share nearly the same amount of attention as the negative sequelae. Similarly, Collins and Long (2003) view the current conceptualisation of vicarious traumatisation to be an inadequate framework for understanding the full range of effects. However, the present study maintains that viewing vicarious trauma in the way it was intended – as a process and framework – allows it to account for any and all effects. McCann and Pearlman's conception even makes allowance for positive effects.

For instance, McCann and Pearlman (1990) state that the absence or presence of negative outcomes largely depends upon the level to which painful traumata accumulated from clients are addressed and resolved. These authors add that it also depends on the extent to which client traumata are synthesised and made sense of. Even though they do not specify any positive outcomes as such, their conception of vicarious trauma acknowledges that positive, symptom-free outcomes are possible, most often when client traumata are worked through correctly and timeously. Sabin-

Farrell and Turpin (2002) have added to the criticism by stating that vicarious traumatisation demonises a natural human response. However, McCann and Pearlman (1990) have consistently presented vicarious trauma to be a normal, predictable, unavoidable process set in motion by continued exposure to traumatic materials. Their conception has therefore even attempted to normalise vicarious trauma and to diminish any stigma attached to it.

For the various reasons expounded above, the intended definition and formulation of vicarious trauma as a complex process and framework is adopted as it is the most tensile and inclusive view available to the study. Secondary traumatic stress and negative cognitive schemas are the two measurable products or outcomes of this process examined by the present research. Also, the study attempted to be cognisant of the debates outlined thus far and attempts to address some of the caveats expressed by other researchers. For one, it has moved away from the groups traditionally favoured by vicarious trauma researchers by focusing on a group that is quite unfamiliar in vicarious trauma terms. It also looks at compassion satisfaction, a more optimistic aspect of working with trauma survivors, and is cognisant of any positive outcomes described by participants. Therefore, the negative effects associated with vicarious trauma are not the only focus of the study and it is hoped that the inclusion of positive experiences will offer a more balanced view. Next, research on South African soil is looked at.

6 South African Studies

The majority of research studies performed in South Africa are mostly relevant to and reflective of our social issues. For instance, various researchers have looked at post-traumatic stress in general (*e.g*. van Rooyen & Nqweni, 2012). Others have focused on post-traumatic stress in HIV sufferers in particular (*e.g*. Martin, 2008; Olley, Zeier, Seedat & Stein, 2005; Young, 2011). In the same vein, Gwandure (2007) explored the effects of home-based care of AIDS sufferers on children from these households. There are a myriad of studies on the traumatic and psychological impact of violent crime on South Africans. For instance, the Centre for the Study of Violence and Reconciliation (CSVR) in Johannesburg is dedicated to researching the effects of violence and crime on South Africans and has produced an impressive body of work. Esprey (1996) investigated individual responses in relation to dimensions of exposure to violence in the development of post-traumatic stress disorder. Her participants were residents from an East Rand township who were exposed to recurrent acts of civil violence in South Africa during 1990 to 1994.

Amidst the many cash-in-transit robberies that plague South Africa, Allen and Ortlepp (2000) researched the effects on cash-in-transit security guards. Bowman, Bhamjee, Eagle and Crafford (2009) have looked at the traumatic impact of violence in the workplace. Williams, Williams, Stein, Seedat, Jackson and Moomal (2007) presented findings on the effects of multiple traumatic events on South Africans. There has also been great interest in the impact of apartheid and its remnants in post-apartheid South Africa (*e.g*. Beetzke, 2012; van der Watt, 2005). In the same vein, the psychology of perpetrators of political violence was considered in some depth by Fourie (2000). South African studies have also looked at the traumatic effects of violence in schools (*e.g*. Brown, 2009) and others have focused on trauma exposure within schools (Seedat, Nyamai, Njenga, Vythilingum & Stein, 2004). Violence on the home-front is another theme of interest (*e.g*. Kubeka, 2008) and the effects of violence in general on our youth have been a popular point of study (Lockhat & van Niekerk, 2000; Peltzer, 1999; Suliman, Kaminer, Seedat & Stein, 2005).

Many vicarious trauma studies have been executed on home soil. However, in line with the trend in the rest of the world, the majority of South African studies are primarily dedicated to the more obviously affected groups, such as therapists, counsellors, mental healthcare workers, caregivers, healthcare professionals and various emergency workers (*e.g*. Basedau, 2004; Booysen, 2005; Eagle, 2005; Fourie, Rothmann & van de Vijver, 2008; Martin, 2006; Smit, 2006). Even when looking at international research studies, highly relevant vicarious trauma literature on more administrative, less obvious groups are scant. However, some interesting South African studies were discovered that focused on a few groups less obviously associated with trauma and vicarious trauma.

Among these, for instance, was a longitudinal study von Klemperer (2009) performed on subjects living and working in Johannesburg, focusing on the effects of indirect exposure to violent crime. Roe-Berning (2009) looked at post-traumatic growth in a sample of South African adults. Thompson (2009) excavated the effects of crime reports on adult newspaper readers. Marais (2004) as well as Marais and Stuart (2005) explored work-related trauma and post-traumatic stress disorder in South African journalists. Dzuguda (2001) focused on secondary traumatisation in South Africans employed by the Truth and Reconciliation Commission. Finally, Hlengani (2006) investigated compassion fatigue in a group of Employee Assistance Programme workers.

Needless to say, vicarious trauma studies pertaining particularly to short-term insurance claims workers, are rare. The closest study that could be located was that of Coetzer and Rothmann (2006),

who looked at occupational stress of employees in the insurance industry. They do not elaborate on which segment of the insurance industry their sample was sourced from, but they assessed the relationship between occupational stress, ill-health and organisational commitment in insurance workers. Els (2005) performed research to develop and test a holistic work-wellness model for employees, but their research was aimed at the life insurance industry in South Africa, a segment of workers close but still very different from those focused on by the present study.

Even searching internationally, research studies pinpointing vicarious trauma in the insurance industry were near impossible to find. Chan, Lai, Ko and Boey (2000) explored work-stress among professional groups in Singapore. Their study focused on work-stress and coping processes in six different professional groups, of which life insurance workers were one. Murphy (1996) similarly reported stress levels in life insurance workers. Even though no reference is made to vicarious trauma, these studies have collectively identified specific stressors posing a threat to insurance workers as a whole, emanating from dealing with difficult or demanding clients as well as from their unique work demands. Although the latter studies are not South African, they are nonetheless relevant as they are some of the very few studies that were performed on segments of insurance workers that share some features with the group focused on by the present research.

Next, Ortlepp and Friedman (2001; 2002) conducted very compelling research within the South African banking industry. Their studies looked at bank workers who were trained to act as non-professional, first-line, workplace trauma counsellors. These workers are mainly administrative workers occasionally called upon to counsel their colleagues after the occurrence of bank robberies. Therefore, they perform an interesting mix of duties – mostly administrative, offering counselling occasionally.

This relates somewhat to the present study seeing that claims workers, although lacking the counselling training, are also largely administrative workers affected by traumatic materials from the work environment. There are, however, distinct differences in that the bank lay counsellors' exposure to traumatic materials is a self-elected and somewhat sporadic activity. In the case of claims workers, trauma exposure is unintended, inadvertent and happens on a far more regular basis. Claims workers neither perform counselling, nor do they elect to do so and their exposure is therefore, as previously pointed out, incidental and a by-product of their primary function of documenting and settling claims.

For the most part, the South African studies concur with the fundamental view that individuals who are in continuous contact with traumatic materials are at risk of developing negative outcomes (*e.g.* Figley, 1995; McCann & Pearlman, 1990; Stamm, 1997). For instance, MacRitchie (2006) found that trauma workers who work with victims of violent crime experienced many negative reactions. Her study reported that 28% of her participants were at risk of secondary traumatic stress, and that a further 30% were at risk of being traumatised vicariously. Harinarain (2007) similarly found that 28% of a sample of counsellors experienced compassion fatigue. Also, the exploratory research on short-term insurance claims workers, which preceded the present study, found that 43% of the sample expressed high levels of secondary traumatic stress (Ludick, 2006). Similarly, Ortlepp and Friedman (2002) also reported incidences of secondary traumatic stress in their group of lay counsellors. Marais (2004) found that journalists with a higher frequency of trauma cases or interactions with traumatised individuals exhibited more severe post-traumatic stress reactions.

These findings, as with international studies, allude to a relationship between the severity of a traumatic incident, the frequency of exposure and the development of post-traumatic stress disorder. Similarly, Moultrie (2004) reported elevated levels of compassion fatigue in a sample of indigenous trauma volunteers from South African townships. Finally, Booysen (2005) reported a wide array of negative emotional as well as physical effects indicative of vicarious trauma in a group of caregivers working with children in a place of safety.

However, South African studies are plagued by the same inconsistencies displayed by the international studies highlighted throughout this chapter. The same ambiguities in establishing the roles and significance of certain correlates of vicarious trauma are equally indecisive in local studies. For instance, Harinarain (2007) as well as MacRitchie (2006) found that participants with a personal history of trauma consistently scored higher on compassion fatigue than those without a history. These findings offer support to Figley's view that unresolved personal trauma can be evoked by similar traumatic materials from clients (Salston & Figley, 2003). Ortlepp and Friedman (2002), however, did not find a higher prevalence of secondary traumatic stress in lay counsellors with a history of personal trauma.

Also, Martin (2006) found no significant relationship between personal trauma history and vicarious trauma in her sample of healthcare workers. Esprey (1996) also reported contradictory research findings. In her study, perceived social support showed a strong positive relationship with post-traumatic stress disorder symptomatology in a group of township residents who had witnessed

recurrent acts of civil violence. Counter-intuitively, the correlation analysis suggested that those with higher levels of perceived social support also expressed higher levels of traumatic stress. Esprey pointed out that a number of social support studies similarly could not pinpoint the impact that social support has on trauma victims. Lutrin (2005) similarly reported on the paradoxical nature of social support. These findings resonate with Figley's (2002a) view that social support can be a great source of help, but also a source of interpersonal stress. This brings into question not only the quantity of support, but also the quality, as toxic relationships can be more distressing than helpful.

Finally, the collective divergent results discussed here are no surprise. This proves that the relationships between vicarious trauma and the various correlates discussed thus far are complex and no easy feat to research within any context. The real value of this statement was realised after a plethora of studies had been reviewed for the present study. Those that attempted to home in on these relationships soon reported on the difficulties and challenges of doing so.

In summary, vicarious trauma is an elusive, multidimensional and composite phenomenon. There are also several closely related concepts that share certain areas of overlap as well as a host of correlates that are associated with vicarious trauma, each contributing and exerting their own influence. These correlates are often problematic, inconsistent and varied as each is an equally challenging phenomenon to conceptualise and measure. Differentiation was made between viewing vicarious trauma as a process as opposed to the more simplistic, incorrect view of an outcome which seriously detracts from its complexity.

Research in the area of vicarious trauma is largely no easy feat, riddled with complexities and challenges that continue to frustrate research studies in South Africa and abroad. These inconsistencies clearly highlight the internationally expressed need for continued research to fully understand and reveal vicarious trauma as well as the implicit mechanisms that underlie and drive this phenomenon. The next chapter reviews literature on the wide array of negative effects associated with vicarious traumatisation that extends beyond the clinical view as well as the discrepancies surrounding amelioration.

"The rewards of working with the traumatised far outweigh the cost. And this happens when caring for others is balanced with caring for ourselves" (MaryDale Salston & Charles. R. Figley 2003).

CHAPTER THREE: THE NATURE OF VICARIOUS TRAUMA

Negative Effects of Vicarious Trauma

This chapter aims at presenting the wide array of negative effects associated with vicarious trauma. A bio-psychosocial stance is adopted which offers a theory-neutral conceptual framework from which effects within different domains of functioning are considered (MacDonald & Mikes-Liu, 2009) In doing so, a more holistic understanding of effects is facilitated. Vicarious trauma is then looked at beyond the clinical view by focusing on the effects in the workplace as well as the wider context of organisations. The chapter concludes with a discussion of the controversies of amelioration.

1 The Burden of Vicarious Trauma

1.1 Negative effects of vicarious trauma on the individual.

Vicarious trauma has effects on various levels of functioning. In line with a bio-psychosocial approach, effects are considered at the intrapersonal, physiological and psychological as well as interpersonal or social levels of functioning. Applying this systems thinking can enrich the understanding of vicarious trauma by contemplating the full range of effects.

1.1.1 Intrapersonal level.

1.1.1.1 Cognitive changes.

Victor Frankl posited decades ago that our need for finding meaning is a fundamental human motivation (Joseph, Williams & Yule, 1993). Furthermore, our world and our experiences are viewed and filtered through schemas or *"core beliefs"* (Sabin-Farrell & Turpin, 2003, p. 456). As explained before, direct exposure to trauma as well as engaging with the trauma of others can negatively transform these schemas (McCann & Pearlman, 1990). Janoff-Bulman started this line of thought in 1985 by asserting that exposure to trauma challenges three basic beliefs: the belief that you are invulnerable; a positive view of yourself and the belief that the world is a just and meaningful place (Sabin-Farrell & Turpin, 2003). Following this train of thought, Epstein presented four basic beliefs around 1989 that are vulnerable to change: the belief that the world is benign, the world is meaningful, the self is worthy and that people are trustworthy (McCann & Pearlman, 1990).

From constructivist self-development theory introduced in the previous chapter, McCann and Pearlman (1990) propose five need areas that are vulnerable to change by direct and indirect trauma: trust, safety, control, esteem and intimacy. These need areas involve beliefs in relation to the self as well as to others. As indicated before, these authors have found one's frame of reference and the memory system to also be susceptible to alteration following trauma or vicarious trauma. These aforementioned developments have become central to many current conceptions, theories and models about the effects of direct and indirect trauma (McCann & Pearlman, 1990). According to Pearlman and McCann the affected person can adopt a very grim view of the world. They explain that painful images or emotions associated with the client's traumatic memories may plague a person and may even be incorporated into his/her own memory system in time. In such cases, post-traumatic stress symptoms develop. Taking this view up a level, changes in religiosity and spirituality have also been observed in the aftermath of trauma (Falsetti, Resick & Davis, 2003).

Research undertaken by Black and Weinreich (2000) has shown that many of the trauma counsellors under investigation experienced shifts in their belief and value systems after being constantly exposed to traumatised clients. Similarly, Anderson (2004) reported that narratives about the many atrocities gleaned from crime victims have caused advocates to develop more cynical and less hopeful views. Pyevich, Newman and Daleiden (2003) also reported that, the greater the exposure to traumatic materials, the more negative the cognitive schemas were in a group of news journalists. In the present research, the cognitive schemas in claims workers were examined, to determine whether they were experiencing greater levels of negativity compared to trauma counsellors and holiday booking consultants, who do not routinely deal with traumatised individuals. Next, the psychological and physiological outcomes of vicarious trauma are considered.

1.1.1.2 Secondary traumatic stress, compassion fatigue and post-traumatic stress disorder.

In the previous chapter, the cognitive changes associated with vicarious trauma were outlined. McCann and Pearlman (1990) report that it is crucial for affected persons to work through their painful feelings, and to acknowledge their responses within a supportive environment. Should the aforementioned be left unaddressed, it could have serious ramifications for the individual (Salston & Figley, 2003). As alluded to in the preceding section, the person could become plagued by sleeplessness, flashbacks, nightmares or intrusive thoughts (Jenkins & Baird, 2002). These are believed to be characteristic of secondary traumatic stress or what some refer to as compassion fatigue (Stamm, 2005a). As also pointed out before, these experiences are the hallmarks of post-traumatic stress disorder (McNally, 2003). Several authors have detected the similarities in the

symptoms described by trauma and vicarious trauma sufferers, and suggest that severe secondary traumatic stress and post-traumatic stress disorder are synonymous (Hesse, 2002; McNally, 2003).

Figley defines secondary traumatic stress or compassion fatigue as a condition of symptoms nearly identical to those of post-traumatic stress disorder (Figley, 2002a). As explained before, the only difference is that secondary traumatic stress results from indirect exposures to trauma, whereas post-traumatic stress disorder results from direct traumatic experiences. The first set of secondary traumatic stress reactions reported most frequently share features with direct traumatisation, such as initial feelings of horror, intense fear, helplessness, shock and disbelief. The resultant set of symptoms often described shares features with post-traumatic stress disorder, including intrusive imagery, avoidance behaviour, emotional numbing and hyper-arousal (Bride *et al*., 2003). Post-traumatic stress disorder or the development of trauma-related symptoms is important in the present study due to the potentially disruptive nature of such effects. Post-traumatic stress disorder is the most commonly reported psychiatric consequence of trauma and vicarious trauma (Norman, Means-Christensen, Craske, Sherbourne, Roy-Byrne & Stein, 2006).

Seeing that secondary traumatic stress and post-traumatic stress disorder are such similar phenomena, and to avoid duplication of data, a secondary traumatic stress measure was used. Profiles of post-traumatic stress disorder-like symptoms can be inferred from this secondary traumatic stress measure, as the items of this instrument were carefully formulated around the core traits of post-traumatic stress disorder (Bride *et al*., 2003). They point out that, as with post-traumatic stress disorder, secondary traumatic stress also encompasses several somatic symptoms such as insomnia, sleep disturbance, exaggerated startle responses, difficulty breathing, sweating, a racing heart as well as the physical changes associated with hyper-arousal.

A study of a group of research interviewers reported insomnia, anxiety and depression as well as psychological difficulties that shared features with post-traumatic stress disorder (Goldenberg, 2002). Intrusive imagery was also observed in a group of crime-victim advocates supposedly caused by exposure to continuous testimonies of atrocities from clients (Anderson, 2004). Levin and Greisberg (2003) looked into the experiences of attorneys and revealed that they displayed high levels of intrusive recollections of trauma material and avoidance of reminders of such material. They also reported reduced pleasure and a loss of interest in activities they previously enjoyed, and sleep disturbances, irritability, and diminished concentration were found to be equally prevalent. The situation was further exacerbated by a lack of preparation in understanding clients and also a

lack of regular opportunities to discuss and ventilate personal feelings (Levin & Greisberg, 2003).

When looking at claims workers, they also largely lack supervision surrounding vicarious trauma and similarly have very few opportunities to ventilate their emotions. As suggested earlier, constantly attempting to assimilate an influx of negative information has the capability to negatively transform one's core beliefs and that can result in cognitive disruption and even a sense of disorientation (McCann & Pearlman, 1990). Falsetti *et al*. (2003) add that the development of post-traumatic stress disorder is usually symptomatic of a conflicted belief system produced by augmented negative information. In claims workers, a daily reality overflowing with traumatic experiences and losses described by clients could indeed be conducive to predominantly negative input.

Another group of post-traumatic stress-related behaviours associated with vicarious trauma that could pose specific implications for claims workers is that of avoidance. It entails the evasion of stimuli associated with the trauma that is often expressed across all life situations (McNally, 2003). In the work environment, for instance, it could be particularly problematic. Avoidance-behaviour at work would typically manifest as avoiding certain tasks or certain clients (Annshuetz, 1999; Perry, 2003). It could even manifest in avoidance of the workplace altogether, where high levels of absenteeism or staff resignation could prevail. Even though the study did not intend to diagnose post-traumatic stress disorder, it aimed at revealing any problems or symptoms associated with vicarious trauma, also those that share features with post-traumatic stress disorder. This was done in order to create a greater understanding of the range of implications vicarious trauma might hold for these workers.

It has to be mentioned here that there are, however, two contentious points that are important to be cognisant of – that of both under- and over-diagnosis of post-traumatic stress disorder. In the first instance, McNally (2003) points out that the Diagnostic Statistical Manual's broadening of qualifying stressors for post-traumatic stress disorder, and particularly the inclusion of the notion of indirect exposure, poses the problem of over-diagnosis. This author points to various published research studies that have produced rather questionable theories about post-traumatic stress disorder. For instance, situations such as repeatedly hearing sexist jokes have been considered as being sufficient triggers. McNally (2003) fears that this has led to any substantial level of stress being over-hastily diagnosed as post-traumatic stress disorder.

However, there are also a myriad of research studies that have ratified indirect trauma as an unequivocal trigger (*e.g*. Figley, 2003; Hesse, 2002; McCann & Pearlman, 1990; Sabin-Farrell & Turpin, 2003; Sexton, 1999; Steed & Downing, 1998). It is true that to push the diagnostic boundaries in this way is perhaps unwise and over-inclusive. However, *not* to include indirect traumatisation due to what McNally (2003, p. 231) refers to as "*conceptual bracket creep*" is deleterious contrariwise. This, in turn, will perpetuate under-diagnosis, which is the second point of contention.

There are theorists who feel that post-traumatic stress disorder, as it is, often goes under-diagnosed, especially in those who present with atypical symptoms, or those who do not meet the specified criteria in all three clusters of symptoms (Basedau, 2004). Out of concern, Schützwohl and Maercker (1999, p. 156) endorse the concept of "*partial*" or "*sub-threshold*" post-traumatic stress disorder to describe sub-syndromal or atypical forms. The purpose of the study, as stated before, is not to diagnose post-traumatic stress disorder, but to uncover the full spectrum of effects reported by the study participants. The next section elaborates more on the somatic effects of vicarious trauma.

1.1.1.3 Negative physical outcomes.

Even though the study did not measure physical symptoms associated with vicarious trauma directly, prevalence of reported somatic symptoms was examined. Evaluating trauma-related physical implications is important in that it further accentuates the seriousness and disruptive nature of this phenomenon. It also enables one to consider the full range of effects. Of course, fully understanding vicarious trauma brings researchers one step closer to preventing and ameliorating it.

For more than a decade, there has been mounting evidence that psychological trauma bears a strong association with poor physical health (Norman *et al*., 2006). There is even some evidence that suggest that particular types of trauma may be associated with particular kinds of physical illnesses (Norman *et al*., 2006). As stated before, these authors believe that post-traumatic stress disorder is the most commonly reported psychiatric consequence of trauma exposure. Similarly, post-traumatic stress disorder and secondary traumatic stress have been found to be related to numerous negative health outcomes as well as incidences of serious, acute and chronic physical illnesses (Norman *et al*., 2006). Some of the symptoms experienced at a physical level, such as insomnia, sleep disturbance, exaggerated startle responses, difficulty breathing, perspiration and a racing heart, were referred to earlier (Bride *et al*., 2003). There is also a host of physical changes

associated with hyper-arousal.

For instance, biological and biochemical effects such as changes in cortisol, angiotensin and cholesterol levels have been reported as well as changes in the hypothalamic-pituitary-adrenal axis, noradrenergic and immune functioning (Norman *et al.,* 2006). Psycho-physiological changes affecting heart-rate, muscle tension and blood-pressure have also been documented (Murphy, 1996). In support of these views, a wide array of somatic complaints was reported by a group of crime-victim advocates (Anderson, 2004). Booysen's study carried reports of incessant headaches, flu-like symptoms, lack of energy and vertigo in the majority of her participants. Ulcers, digestive and nervous diseases as well as an increase in bouts of stomach ailments are often described (Booysen, 2005; Norman *et al.*, 2006). More serious conditions such as respiratory diseases, cardiac disease, coronary heart disease and diabetes have also been associated with trauma, vicarious trauma and post-traumatic stress disorder, where high levels of secondary traumatic stress are present (Annschuetz 1999; Murphy, 1996).

Norman *et al.* (2006) compiled a compelling literature review where substance abuse, smoking, physical injury, ethnicity, other health-related risk factors and psychiatric disorders were controlled for over the course of several studies. The relationship between trauma/post-traumatic stress disorder and physical illness remained apparent even after all the above factors had been controlled for (Norman *et al.,* 2006). In fact, they found that post-traumatic stress disorder was associated with an increased risk for the development of physical illness, more than with any other anxiety disorder. As alluded to before, individuals are believed to be at *particular* risk of negative outcomes if the trauma they are exposed to is constant (Jordan, 2001). Although the human body is able to withstand substantial levels and periods of stress, when the stress is prolonged the body will inevitably sustain some form of damage through ongoing exposure to raised levels of glucocorticoids (Barlow & Durand, 2001).

McNally (2003) explains that glucocorticoids are released as part of the fight or flight reaction. These stress hormones actively facilitate defence responses. However, long-term exposure to these stress hormones is believed to cause hippocampal atrophy in the brain, which has given rise to the hypothesis that prolonged traumatic stress and post-traumatic stress disorder can potentially damage the brain. In fact, MRI studies have shown the hippocampi in post-traumatic stress disorder patients to be significantly smaller compared to unaffected counterparts (McNally, 2003). These assertions have been met with some controversy, but empirical evidence is ample. Also, in the case of both

post-traumatic stress disorder and vicarious trauma, strong links have been made to the presence of substance abuse, smoking, overeating and over-medicating (Norman *et al*., 2006; Sexton, 1999). These hold yet another array of negative health outcomes for those affected by trauma.

The present study will be sensitive to any health complaints reported by participants in pursuit of capturing the full spectrum of intrapersonal effects. Finally, the affected person does not exist in a vacuum and the effects of vicarious trauma are not only limited to the afflicted individual. Effects can easily reach beyond the person, which is considered next.

1.1.2 Interpersonal level.

1.1.2.1 Relationships and social interaction.

Hesse (2002) points out that the intrapersonal effects of vicarious trauma can spiral out into the interpersonal realm. Booysen (2005) revealed that most caregivers in her study felt emotionally drained to the point where they were incapable of supporting their families or caring sufficiently for their children. Other effects of vicarious trauma also include a more mechanical, less caring attitude, emotional numbing, detachment from others and distancing within relationships (Salston & Figley, 2003). It is easy to surmise what effects these behaviours might have on relationships and others in close proximity to individuals expressing such emotional frigidity. On the social front, most of the participants in Booysen's study (2005) admitted to being socially withdrawn. Black and Weinreich (2000) reported a general incapability of social interaction and subsequent alienation in a group of trauma counsellors. McCann and Pearlman (1990) found that both diminished social interaction and taking less pleasure in social activities are not uncommon in those exposed to trauma.

As alluded to earlier, avoidance-behaviour in the work context, such as avoidance of certain tasks, clients or even the workplace could be particularly problematic, also to claims workers' employers and colleagues. Booysen (2005) found that greater absenteeism is often the case in those with high levels of secondary traumatic stress, as sick leave is utilised as a coping mechanism. Colleagues having to often take responsibility for an absent worker's duties could easily generate resentment and interpersonal tension. Grove (2004) indeed reports an increase in conflict between workers in cases where high levels of absenteeism are present. The present study will investigate whether participants, especially claims workers, are in fact employing sick leave as a means to cope.

Within the realm of the proposed study, social support will receive specific attention. Social support is generally viewed as a possible mitigating factor of psychological distress, and as a predictor of psychological well-being in those affected by a traumatic experience (Elklit, Pedersen & Jind, 2001). Social support is also viewed as being important in relation to secondary traumatic stress or post-traumatic stress disorder-related symptoms and to have an ameliorating effect (Hyman, 2004; Jordan, 2001). It is believed that looking at social support should give some insight into how secondary traumatic stress might affect social interaction and support networks in those affected. The study was also cognisant of any interpersonal difficulties reported by participants affected by vicarious trauma. In conclusion, Sabin-Farrell and Turpin (2003) reported in an extensive review on vicarious trauma that there is a general dearth of literature dealing with the effects on interpersonal functioning, which necessitates further research in this area. The next section looks at the scope of vicarious trauma as well as how this variable is approached by the current study.

1.2 Vicarious trauma: beyond the clinical view.

1.2.1 Vicarious trauma in the workplace.

People are not only affected by random traumatic events in a happenstance manner. Some individuals are systematically brought into contact with trauma by the work they do (Anderson, 2004; Goldenberg, 2002). The most obvious occupations associated with vicarious trauma have already been pointed out to be emergency and rescue as well as healthcare and mental health workers (Sabin-Farrell & Turpin, 2003; Steed & Downing, 1998). Within these more obviously affected groups, vicarious trauma is an expected complication, and this has led to these groups being well served by research studies as well as ameliorative resources.

Past studies involving less obviously associated occupations are considerably fewer, but have reported interesting findings on vicarious trauma. Newman and Kaloupek (2004), for instance, conducted research to establish the risks and benefits from doing trauma-focused research. They reported that trauma researchers and trauma research institutions often reported vicarious traumatisation as one of the most salient risks to their research staff (Newman & Kaloupek, 2004). Goldenberg (2002) performed a study of the effects of trauma research on a group of eighteen researchers who interviewed Holocaust survivors. Although this study indicated that researchers reported positive as well as negative effects, vicarious traumatisation was nonetheless the most prominent concern.

Similar effects were reported by a study that focused on jurors. The National Centre for State Courts in the USA (1998), reported that a group of non-death-penalty jurors ranked exposure to the details and witness statements of the event, as well as disturbing evidence, as each being one of the ten highest sources of distress to them. As previously mentioned Levin and Greisberg (2003) studied vicarious trauma responses in attorneys and found higher levels of vicarious trauma, despite having relatively few cases involving trauma. Although inspirational, life-changing and positive outcomes are often reported by those who work with traumatised individuals, they are nonetheless constantly at risk of being affected by traumatic materials (Anderson, 2004).

To reiterate, the claims workers at the core of the study are called upon to interact with clients seeking indemnification after suffering a loss. This interaction between claims worker and client has largely not been documented by researchers. The claimed losses often coincide with traumatic events that frequently leave claimants in various states of trauma. Moreover, most policy contracts require clients to lodge their claims very soon after the incident. In some cases, the right to a claim is forfeited if the insurer is not notified within a specified time-frame. Contractual stipulations calling for action so soon after an insured loss, be it a traumatic event or otherwise, often result in the details of the event still being fresh in the claimant's memory. Inadvertently, when interacting with claims workers, clients share distressing details about the event. Claims workers have to document the incident for record purposes, during which time they are often confronted with the claimant's traumatic imagery and emotional trauma. It is not unlikely that clients might often express intense emotional distress when talking about the incident or loss.

Within the domain of the short-term insurance industry, there is a host of insured incidents, of which some are highly traumatising, which policyholders can claim for. For instance, as stated before, reports of violent crimes, often including the rape, torture and murder of crime victims are unsettlingly frequent in our society. During these horrifying incidents, victims often suffer monetary or property losses that they as policyholders, or their next of kin in some cases, have to claim for in a speedy fashion. Collisions are equally prevalent on our roads and claimants approach insurers for indemnification shortly after accidents that might have involved death or serious injury, not only to the insured, but to other parties involved. Similarly, colliding with a pedestrian or animal, which in itself is extremely disturbing, is also covered under insurance policies under their definition of road accidents. In some cases, photographs of an accident or crime scene accompany the assessor or loss adjuster's reports to insurers for claims record purposes. Photographs of salvage (car wrecks) are also frequently placed on file in order to qualify claims for damaged vehicles or

vehicles that are written off. These photographs can often be quite graphic and unsettling to all those in the department who have to deal with them.

Furthermore, even though motor vehicle accidents are rarely researched, Bryant and Harvey (1996) report that such accidents are among of the most widespread and frequently experienced forms of trauma. They further state that as many as one-third of their sample of injured vehicle accident victims reported high levels of post-traumatic stress and anxiety approximately two weeks after the incident. Hickling and Blanchard (1992) reported post-traumatic stress symptoms in as many as 50% of their sample of motor accident victims. By implication, claims workers would most likely encounter vehicle accident survivors with great frequency, including those with high levels of trauma and post-traumatic stress disorder.

In addition, natural disasters that leave large numbers of people dead, injured, destitute and severely traumatised is another risk covered by most short-term insurance policies. In more recent years, short-term insurers have diversified their portfolios. For the past decade or so, most policies have started to include a personal accident component which allows policyholders to claim limited death, personal injury or disability benefits. Moreover, short-term policies often include a funeral plan for policyholders and their dependants. Therefore, claimants can also seek monetary compensation after death, injury or dismemberment.

To settle these claims, insurers request the deceased person's identity document, death certificate and medical or post-mortem report. They also require a description of the event for their records. Working with artefacts such as these has been shown to be sufficient to, over time, cause vicarious traumatisation (Stamm, 1997). Furthermore, leading insurers offer emergency assistance via their claims call centres, staffed by claims workers, purely for the purpose of assisting an insured, often during the trauma and chaos of an emergency, to dispatch the necessary services offered by policies.

As with all trauma-centred occupations, working for an extended period of time within the environment described here, workers can experience vicarious traumatisation and even severe levels of secondary traumatic stress. As pointed out previously, the exploratory study that preceded the current research indeed found elevated levels of secondary traumatic stress in a sample of short-term insurance claims workers (Ludick, 2006). This study also found that their levels of self-esteem, which refer to their regard for themselves, their level of confidence in their skills and their self-assessed ability to cope with stressful events, were not particularly high. Furthermore,

participants were also not found to harbour particularly optimistic views. This ubiquitous neutrality was taken as indicative of the onset of the emotional detachment and the flattened affect so closely associated with secondary traumatic stress and post-traumatic stress disorder (Ludick, Alexander & Carmichael, 2007). Subsequently, affects on an organisational level are considered.

1.2.2 Impact of vicarious trauma on organisations.

As stated above, vicarious trauma was found in the previous exploratory study to pose a real threat to claims workers in the short-term insurance industry (Ludick, 2006). This is not necessarily reflective of negligence on the part of the industry, but is an inevitable, unfortunate and unintentional outcome of doing this work. Nevertheless, when workers are distressed, there is a greater likelihood of negative effects, not only on workers, but also on the organisations within which they operate (Sexton, 1999).

Dunkley and Whelan (2006b) report that vicarious trauma can lead to short-term or long-term defensive reactivity such as psychological numbing, distancing and denial. Subsequently, the person's quality of work and the general effectiveness of the organisation may be jeopardised (Dunkley & Whelan, 2006b). As stated in the previous section, moderate self-esteem, lack of optimism and sings of emotional detachment and a flattened affect were indeed observed in short-term insurance claims workers (Ludick, 2006). Furthermore, they are also likely, as with other groups affected by vicarious trauma, to experience a lack of energy and commitment and there might be greater absenteeism and resignations within this group.

High staff turn-over is very costly, as the loss of talent as well as experience, and the additional costs of recruitment and training of new staff can be extensive (Loi, Hang-Yue & Foley, 2006). A point made previously by Sexton (1999) warns that, when experienced staff members are replaced, the newer, inexperienced members are even more vulnerable to vicarious trauma. For instance, novice therapists new to the field, who lacked adequate education about vicarious trauma, experience, skills, sufficient organisational support and suitable supervision, presented with the most serious difficulties (Sexton, 1999). Anderson (2004) similarly reported younger less experienced crime-victim advocates to be more vulnerable to negative outcomes of vicarious trauma.

Considering that negative effects and emotions can be passed around almost like a contagious virus, these negative effects can be further disseminated into the worker group. Under the previous

chapter, the phenomenon of emotional contagion was introduced. Reference was also made to Sexton's (1999) suggestion that there are powerful unconscious processes that constantly operate within and beyond individuals, affecting human groupings as well as service organisations. To further these points, some theorists are in agreement that emotional contagion not only happens at an individual level, but that feelings, such as aggression, supremacy, pessimism or jealousy may also become the way by which group entities become known (Barsade, 2002).

Sexton (1999) proposes that a whole organisation can become trapped in 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. The stronger this identification, the greater the likelihood that the client's problem will be played out continuously within the organisation (Sexton, 1999).

Pross and Schweitzer (2010, p. 8) found that organisations across the world that exhibited high conflict and stress levels were found to almost resemble the "*traumatic world*" of their clients. The work atmosphere largely mimicked the fear and persecution experienced by their trauma clients. These workers were found to be obsessed with violence and "s*plitting behaviour*" whereby people, even colleagues, are appraised to be good or bad and friend or foe. They found that the chaotic, disorderly and unpredictable atmosphere in these organisations mimicked the scenario of a victim being at the mercy of a perpetrator. This clearly shows how the development of such a group emotion, including trauma, can often define a group and largely distinguish it from other collections of individuals (Barsade, 2002).

According to Barsade (2002, p. 645), several authors have presented evidence of this phenomenon which is called "*mood convergence*" within groups and even organisations. She explains that the moods of different teams of workers or even sportsmen can converge and that this work-group mood is something that can be both recognised and reliably measured. Barsade and Gibson (2007) conclude that affect in organisations can shape vital organisational outcomes such as worker performance and turnover as well as decision-making, creative thinking, teamwork and leadership within these organisations. In the case of claims workers, they might be identifying strongly with distressed clients and might even, unconsciously, transmit the trauma further into the worker group. This collective mood might include trauma, fear, anger, helplessness or anxiety, as recurrently expressed by their clients who have survived traumas.

Barsade (2002) further explains that the understanding of shared social processes within groups is gradually mounting in importance as organisations are becoming increasingly team-oriented. However, research on the influence of shared social processes has focused almost solely on the cognitive aspects, favouring how mental objects are shared in the group context. Even though understanding how ideas are shared within groups significantly adds to our understanding of group dynamics, it offers but a limited view (Barsade, 2002). There seems to be much less focus on how emotions are shared and transmitted within groups.

Furthermore very little information could be found on how trauma in particular may be transmitted beyond the vicariously affected individual, into a larger worker group or organisation. However, in line with emotional contagion theories, theorists from other knowledge domains similarly appreciate the emotional impact and contagious nature of traumatic materials and suggest that empathic engagement is yet another way of transmitting trauma (Bell *et al*., 2003; Figley, 2002a; Stamm, 1995). However, these phenomena of trauma transmission and the underlying processes have not yet received much research attention, and even less so within organisations.

Helping professions involved in contact with traumatised clients often creates the expectation that workers might be affected and there usually is an understanding from workers that they would have to deal with the effects (Bell *et al.*, 2003). For instance, some mental healthcare workers receive regular debriefing, supervision, peer support, ongoing self-care, additional training, and even counselling and therapy, to continuously curb the effects of vicarious trauma (Figley, 2002b). However, there are those professions, such as claims workers, where the risks of vicarious trauma are far less considered. The aim is to show insurers how vicarious trauma might be affecting them and their workers. It is hoped that, by perhaps giving prospective employees clearer expectations of exactly what the work entails, this may help place workers in the best position to make informed choices and to effectively deal with vicarious trauma.

Fahy (2007) states that excellent literature and theories have emerged on the concept of vicarious traumatisation in the course of the past 25 years. However, Fahy feels that these are but anecdotally understood elucidations about the risks which merely highlight a need for systemic support. However, this wisdom has not yet filtered down into practice to improve the everyday lives of affected workers. The knowledge gained has also not yet facilitated policy-making or effected any significant policy changes (Fahy, 2007). Collins (2009) made a similar observation within public child-welfare agencies. Although these workers mainly recognise secondary traumatic stress to be

an issue, they unanimously agree that there is a distinct gap between this recognition and what is actually done in practice.

Finally, extensive literature on vicarious trauma acknowledges its seriousness and the many potentially damaging effects from working with traumatised clients (Sabin-Farrell & Turpin, 2003; Sexton, 1999). The next section continues the debate on whether vicarious traumatisation can and should be ameliorated.

1.3 To ameliorate or not to ameliorate?

Ameliorating vicarious trauma is yet another subject that is not clear-cut. It was surprising to see the many misgivings and concerns about this issue. For instance, some authors have expressed concerns about the negative impact of amelioration (Elwood *et al.,* 2011; Kadambi & Ennis, 2004). Others have raised the question as to whether these amelioration strategies even work (Bober & Regehr, 2006; Sabin-Farrell & Turpin, 2002). As stated previously, some feel that the diagnostic limits of post-traumatic stress disorder have been far over-reached to include vicarious trauma (McNally, 2003).

The credibility of vicarious trauma is questioned by several authors as the evidence-base to support either its existence or its prevalence, is in their opinion, modest (Jenkins & Baird, 2002; Kadambi & Ennis, 2004). Sabin-Farrell and Turpin (2002) have found that symptoms of post-traumatic stress disorder, burnout, and general psychological distress have been implicated by many research studies on trauma-work, but that most of the correlations described were weak. Similarly, Jenkins and Baird (2002) found few studies that have examined the construct validity of vicarious trauma and associated concepts. Accordingly, it might be argued that the eminence accorded to vicarious trauma may be premature and not well supported by research evidence at all.

In the same vein, Kadambi and Ennis (2004) state that the notion of vicarious trauma has been warmly and eagerly embraced. They add that it has called for changes in the workplace to improve wellness and working conditions, even long before researchers pinpointed *what* vicarious trauma is. Furthermore, Sabin-Farrell and Turpin (2002) refer to the valuable lessons learnt from psychological debriefing implemented without due consideration. Out of concern, several organisations enforced debriefing programmes to curb a host of different types of traumas, long before research evidence for the effectiveness of debriefing was considered. Subsequent controlled trials later offered very little consistent support of the role of debriefing in the reduction of post-

traumatic stress symptoms (Sabin-Farrell & Turpin, 2002). From this research, some evidence emerged which suggested that debriefing might actually harm more than help. They concluded that this lesson emphasised the value of collecting research evidence and critically evaluating it before initiating any intervention, treatment or prevention strategies. This lesson also showed that not nearly enough research has been done on the value of debriefing.

Bober and Regehr (2006) drew attention to a similar scenario. Their study looked into the efficacy of strategies that are often prescribed to reduce secondary traumatic stress. These included self-care, leisure-time, supervision, active participation in research as well as programme planning and development. They could find no evidence that these coping strategies offered significant protection against the symptoms of acute distress. They also add that those with long-term negative outcomes, such as negative cognitive schemas, particularly in the areas of self-intimacy and other-intimacy, are naturally less inclined to engage in leisure activities. It makes sense that those workers affected by vicarious traumatisation might not recognise the value of ameliorating activities to begin with and might thus not be motivated to participate in them.

The same can be said of increasing social support. It might be quite a challenge to convince a person who is not normally inclined to seek out the company of others, to suddenly become more socially connected. As stated earlier, even a strategy as benign sounding as increased support can be a double-edged sword and, despite how helpful supportive relationships mostly are, they can just as easily induce tremendous stress (Figley, 2002a; Lutrin, 2005). Bober and Regehr (2006) insist that, unless the value of a strategy is well-recognised and fully embraced, it is unlikely that workers would devote any time and energy to it.

As also pointed out before, Sabin-Farrell and Turpin (2002) fear that alongside the recognition of vicarious traumatisation also came the vilification of a process that is natural, normal and expected. They conclude that researchers might be medicalising something that is nothing more than normal distress from hearing traumatic stories. Sabin-Farrell and Turpin (2002) further argue that post-traumatic stress disorder might be a socially constructed rather than a psychopathological concept. This is a valid point and increased awareness might very well have contributed to displacing a natural response into the domain of psychopathology.

However, even though the emotional responses documented by researchers might not differ from natural responses to hearing traumatic stories, the fact that certain worker groups are exposed to

such stories continuously is nonetheless a concern. It is one thing to hear a traumatic story, as everyone does from time to time, and quite another to be confronted with such unsettling stories on a daily basis. Therefore, although one does not want to vilify or medicalise a normal human response, it is the *frequency* with which these responses are experienced by some workers that raises concern – not the response itself.

Furthermore, concluding that a response is normal is also not a convincing argument and does not take away from the deleterious nature of some *normal* responses. Stress is also a completely normal human response. But if left unchecked it can cause illness and even death. Stress has been described to be one of the most pressing health issues of our time (*e.g*. Coetzer & Rothmann, 2002; Lu, Tseng & Cooper, 1999). Just because a response falls within the realm of a natural human response does not mean that it cannot bring serious harm or that it does not need to be addressed.

Furthermore, Elwood *et al*. (2011) suggest that even the mere encouragement among workers to be aware of any negative emotional reactions associated with vicarious trauma could turn into a self-fulfilling prophecy. There is value in this argument as it can easily be fathomed how the expectation of negative outcomes might actually create them. The realisation that work could be potentially harmful might cause stress in and of itself. It could cause workers to become hyper-vigilant and perhaps even lead to over-interpretation of every response, or overreaction towards the slightest inkling of a symptom. It is true that insurers calling attention to the potential hazards of working with traumatised individuals could potentially dissuade prospective claims workers from entering into this profession in the first place.

However, this does not mean that claims workers should not be informed of the hazards of vicarious trauma. To leave workers to their own devices out of fear of harming them further by informing or educating them about vicarious trauma would be equally unwise and even irresponsible. Elwood *et al*. (2011) indicate that *how* vicarious trauma is portrayed is imperative. Excessively negative portrayals seem to be at the helm of what is causing a whole host of problems as well as fuelling the objections heard from scholars. Therefore, rather than enjoining employers to eschew education about vicarious trauma, workers should rather be informed in a thoughtful and sensible manner, without minimizing or inflating what vicarious trauma is.

Another point of criticism is that some strategies such as additional supervision, counselling or debriefing could systematically eat away at precious resources from organisations that might

already be financially over-extended (Elwood *et al*., 2011). This would be especially true for the South African context, given our socio-economic situation, as well as the current persistent downturn in the international economy. However, amelioration need not be a costly exercise. There is ample evidence that indicates even the most modest of strategies to be effective (*e.g*. Collins, 2009; Gentry, Baranowski & Dunning, 1997; Salston & Figley, 2003).

For instance, Gentry *et al*. (1997) devised a comprehensive accelerated recovery programme for compassion fatigue, which embraces simple but highly effective self-help strategies. They prescribe commitment to a self-care discipline that calls for focus in four areas: skills acquisition, increased self-care, forging a connection with others and addressing internal conflicts. Salston and Figley (2003) strongly agree that it often takes very little to ameliorate secondary traumatic stress. Another simple but effective strategy is visiting with friends and family, staying connected to others and spending time with those whose company is enjoyed (Radey & Figley, 2007). Also, Figley (2002b) is a firm believer in the power of humour to inject positive energy into one's life.

From looking at the Self-Care Assessment Worksheet devised by Saakvitne and Pearlman (1996), a checklist that keeps self-care efforts structured and on track, it becomes clear that they also value the power of a positive affect. Within the realm of finding more joy, they suggest participating in activities that the person finds enjoyable – such as dancing, receiving a massage, taking time to be sexual, finding things that makes the person laugh and even just wearing clothes the person likes. Radey and Figley (2007) conclude that organisations should offer their support and be devoted to promoting a warm, friendly, and inviting environment where workers feel valued and where they can depend on colleagues when they need to.

It was gathered from reviewing the many studies on amelioration of vicarious trauma that the strategies for general wellness in the workplace as well as minimising secondary traumatic stress often intersect. For instance, simple strategies, such as exercising, eating healthily and regularly, taking time off, as well as allowing time for self-reflection, have been shown to greatly alleviate secondary traumatic stress (Radey & Figley, 2007). When considering these strategies carefully, these simple life-style changes are often prescribed by most physicians and healthcare practitioners to combat an array of diseases, to promote wellness, to improve health and to combat stress. These practices would also most definitely create wellness in other areas of one's life, as well as equip one better to deal with stress and pressure, not only at work, but in all areas of life. Therefore, organisations that are experiencing financial strain do not necessarily have to invest in costly

services and programmes. They need only instil, promote and perhaps motivate health-promoting behaviours among their staff, a point that will be returned to later.

Despite the many misgivings outlined earlier, there are nonetheless ample sapient as well as seminal studies that clearly highlight the negative effects of vicarious trauma within a variety of work settings (*e.g*. Adams *et al*., 2008; Anderson, 2004; Annschuetz, 1999; Bell *et al*., 2003; Black & Weinreich, 2000; Collins & Long, 2003; Figley, 2002a; Hesse, 2002; Levin & Greisberg, 2003; McCann & Pearlman, 1990; Newman & Kaloupek, 2004; Pross & Schweitzer, 2010; Pyevich *et al*., 2003; Saakvitne, 2002; Schauben & Frazier; 1995; Sexton, 1999; Simpson & Boggs, 1999; Stamm, 1997; Stebnicki, 2007; Steed & Downing, 1998; Way *et al*., 2007). The threats associated with vicarious trauma can therefore not be ignored. The points of criticism raised earlier do not mean that amelioration should *not* take place. One very valid point that can be taken from the research information outlined here is that amelioration is not a simple issue and should be approached with great care and circumspection. It should be entered into thoughtfully and not over-hastily.

It also means that every decision or strategy should be carefully weighed and, where possible, based upon sound research findings before they are implemented. For the purposes of the present study, it is felt that neither education about nor amelioration of vicarious trauma should be abrogated. Employers should perhaps seek ways to educate and ameliorate vicarious trauma without perpetuating stress over it. The point of whether vicarious trauma should be ameliorated or not is revisited at the end of the thesis when the concluding thoughts on this point are presented. The next chapter looks at the theoretical framework that will both structure and inform the present research.

CHAPTER FOUR: THEORY

Theoretical Framework

1 Theoretical Framework for the Study

This chapter considers the various theories demarcated by the study. The bio-psychosocial model is discussed first, which provided the study with an overarching structure. Next, Figley's model of compassion fatigue (2002a) served as a cornerstone to the study and further aided in structuring the research. Concomitantly, the different concepts and variables explored by the study and how each of these was approached, are also outlined. Constructivist self-development theory is then examined, which added the interesting dimension of cognitive outcomes to the study. Finally, mixed methods theory, which drove the research design and practical execution of the research, concludes this chapter.

1.1 Bio-psychosocial theory.

To better understand a phenomenon and its effects on organisms and systems, one course of action might be to view the phenomenon in relation to other related variables. Another might perhaps be to consider the phenomenon from various perspectives and within different contexts. This multidimensional, eclectic and holistic way of thinking has always resonated with the author. For these same reasons, a bio-psychosocial approach was considered appealing for the present study. This endeavour aimed at comprehensiveness and elucidation united aspects and theories from three domains of functioning, these being biological and psychological (in*tra*personal) as well as sociocultural (in*ter*personal). To gain insight into the effects of vicarious trauma at these various levels, a bio-psychosocial approach was adopted for the study. However, the model serves purely as a structuring agent to systematically and comprehensively gauge the wide array of effects within different areas. As this is mainly an exploratory study, looking at vicarious trauma from different perspectives and within different domains of functioning seemed to be a sound starting point in illuminating this complex phenomenon.

Even though bio-psychosocial *theory* did not play a central role in the present study, it nonetheless warrants some discussion. Its main strength lies in its non-dogmatic allowance for any and all approaches and its not excluding any method or favouring another as being superior (Ghaemi, 2011). This theory also emphasises the complexity and importance of the domain of interaction in illuminating important processes (Gilbert, 2002). The bio-psychosocial model was developed by George Engel around 1977, and this "*systems thinking*" has continued to evolve (MacDonald &

Mikes-Liu, 2009, p. 271). It, however, maintained an emphasis on conceptualising the complexity of individual responses. As stated before, the model is theory neutral and encourages the application of a wide range of theories within a comprehensive assessment process (MacDonald & Mikes-Liu, 2009). These authors note that it therefore does not adhere to any prescribed structure, though some have been proposed. Bio-psychosocial theory is essentially a conceptual framework which accommodates all aspects relating to a particular problem, is congruent with other modern-day theories and is responsive to empirical scrutiny (British Columbia Ministry for Children and Families, 1996).

Within this eclectic framework, phenomena – including vicarious trauma – are viewed as complex, involving a dynamic and multifaceted interplay of factors (Schwartz, 1990). For instance, our inherent biological and psychological vulnerabilities are brought into all life situations. Social and environmental factors play precipitating roles, triggering these biological and psychological predispositions (Schwartz, 1990). These aforementioned tenets tie in well with the constructivist self-development view, one of the two theories employed by the study, that trauma and vicarious trauma filter into all aspects of existence (McCann & Pearlman, 1990). In other words, disruptions and effects can potentially be experienced at the biological, psychological and social levels.

A bio-psychosocial stance served as the overarching framework which united the theories employed in the present research. Within this framework, Figley's model of compassion fatigue (2002a), developed for therapists, served to expound the process of vicarious trauma. The study also intended to establish whether Figley's model can be applied wider, to include the claims workers earmarked by the present study. It is important to stress that Figley's model was not tested *per se*, but its suitability to the administrative context was considered and argued. Constructivist self-development theory further assisted in illuminating the cognitive aspects of vicarious trauma, as well as how cognitive changes can affect one's cognitive orientation towards the world and, ultimately, its impact on behaviour and relationships.

A bio-psychosocial framework further enabled the study to evaluate outcomes of vicarious trauma within various areas. In the psychological domain, the two most widely reported outcomes of vicarious trauma, those of secondary traumatic stress and negative cognitive schemas, were investigated. These are mainly intra-psychic artefacts of trauma, but also include a physical element, often entailing somatic symptoms that share features with post-traumatic stress disorder. In conjunction with the aforementioned concepts, qualitative data on physical effects were further

utilised to gauge the physiological facet of vicarious trauma. Data on interpersonal experiences and perceived support brought the bio-psychosocial conceptualisation full circle. In order to ascertain the relevance of Figley's model to the claims worker context focused on in the study, key aspects such as empathy and compassion satisfaction were measured, which are further psychological constructs. Although most of the constructs outlined in this paragraph are mainly intra-psychic concepts, each also strongly regulates our experiences and behaviours in the interpersonal and social domains.

Bio-psychosocial theory is, however, far from perfect, often eliciting strong criticism. However, these debates are not developed further for the sake of brevity, seeing that the approach was utilised merely as a structuring tool. Finally, within the context of claims workers, the work setting constantly exposes them to client traumata, which could trigger pre-existing biological and psychological vulnerabilities or facilitate undesirable outcomes. It is also reasonable to note that traumatising and distressing aspects of their work could permeate other levels of functioning and continuously affect most other areas of their lives. Subsequently, Figley's model and its role in the present study are looked at.

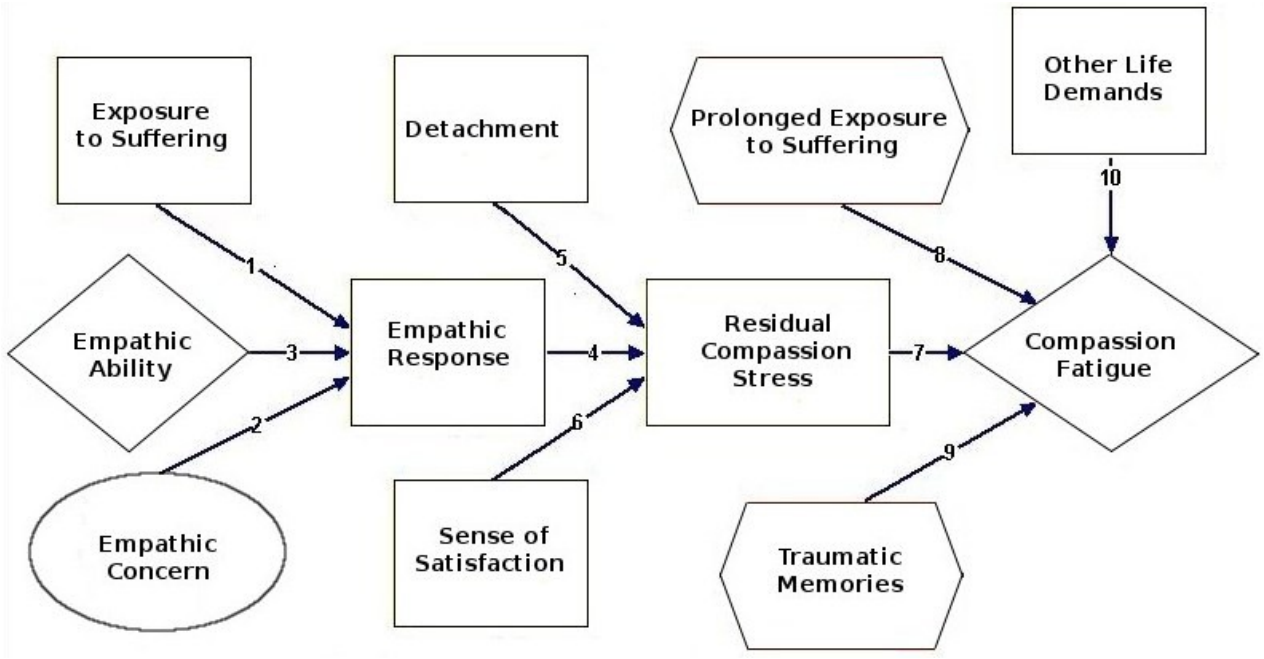
1.2 Figley's model of compassion fatigue.

In the literature review, several models of vicarious trauma, secondary traumatic stress/compassion fatigue were briefly mentioned. Figley's (2002a) model was earmarked by the present study because of its wide use and popularity, as well as Figley's stature and importance in the field of vicarious trauma. From reviewing scores of literature sources on vicarious trauma, it soon became evident that Figley is a well-respected authority and one of the most cited authors in this field. Whilst reviewing current literature, Figley's model also stood out as one of the most recognised, cited and utilised out of those mentioned in the literature review. Moreover, his model has been utilised in a number of South African studies (*e.g*. Harinarain, 2007; MacRitchie, 2006; Ortlepp & Friedman, 2001).

Furthermore, Figley is seen as a "*pioneer*" in the field of vicarious trauma (Perry, 2003, p. 12). For instance, he first identified and developed the term compassion fatigue (Adams *et al*., 2008; Fahy, 2007). He is also credited with having coined the term "*secondary traumatic stress*" (Dunkley & Whelan, 2006b, p. 108). His involvement in the field of vicarious trauma has resulted in a notable body of work. Figley also contributed to the formulation of several measuring instruments. Most recently, he assisted in the development of the Secondary Traumatic Stress Scale (Bride *et al*., 2003)

which was utilised by the present study.

Figure 1: Figley's Model of Compassion Fatigue (2002a)



As with the literature and theories on vicarious trauma and associated concepts, the various models mentioned in the literature review are mostly relevant to therapists and trauma workers. These models largely include aspects unique to the trauma worker context, rendering them mostly unsuitable to the present study. These include aspects such as the therapist's training, professional coping strategies, resources, skills, experience and, in some cases, the client/therapist relationship or therapeutic context. Beaton and Murphy (1995) as well as Ortlepp and Friedman (2001) have included very useful organisational factors in their respective models, but again, these are mostly relevant to the trauma worker context. To reiterate, claims workers do not have the training, professional coping strategies or skills associated with professional counsellors, nor do they form a therapeutic alliance with clients.

Even though Figley's model was also developed for therapists, he nonetheless encourages and welcomes its use with other populations. From a pragmatic point of view, Figley's model uses more general, familiar variables, with empathy and emotional energy at its core (Sanchez, 2006). The

variables contained in this model could easily be applied more commonly and relate more widely. The model seems to be more comprehensible and applicable to groups other than therapists, because of its more general nature, and could therefore be integrated more meaningfully into administrative worker groups similar to the claims workers chosen for the study.

As stated in the introductory chapter, applying Figley's model more widely also has further value. It will eventually assist in answering the burning question of who else is at risk, in what work setting and under which conditions? (Figley, 2003). Figley's message is quite clear – *"Those who work with the suffering suffer themselves because of the work"* (2003, p. 3). Figley argues that the levels of secondary traumatic stress/compassion fatigue might differ from profession to profession, but constant exposure to the trauma of others almost always comes at a cost.

This is an important point as researchers could still be underestimating the full reach and scope of vicarious trauma by not focusing sufficiently on less obvious groups. Having too little empirical data on how vicarious trauma in these less familiar groups might compare to results from select groups, is most definitely a factor that limits our view and understanding of this phenomenon. Figley explains that compassion and empathy "*extract a cost under most circumstances*" (2002, p. 1434). Attempting to understand the world from the perspective of a traumatised individual can in itself cause secondary trauma (Figley, 2002a). Figley reminds us that the meaning of compassion is, after all, to bear the suffering of another.

Figley's model was considered in the present study to establish its applicability to and utility within administrative groups that deal with traumatised clients, such as claims workers. This was achieved by deconstructing the model into its various constituent elements for examination. Due to the difficulties surrounding participant time and cooperation, not all eleven model elements could be covered in equal detail. Therefore, some components were employed as central study variables whereas others were covered to varying degrees by a self-constructed questionnaire used to obtain more qualitative information. The ensuing part of the discussion briefly explains each of the eleven model elements as well as how each relates to the context of claims workers. It is also discussed how the study proceeded to examine each of the model components. *Appendix A* offers a bird's-eye view of how the elements were covered.

The first variable presented by the model is that of exposure to suffering. This element refers to the worker experiencing the emotional energy of the client. Figley states that those in *"direct practice"*

such as trauma workers and therapists, carry the heaviest burden, and that the cost of direct exposure to suffering can often surpass the gains of working with traumatised individuals (2002a, p. 1437). In the case of the claims workers and trauma counsellors sourced by the study, client contact occurs in the call-centre environment. As explained before, the distress and trauma from clients can still adversely affect the worker, even in a telephonic set-up. It was also explained previously how simply hearing or learning about a traumatic event can cause vicarious traumatisation (McCann & Pearlman, 1990).

A second aspect of exposure to suffering proposed by Figley's model is that of a prolonged nature. It is understood that the trauma or suffering of others become more deleterious and the effects more cumulative when exposure is prolonged (Figley, 2002a). The claims workers examined by the study have daily, ongoing exposure to traumatic materials from their clients in the process of collecting information for their claims reports. This places them at considerable risk for negative outcomes. In the present study, exposure and frequency of exposure to suffering were gauged by means of qualitative data from the self-constructed questionnaire developed for the study. These data offered insight into the type and level of trauma presented to claims workers by their clients. The frequency of the more severe cases was also considered as well as feelings evoked by dealing with traumatised clients. This again offered some insight into the level of exposure, severity of cases as well as the emotional energy that affect participants the most.

Next, empathy, being a very important and central component to the model, is presented in three prongs. As explained before, empathy is seen as the *"keystone"* to vicarious trauma (Figley, 2002a, p. 1436). Empathic Ability refers to a person's capability and proclivity to recognise suffering in others (Figley, 2002a). Empathic Concern relates to the person's motivation to respond to this suffering. Figley explains that during an empathic response, professionals draw upon their skills, training and talent to provide the best possible service. Herein is the danger: when providing an empathic response, the worker is projected into the distressed client's position, even experiencing their fear or suffering. In claims workers, the effective provision or the motivation to provide empathy is not their primary function. As previously explained, exposure to client trauma and resultant compassion and empathy is only *incidental* to the main work-goal of these more administrative workers.

However, empathy, as with therapists, nonetheless remains a pathway to secondary traumatic stress, even in claims workers. In the present study, empathy was quantitatively measured as a

multidimensional variable. This was done in order to gauge how the empathic response differs across the worker groups in the study and to ascertain if it plays an equally important role in claims workers. In addition, the self-constructed questionnaire posed the questions whether the person tries to offer comfort to a traumatised client by talking about their experience, or if they prefer to just focus on the work at hand? This gave further insight into the general level of empathic engagement employed by each worker group in the study.

Next, Figley's model (2002a) refers to residual compassion stress and compassion fatigue. Compassion stress can be defined as the emotional energy remnants that live on in the person after every empathic engagement. The ongoing demand for empathy and compassion from traumatised clients can cause residual compassion stress to accumulate in affected workers (Figley, 2002a). This can eventually lead to compassion fatigue or what the present study refers to as secondary traumatic stress. Tempered by other life demands and traumatic memories, two complicating factors presented by Figley's model, compassion stress can quickly reach harmful intensities. This is especially true where conscious efforts are not made to manage secondary traumatic stress. In the present study, secondary traumatic stress was quantitatively measured and treated as a central vicarious trauma measure.

The next two model components represent useful ways in which compassion stress can be alleviated or even prevented. These are a sense of satisfaction with one's efforts to help as well as detachment. In the study, sense of satisfaction was tapped into by quantitatively measuring compassion satisfaction. Detachment refers to the worker's ability to disengage or to let go of the client's suffering (Figley, 2002a). Figley notes that in order to disengage effectively, therapists draw heavily upon their skills.

Not everybody has the same ability to disengage and it is through training, experience and ongoing self-care that therapists achieve complete removal of residual stress (Figley, 2002a). Data on detachment were collected by the self-constructed questionnaire. The first question entailed how long effects persisted with regards to the case that affected them most negatively? Then they were asked whether they are generally troubled by client traumas, or if they can forget about it and continue with their day? They were finally asked to reflect on whether they tend to take work matters home, or if they can leave them at work effectively? Responses to this set of questions offered insight into the abilities of participants to disengage from client traumata.

However, despite ongoing efforts to disengage and even in the face of satisfaction with compassion responses, if compassion stress accumulates, compassion fatigue or secondary traumatic stress is the end destination posed by Figley's model. Claims workers might experience compassion satisfaction, possess empathic abilities and the motivation to respond, but it is unlikely that they would have mastered the skill of effective disengagement. Also, ongoing self-care, training, skills and resources often associated with trauma workers are not widely available to claims workers, placing them at considerable risk for secondary traumatic stress.

As touched upon earlier, the model elements of traumatic memories and other difficult life demands are complicating factors faced by everyone, which could further contribute to a negative outcome. Traumatic memories refer to the person's own trauma recollections that could take the form of the persons' personal trauma history or traumatic memories from previous client dealings (Figley, 2002a). These memories have the potential to be reactivated and to cause further distress, anxiety or depression. Difficult life demands refer to those unexpected changes in schedule, routine, or the management of life's responsibilities that require attention (Figley, 2002a). These could emanate from health issues, or changes in lifestyle, social standing, or professional and personal responsibilities. Usually, these life demands cause a manageable level of stress. However, when linked with the factors portrayed by Figley's model, life disruptions can increase the likelihood of compassion fatigue/secondary traumatic stress (Figley, 2002a).

Data from the self-constructed questionnaire that presented some open-ended questions to participants covered these two model elements. Traumatic memories were explored by asking participants about any recent traumas, how traumatised they were after the event and at the time of data collection? The study was also sensitive to any instances where the theme of personal trauma emerged from other parts of the data. Difficult life demands were explored in the same way and by posing the questions of what recent difficult demands participants had to contend with as well as how deeply they were affected?

Of course, no model or theory is without limitation or flaws, especially when applied to a group other than it was intended for. For instance, as stated before, Figley often and explicitly acknowledges the importance of social support in the development and prevention of negative outcomes from dealing with client traumata. He also often extols the importance and value of self-care in alleviating and obviating negative outcomes. Despite their felt importance, neither social support not self-care feature in his model. Figley's model only focuses on detachment and

satisfaction as alleviating avenues.

The author has speculated before regarding why such important concepts are not featured by this model. The author concluded that the uniqueness of the trauma work context might have played a role. It could be that the importance of each model component eclipsed such rudimentary, basic constructs as social support and self-care. However, due to the limited vicarious trauma resources in the administrative context, the study chose to quantitatively examine social support to determine its importance in claims workers. Additional questions were also included to gauge the level of support from the work context as well as explore attitudes towards trauma counselling as an additional avenue for improved social support. Self-care was also investigated, however more qualitatively, to determine the need for self-care and the degree of self-neglect.

Finally, Figley's model is not only useful in predicting the onset of compassion fatigue, but is also a good starting-block for treatment (2002a). Instead of aiming to "reinvent the wheel", it was decided that structuring the study around this popular model would be a wise approach. Through the actions taken by the study, as well as those outlined in this section, the suitability of Figley's model to administrative workers dealing with traumatised clients was explored. Again, the model was not tested but the appropriateness of each component was considered. Areas in the model that need to be amended, expanded upon or added to best serve claims workers were also highlighted. The end goal was to produce a model that is more tailor-made and suitable to the administrative domain. The revised model, presented at the end of the study, could serve as a map to illuminate the process of vicarious trauma in administrative workers. It could perhaps even serve as a treatment plan for those workers experiencing negative outcomes or those wanting to take charge of their well-being and self-care.

In keeping with a bio-psychosocial stance, other areas of affects are also looked at in pursuit of comprehensiveness. In an earlier chapter, the correlation between psychological trauma and ill-health was made. At the outset of this chapter, it was explained that physical effects and symptoms associated with vicarious trauma were thus explored to add a physiological component to the study. In addition, McCann and Pearlman (1990) propose that, once secondary traumatic stress reaches a certain level, negative cognitive changes are other likely threats. Cognitive schemata often become increasingly negative because of prolonged exposure to traumatised clients and their painful stories (McCann & Pearlman, 1990). To add a cognitive component to the study, negativity in certain schemas were measured. The rationale was that, to determine the importance and role of both

undesirable physical outcomes and negative cognitive schemas in claims workers, would offer a more comprehensive description of the effects experienced by administrative workers. The cognitive changes believed to be brought about by vicarious traumatisation are considered next, within the framework of constructivist self-development theory.

1.3 Constructivist self-development theory (CSDT).

Pearlman and Saakvitne are equally prominent and well-respected experts in the field of vicarious trauma. As indicated in a previous chapter, these authors are credited for coining the term vicarious trauma (Stamm, 1997). As part of their endeavours, they focused on cognitive changes and developed the constructivist self-development theory (CSDT) to assist in understanding these changes. They also developed the TSI Belief Scale utilised to measure negative cognitive schemas in the present study.

The underlying premise to CSDT is that we construct our own realities by developing complex cognitive structures involving core schemas (McCann & Pearlman, 1990). Through these, we interpret all events which ultimately regulate our thoughts, feelings, attitudes and behaviour. The many traumatic experiences described by clients can negatively transform the worker's personal schemas through continuous attempts to assimilate and give meaning to these experiences (McCann & Pearlman, 1990). Consequently, schemas become increasingly negative, hinder the development of adaptive schemas and promote maladaptive ones (Pyevich *et al*., 2003). Our schemas evolve over time in order for us to make sense of our world in a constant and stable way, therefore such negative changes are usually lasting (McCann & Pearlman, 1990).

In terms of CSDT, vicarious traumatisation is seen as a process of negative transformation of cognitive schemas through the empathic engagement with and the sense of responsibility for traumatised clients (Saakvitne, 2002). When traumatic experiences are shared, the therapist or worker becomes vulnerable. It is believed that we respond to traumatic materials through a "*personal lens*" shaped by our previous experiences, our most significant psychological needs, as well as our own distinctive emotional styles (Saakvitne, 2002, p. 446). When the therapist or worker encounters a source of anxiety not yet considered, or the client describes a scenario that coincides with the worker's greatest anxieties, the emotional burden and the task of coping can become unmanageable (Saakvitne, 2002). She also explains that when a client's way of adapting or coping clashes with the beliefs and defences of the worker, the situation becomes even more emotionally onerous.

Vicarious trauma is also believed to affect the same general aspects of the self that are impinged upon by direct traumas (Saakvitne, 2002). Changes mainly take place in five distinctive areas:

- Frame of reference
- Self-capacities
- Ego resources
- Cognitive schemas in five psychological needs areas
- Perceptions and memories

Appendix B gives a broader explanation of these five areas as well as further points which explain what each area entails.

The most devastating impact of vicarious trauma becomes discernible when cherished beliefs, hope or meaning are crushed and the person becomes trapped in a downward spiral of cynicism and pessimism (Saakvitne, 2002). Saakvitne explains that the dangers lie in the negative effects such as intrusive imagery and negatively transformed beliefs as well as our defences against the pain, such as numbing. Next, McCann and Pearlman (1990) identify five basic beliefs or schemas in various psychological needs areas that are particularly vulnerable to negative change. These are safety, trust, esteem, intimacy and control, in relation to oneself as well as others. The reader is again referred to *Appendix B* for more details on each of the five beliefs.

There seems to be a complex interplay between the five areas and the five basic beliefs. To begin with, the five areas outlined are our typical cognitive and experiential modes for organising our experiences (Saakvitne *et al*., 1998). Following trauma, persons must integrate the event, its context and consequences into their belief system about the self and others (Saakvitne *et al*., 1998). Reflecting on this statement for a moment, it would seem that negative changes in any of the five distinct areas outlined above could lead to negatively transformed schemas. It would also seem that negatively transformed schemas might in turn adversely affect any or all of the five distinct areas. Evidently, a vicious cycle of negative change feeding from psychological trauma is set in motion.

Regarding the five schemas vulnerable to trauma and vicarious trauma, **trust** could easily be negatively affected as those who deal with traumatised clients are constantly exposed to many examples of how criminals and predators deceive, betray and violate trust (McCann & Pearlman, 1990). They further explain that constant exposure to testimonies of loss of **safety** may challenge the worker's own schemas and cause constant fear for their own safety and the safety of loved ones.

They add that loss of safety is usually flanked by loss of **control** or personal power and even paralysis. Negative changes in this area could also take the form of a fearful awareness of the illusory nature of power, life's fragility and how little control we have in our lives (McCann & Pearlman, 1990).

Trauma survivors often compromise their independence, restrict their freedom and personal autonomy or grow overly dependent on others (McCann & Pearlman, 1990). Reflecting on this point, the complete opposite could also happen: a person could disengage completely out of loss of trust. Victimisation often leads to loss of **esteem** for others, themselves or even result in a disappointment in the human race (Goldenberg, 2002). A less caring stance towards oneself could result in serious secondary problems, such as self-destructive or risky behaviours, substance abuse and other numbing behaviours as well as self-neglect (Norman *et al*., 2006).

With regards to **intimacy**, trauma often causes profound alienation (McCann & Pearlman, 1990). Those who work with traumatised clients can also experience detachment as they become over-invested in their clients and emotionally unavailable to others, even to themselves (Hesse, 2002). Finally, the need to develop a meaningful frame of reference is an innate human need (McCann & Pearlman, 1990). This need, in part, is represented by cognitive schemas about causality. Traumatised individuals often obsess about why something happened (McCann & Pearlman, 1990). Similarly the worker may also attempt to understand why the event happened and may even start internalising the clients' unhelpful causal beliefs about the event. As in the trauma survivor, those who listen to ongoing reports of trauma may experience trauma imagery to return in fragments as intrusive and disruptive flashbacks, dreams or thoughts (McCann & Pearlman, 1990). They add that temporary or even permanent alteration of the memory system and a general sense of disorientation are not uncommon when the worker internalises client memories.

Simply put, one cannot remain completely unmoved and unchanged by continuous stories of trauma and suffering. Even mental healthcare professionals, despite their training and ongoing supervision, cannot fully escape the effects. Claims workers could be experiencing similar cognitive changes and their beliefs could be equally uprooted. It is also logical to argue that any negative cognitive changes could result in consequent behavioural changes. For instance, if one has constructive beliefs regarding safety, this will allow one to comfortably roam about public places. When safety beliefs are challenged, the person could start behaving differently – becoming nervous when leaving home, avoiding public places and perhaps even attempting to restrict the behaviour of loved ones

out of fear for their safety. Needless to say, these behaviours could cause friction and interpersonal conflict.

As with most other theories and concepts related to vicarious traumatisation, constructivist self-development theory was also mainly developed with professional trauma workers in mind. However, and very importantly, Pearlman and Mac Ian (1995) acknowledge that the effects of vicarious trauma do not arise only from client/therapist relationships but can occur across time in *any* helping relationship with trauma survivors. CSDT is not without flaws, but it was favoured by the present study for being very flexible and responsive. It suggests that each individual's reaction to traumata is based on a complex interaction between the individual's personality, personal history, the traumatic event, the context of the aftermath as well as the work context (Saakvitne *et al*., 1998; Dunkley & Whelan, 2006). Therefore, CSDT accounts well for variability in individual trauma responses. This theory is highly adaptable and relevant to most situations involving vicarious trauma, especially when one takes into account the principle that we each construct our own unique reality and are thus affected in very different ways (Saakvitne *et al.,* 1998).

In conclusion, CSDT fits well into the theoretical framework employed by the study. As stated before, the tenet that trauma and vicarious trauma filter into all aspects and levels of existence, ties in with the bio-psychosocial notion of systems thinking about phenomena. It also shares features with Figley's model, in that it acknowledges and draws upon the same concepts and processes of vicarious trauma. Figley (2003) states that his conception of compassion fatigue and the CSDT conception of negative cognitive changes are complementary. The two concepts in combination give a wider perspective and understanding of vicarious trauma. Figley's model focuses on delineating the process of vicarious trauma whereas CSDT focuses on negative cognitive changes – two related but different outcomes of the same process.

However, CSDT goes beyond describing an outcome of vicarious trauma, by showing how construction of reality is affected by direct and indirect trauma and how this reality, alongside beliefs, feelings and attitudes, can eventually impact behaviour and relationships. As stated earlier, the study utilised the TSI Belief Scale developed to quantitatively measure negative cognitive changes. This instrument was utilised to gauge the level of negativity in the cognitive schemas of the worker groups in relation to one another. Finally, the next part of the discussion focuses on the theory behind how vicarious trauma will be approached and investigated by the study.

1.4 Investigation of vicarious trauma.

Chosen variables were investigated by following a mixed methods research approach. Seeing that mixed methods research is relatively new, trendy and controversial, a review of some of the important literature is considered to offer background information on this research method.

1.4.1 A mixed methods approach to vicarious trauma.

The mixing of research methods has gained in popularity in recent years and has become increasingly appealing. Although it is seen as a new-found research approach, some believe that it originated from the writings of Campbell and Fiske as far back as 1959 and that of Jick in 1979 (Creswell, 2008; Tashakkori & Teddlie, 2003). Others have pointed out that its formal beginnings were in the late 1980s (Haines, 2011). This blending of methods is sometimes referred to as an integration or synthesis, multi-methodology or multi-method approach. However, from reviewing relevant literature, the preferred term seems to be "*mixed methods*" (Creswell, 2008, p. 25). The mixed methods movement is believed to have taken on the shape of a third research paradigm for the social sciences and Johnson and Onwuegbuzie (2004, p. 17) offer this definition:

> *...the class of research where the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, concepts, or language into a single study.*

It is stated, although circumspectly, that the mixed methods paradigm is believed to be informed by pragmatist philosophies (Barnes, 2012). Barnes explains that pragmatism acknowledges the existence of an objective reality as well as subjective perceptions of reality. He also feels that there is no reason that one should not strive to understand both and to realise that exploring both types of reality will result in a more fruitful understanding of a problem. Epistemologically speaking, pragmatism expresses the belief that it is near impossible to be subjective or objective and that most researchers fall somewhere between the two.

Barnes (2012) points out that pragmatism postulates that social research is often performed somewhere between qualitative induction and quantitative deduction and that the researcher continuously moves between the two throughout the process of mixed methods research. When it comes to the aspect of inference, the quantitative paradigm seeks to generalise findings to the broader population. By contrast the qualitative paradigm mostly focuses on the validity and relevance of their findings to a particular context, and how closely their findings represent this context. Pragmatism strives towards greater transferability of research findings to other contexts

(Barnes, 2012).

The mixed methods approach is credited with the expansion of the understanding of a phenomenon from one method to another, as well as confirming or converging findings from different types of data, or what is referred to as triangulation (Cresswell, 2008). It is viewed as a creative, eclectic and expansive form of research that can go beyond the limitations of a single approach (Johnson & Onwuegbuzie, 2004). These authors add that it holds promise in the research world, as it resembles more closely what researchers really do in practice.

The underlying view is that mixed methods research strives to combine the strengths of each approach in a way that is complementary, with weaknesses being non-converging (Johnson & Turner, 2003). For instance, a quantitative method, which entails a large sample size, offers generalisability, whereas a qualitative method, with modest sample size, yields in-depth, rich information (Haines, 2011). Through the quantitative method, magnitude can be expressed, while the qualitative component captures perceptions (Barnes, 2012). The qualitative component is often utilised to further explore unexpected quantitative results or to explain results from the quantitative component (Barnes, 2012). The underlying view stated earlier is also treated as a guiding principle whereby researchers should recognise the weaknesses and strengths of each method and align them in a way where one approach completes and supplements the other without amplifying their weaknesses (Johnson & Turner, 2003).

This type of design is especially helpful for construct-seeking, descriptive purposes and in cases where independent variables cannot be manipulated (Rosenthal & Rosnow, 1991). It is also believed that the mixing of the qualitative and quantitative methods will result in the most comprehensive and truthful portrayal of a phenomenon (Johnson & Turner, 2003). The real value of mixed methods research lies in its ability to assist in a deeper understanding of a phenomenon while creating greater confidence in the study and its findings (Haines, 2011). Mixing methods is argued to contribute to overall validity of a study through the triangulation of data as well as methods (Barnes, 2012).

Research methods are mixed for a number of reasons. In some cases, it is as simple as a researcher being inquisitive about or feeling drawn to a new method and way of thinking. In a more practical sense, some research questions are simply too complex to be successfully answered by one research approach alone (Barnes, 2012). As pointed out before, some study contexts might require

contextual particularity as well as context-free generality, or might wish to look objectively at recurring patterns whilst gaining a deeper subjective insight (Greene, 2008). Some studies might need to both explain and understand or initiate and infer and this method can respond to different paradigms and world-views (Haines, 2011). Haines further points out that mixed methods can often-times overcome the limitations of data collection and analysis of one or the other method.

Mixed methods have been used in a surprisingly vast diversity of study fields and usually involves a blend of less extreme versions of quantitative and qualitative methods (Creswell, 2008; Tashakkori & Teddlie, 2003), but it goes beyond simply straddling quantitative and qualitative methods. Denscombe (2008) explains that mixed methods research has developed its own foundation of thinking, as well as distinct practices that offer a valid alternative to the qualitative and quantitative paradigms. It has evolved into an independent methodological approach with its own nomenclature, unique world-view and series of techniques (Tashakkori & Teddlie, 2003). Since its introduction, it has developed its own distinguishable identity, wields a well-recognised name and is almost an embodiment of social research in the 21st century (Denscombe, 2008).

Finally, it is important to note that mixed methods research, along with its marked strengths, also carries certain weaknesses. For example, there are aspects of mixed methods research that lack consensus and consistency (Denscombe, 2008). For instance, Barnes (2012) reported more than 19 competing definitions, 65 guiding purposes for conducting mixed methods research and more than 30 unresolved issues that theorists are struggling with. Barnes (2012) also highlights the fact that there has been a long-standing impasse between the camps of qualitative and quantitative purists. From this stand-off, the incompatibility thesis was birthed, which vehemently argues that the two research traditions cannot and should not be mixed, due to their inherently separate epistemological and ontological world-views (Johnson & Onwuegbuzie, 2004).

However, Barnes' earlier statement on pragmatist philosophies often informing mixed methods research, largely negates the incompatibility thesis and instead provides a compelling set of arguments on why and how qualitative and quantitative methods are compatible. The burgeoning interest in mixed methods research has acknowledged that, while there are differences between qualitative and quantitative methods, there are nonetheless areas of overlap that offer strengths that go beyond what each paradigm can contribute on its own (Johnson & Onwuegbuzie, 2004).

There are also the fiercely debated issues of validity and triangulation. Even though these two concepts are presented as strengths of mixed methods research, there exists fierce criticism regarding these two aspects. For instance, Bazeley (2002) states that mixed methods researchers often assume that merely combining the two methods will produce valid findings. Researchers then often overestimate the validity of their findings by not giving their methodological choice any real consideration. Bazeley points out that the triangulation of results has become trendy and an over-used term that has lost its real meaning. She points out that the term is even used loosely as a synonym for mixed methods research which further obscures its real value. Bazeley stresses that triangulation does not automatically aid in validation and that each data source and method must be understood and evaluated on its own terms. At best mixed methods can express different facets of experience or knowledge (Bazeley, 2002). Given the amount of issues raised by a single method, one can only imagine the number of issues raised when combining two methods.

However, Johnson and Onwuegbuzie (2004) state that, if the fundamental principle of combining the strengths of the two methods without overlapping their weaknesses is adhered to, the resultant research will be far richer than a single method approach can deliver. Another point of criticism raised by Bazeley (2002) is that researchers are not specific about what they are mixing, how they are doing it and exactly at which junctures in the research process it is done. However, she acknowledges that even though mixed methods research might not offer corroboratory evidence, it very well may add breadth or depth to research or illuminate underlying processes.

There is also much truth in what Denscombe (2008) states, in that any research paradigm subjected to the same close scrutiny will show shortcomings, variances and inconsistencies. Therefore, just as with other research paradigms, the mixed methods paradigm cannot merely be disqualified because it holds certain flaws, seeing that no research paradigm is perfect. The researcher must, therefore, not make any assumptions based on the choice of methods and must be critically aware of the implications of methodological choices (Bazeley, 2002). To this, researchers and academia would probably immediately respond that *any* research method should be evaluated and scrutinised in this way. So, critical consideration is not an additional complication reserved for mixed methods research only, it extends to *all* types of research.

In a more practical sense, mixed methods research poses a reasonable challenge to the researcher. It requires intensive effort and time to perform the data collection and the analysis of two different types of data (Bazeley, 2002). The mixed methods approach also requires of the researcher to be

properly versed in both qualitative and quantitative research approaches and to understand the strengths and weaknesses of each (Creswell, 2008). Mixed methods research can often be more expensive in that it combines expenses and resources needed for both methods (Haines, 2011). However, what Barnes (2012, p. 7) points out is very effective in concluding this part of the discussion: "*If a paradigm/method does not advance knowledge or have implications for real world problems, then it is of little value*". This sentiment is shared in recognising that mixed methods research can add new possibilities for answering burning research questions. Why then should it not be embraced?

Since the present study is mainly exploratory and aims to illuminate and understand, the author was drawn to this paradigm. It was believed that a blend of quantitative and qualitative methods would be most appropriate in an effort to achieve the research goals and answer the research questions. The author agrees that mixed methods might add breadth and depth that go beyond what a single method can deliver. The study strives to offer more than one kind of knowledge on vicarious trauma and to expand on how it is traditionally researched. It is hoped that approaching a complex phenomenon in a largely unknown population in a holistic, eclectic way, whilst utilising a more new-found method of inquiry would yield novel information and add value to the body of knowledge on vicarious trauma.

The next chapter focuses on the research methods and revisits the issue of mixed methods research to explain how it was utilised in the present study.

CHAPTER FIVE: METHODOLOGY

Research Methods and Ethics

As explained in the introductory chapter, the study was largely structured around a well-known, comprehensive model of compassion fatigue designed for therapists. To this end, the model was deconstructed into its constituent parts and either qualitative, quantitative or both types of data were collected on each component. This was done to determine the applicability of each element to claims workers as well as to argue the suitability of this model within the administrative context. The reader is again referred to *Appendix A* for a bird's-eye view of how each model component was covered. The study also considered ways in which the model can be adapted or expanded upon to better fit the administrative context. Negative cognitive schemas and social support were also measured and themes were developed from the data.

1 Research Design

To accomplish the research goals and to best answer the research questions, a mixed methods approach was elected.

1.1 The mixed methods approach.

A non-experimental, ex post facto design, employing quantitative as well as qualitative methods, was employed. A mixed methods approach was chosen as it was believed that the research questions posed would be best answered by combining quantitative and qualitative methods. In order to offer a comprehensive and illuminating view of vicarious trauma, other related variables were carefully chosen to broaden insight and to offer a multidimensional portrayal of this phenomenon.

A concurrent triangulation strategy involving the collection of quantitative and qualitative data in a single phase was followed. This implies that the qualitative and quantitative data were collected at the same instant (Barnes, 2012). Qualitative methods were largely used to validate and corroborate the findings of the quantitative data. However, there was also a focus on creating a deeper understanding of vicarious trauma, which further expanded the study. In essence, the author wished to look at the magnitude of responses as well as capture perceptions on certain issues (Barnes, 2012). This involved an integration of research goals and research questions that were addressed by the quantitative and qualitative components of the study. Using this kind of design might create problems as divergent findings, if any, could pose a challenge to manage (Barnes, 2012). However,

the author believed that opting for this design would be a win-win situation as the two methods might, at best, enhance the confidence in the findings, or at worst, impart greater knowledge on the study variables facilitated by divergent information (Johnson & Onwuegbuzie, 2004).

To further elaborate on the triangulation utilised in the present study, both *intra*-method and *inter*-method approaches were used. The intra-method approach is defined as a single method employing both quantitative and qualitative elements simultaneously (Johnson & Turner, 2003). In the present study, a mix of both open-ended and closed-ended items was used to collect data. Such an approach is also often referred to as data triangulation whereby two distinct types of data are rendered. The approach employed by the study can also be viewed to some extent as being an *inter*-method approach, in that the study used neither purely quantitative nor purely qualitative methods, but a mix of the two. This approach, in turn, is often referred to as method triangulation in that two methods are blended (Johnson & Turner, 2003). In the study, both pre-existing, Likert-type, quantitative scales were used in conjunction to a more qualitative self-constructed questionnaire. Again, these two methods yielded distinctly different kinds of data, one being numerical and the other responses written in participants' own words.

Triangulation also involves juxtaposing findings from the two types of data to check whether each points to the same position or result. This allows the researcher to *"home in"* on a more complete and accurate understanding of a phenomenon (Terre Blanche & Durrheim, 1999 p. 128). The phenomenon is therefore studied with constant sensitivity to convergent or divergent evidence from different sources, such as qualitative statements, what is expressed in the scales as well as what is reported in literature (Terre Blanche & Durrheim, 1999).

Furthermore, prominent authors in the field of mixed methods research maintain that it is important to explicate the research strategy in terms of implementation, priority and integration (Creswell, 2008; Tashakkori & Teddlie, 2003). Implementation refers to the collection strategy of data – whether it is carried out in phases or at the same time. Implementation in the current research entailed the concurrent collection of qualitative and quantitative data. Priority refers to the degree of dominance and weight afforded to each of the types of data. In the present study, one method was not seen as dominant as both methods fulfilled an important role in the study. Each method also rendered distinctly different information that contributed in unique ways to the study. However, there was a slightly greater focus on quantitative analyses. Firstly, the quantitative data from measuring instruments were analysed statistically, followed by a quantitative approach to content

analysis. The last leg of the study involved thematic content analysis, which is a form of qualitative analysis.

Regarding integration, performing mixed methods research requires synthesis or mixing of the qualitative and quantitative components which can happen at various junctures in the study. It can happen throughout the study, or at least when drawing conclusions on the data analyses (Bazeley, 2009). The integration of the various elements, which is at the heart of mixed methods research, is a very challenging task as it is often controversial and both under-theorised and under-studied (Bazeley, 2009). In the case of the present study, the more common practice of integration primarily during the data interpretation phase was followed. Mixing, did however occur during other phases, but in a quite rudimentary and simplistic way and only to a limited extent.

Firstly, the research design phase did involve a certain amount of integration, however, only at a conceptual level. During the design phase, the formulation of the research questions featured looking at the various elements presented by Figley's model of compassion fatigue (2002a). A further point of departure involved the wish to systematically measure certain variables fundamental to the domain of vicarious trauma and then to test the accepted relationships between these variables that are consistently purported by theorists. From this point forward, the author had a set of questions in mind according to which pre-existing scales were selected to fit some of the questions, and a more qualitative questionnaire was developed to address the remaining questions that the scales were incapable of exploring. This decision to look at both the magnitude of responses as well as capturing perceptions on selected issues necessitated an integration or mixture of research goals and research questions. One can say that there was a purposeful combination of approaches prescribed by the research questions.

The way in which the research instruments were selected and used served as another point of intersection. The battery of instruments utilised offered a mixture of qualitative and quantitative instruments – that of scales as well as a self-constructed questionnaire. These were presented to each participant simultaneously. Bazeley (2009) observed that blending methods during the analysis phase by researchers is, as yet, quite rare. In the present study, data analysis integration did occur to some extent as frequency counts, a quantitative content analysis technique, was applied to the qualitative data to determine the magnitude and frequency of certain themes. During the discussion phase, the qualitative and quantitative results were integrated and offered side-by-side. An overarching, combined product was therefore created through logical and conceptual summation,

categorising and combining of the results.

1.1.1 Quantitative measures.

Key variables were measured systematically by using tested and validated instruments that were developed by leading researchers and experts of the various phenomena under investigation. These instruments yielded the numerical data that were examined by statistical analyses. For this purpose, test scores were obtained from short-term insurance claims workers who were the main focus of the study. These scores were compared to those from trauma counsellors, who are more closely associated with vicarious trauma.

Scores from a third group of workers who perform telephonic administration, who are not expected to deal with traumatised clients, served as a control group. This group consisted of holiday booking consultants. As indicated before, all participants were sourced from call-centre environments. Score comparisons were made between the main, comparison and control groups. The main focus was on frequencies, patterns and any significant differences between the groups. Widely accepted relationships between the key variables were also examined. The study sought to create a complete representation of vicarious trauma, including its prevalence, extent and nature specific to each of the three groups as well as for the sample. The emphasis was on how participants are typically affected, to what extent and in what areas of their lives.

1.1.2 The qualitative component.

The goals of illumination and expansion were furthered by also including a qualitative component to provide the study with richer, narrative-type descriptions (Terre Blanche & Durrheim, 1999). This not only elucidates and elaborates, but also contextualises phenomena (Regehr, Marziali & Jansen, 1999). For this purpose, variables of interest were formulated into questions presented to participants by a self-constructed questionnaire with a mix of open-ended and closed-ended items, as per *Appendix N.* This questionnaire was used to add more subjective, in-depth information (Neuman, 1997). Quantitative and qualitative content analyses were employed whereby data were classified into themes and the frequency and intensity of these themes were recorded. Themes that naturally emerged from the data were also given considerable attention. Next, the quality, reliability and validity of the study are given consideration.

2 Quality, Reliability and Validity

2.1 Quality issues.

This part of the discussion focuses on the various measures taken into account to increase the quality of the present research.

2.1.1 Weakness minimisation legitimation.

During a mixed methods approach, its fundamental principle should be a guiding precept. This principle requires that methods be combined in a way that the strengths of each approach are complementary and that weaknesses are non-converging. (Johnson & Turner, 2003). It also refers to the degree to which the strengths of one method are utilised to address the weakness of the other (Barnes, 2012). For example, in the present study, the strengths of the closed-ended items were considered to be their objectivity, specificity and their value-free, quantifiable nature that rendered them easy to categorise and analyse. One weakness was that the person and the context were largely lost. The more open-ended questions managed to capture the person's voice as well as the unique phenomenological context and thus offered a truer version of participants' feelings, opinions and attitudes.

Therefore, the use of more open-ended items was believed to palliate the restriction of response range placed upon participants by closed-ended scale items. The weakness of more open-ended items rested in the fact that they were more challenging to categorise and were more open to interpretation, which rendered them somewhat susceptible to misunderstanding. An obvious strength of pre-existing scales is that researchers dedicate much time and effort to ensure reliability. The strength of the self-constructed questionnaire, even though it might not offer corroboration, is that it offered a richer, and at times, more emic point of view.

Barnes (2012) further explains that a study would typically have poor weakness minimisation legitimation if both methods, for instance, repeated the same questions. Therefore, a study would have a stronger weakness minimisation legitimation if the qualitative component is designed to ask questions that the quantitative component does not cover. When the self-constructed questionnaire was developed, care was taken not to overlap questions in this way. Instead, the author attempted to formulate questions that either complemented or supplemented the quantitative research questions. It is believed that the information yielded by the qualitative data completed the quantitative data, by revealing more about the unique nature and process of vicarious trauma within each of the worker groups as well as shedding light on the unique worker contexts. It also highlighted important points

that the quantitative data overlooked.

2.1.2 Sample integration legitimation.

Ordinarily, the inferential quality and generalisability of a study are weakened when sampling is non-random (Onwuegbuzie & Johnson, 2006). In the study, the author used purposive sampling, relying on workers from the various participating organisations to volunteer their participation. However, purposive sampling might not be the ideal when it comes to randomisation. Participation was a challenging issue and each gracious opportunity afforded by organisations was grasped in order to realise the present research. However, Onwuegbuzie and Johnson (2006) also state that, in reality, the majority of empirical research studies do in fact utilise non-random samples. As with the present study, this is often simply a complication of conducting research in the real world.

Small sample size is another factor that could weaken sample integration legitimation (Onwuegbuzie & Johnson, 2006). In this respect, care was taken to use reasonably sized comparison groups in an effort to make results more generalisable to the target populations. Usually, qualitative samples are relatively small, whereas quantitative samples are normally much larger by comparison. In the present study, the author tried to use a sample size that fell somewhere between the two – much larger than is customarily used for qualitative research but smaller than what quantitative research usually calls for.

However, sample integration legitimation is dramatically improved by the degree to which the quantitative and qualitative samples utilise the same participants (Onwuegbuzie & Johnson, 2006). In the present study, the same individuals completed both the qualitative and quantitative instruments. Therefore, inferences made by the qualitative data extend to the exact same group of participants used for the quantitative leg of the study. Even though this strategy was surprisingly time-consuming and yielded a considerable amount of data to cope with, it nonetheless ensured improved legitimacy of inferences made from the quantitative and qualitative data.

2.1.3 Inside-outside legitimation.

This term refers to the degree to which the researcher integrates both the researcher's, or outside view, as well as the research participants', or inside view (Onwuegbuzie & Johnson, 2006). Barnes (2012) adds that it is important not to overly interpret data from the researcher's perspective at the cost of the participant's reality, or vice versa. Researchers often become so engrossed in making the data fit the research questions and in conveying what the study wishes to convey, that the

participant's voice is lost. Ensuring that the emic view is adequately represented by the research is crucial (Barnes, 2012). In the present study, the insider voice was also honoured by not only sorting data according to *a-priori* or predetermined categories, but to also let the data speak more freely. To this end, themes naturally emerging from the data were also afforded attention. Even though these themes might not have had the same compelling academic implications, theoretical significance or the direct bearing of the *a-priori* categories, they were nonetheless regarded as a valuable part of the study and given due consideration in order to present a truer view of participants' experiences.

2.1.4 Conversion legitimation.

This point refers to the fact that all inferences that are made after "*quantitising*" and "*qualitising*" of the data should be scrutinized (Onwuegbuzie & Johnson, 2006, p. 53). The degree to which data conversion techniques result in interpretable data and heightened inference quality is referred to as conversion legitimation. In the present study, the counting of qualitative themes was utilised alongside emergent themes to stymie the overestimation of the importance of either *a-priori* or emergent themes. It was also believed that this practice gave more meaning to qualitative statements in general by considering their magnitude and frequency. However, verbal counting can be misleading (Onwuegbuzie & Johnson, 2006). Even though it was very time-consuming to do, statements were looked at as a whole and within the context they were made in an effort to remedy over and non-contextual counting.

Conversion legitimation of quantitative data proved to be more problematic. Several profiles were used, such as average, comparative, normative and holistic profiles. Such profiles involve creating a narrative as a descriptor to attach meaning to each profile (Onwuegbuzie & Johnson, 2006). However, these authors point out that descriptions can lead to over-generalisation and an unrealistic representation of people. This fact was acknowledged; however, it was hoped that the more qualitative, contextual data would allow for more realistic representations of participants.

2.1.5 Multiple validities legitimation.

This form of legitimation refers to the degree to which all applicable research strategies are used and the extent to which the research can be evaluated as upholding multiple high validities (Onwuegbuzie & Johnson, 2006). For instance, when covering legitimation of the qualitative component, the relevant qualitative validities should be addressed satisfactorily. Similarly, when it comes to the quantitative component the relevant quantitative validities should be treated with the same rigour. During integration, therefore, the applicable mixed legitimation types outlined above

should also be addressed and achieved. The next section confirms how these various validities were dealt with.

2.2 Reliability and validity.

Throughout the process of the research, reliability and validity issues were considered in an attempt to increase the quality of the research. Reliability is described as the degree to which measures or observations are stable or consistent (Rosenthal & Rosnow, 1991). This means that, every-time the instrument is used it should yield the same measure (Martin, 2006). Martin further explains that an instrument is reliable if it is capable of measuring accurately as well as providing a true reflection of the measured attribute. To this Hassett (2006) adds that reliability is about the internal consistency of the measuring instrument or the correlation of the test within itself. This also relates to the instrument's consistency over time.

In the present study, care was taken to ensure that the instruments fit the study domain as best possible. The reliability of the study was increased by using well-researched, tested and validated instruments for the quantitative tier of the study. The reliability of the pre-existing scales was calculated and compared to results reported by previous research studies to evaluate the internal consistency reliability for the present study. These results are discussed later in this chapter. Furthermore, the author did all within her power not to violate the assumptions for the various statistics that were used. Reliability and generalisability were further improved by checking for errors and extraneous variables as far as possible.

For one, all participants were sourced from call-centre environments and the study intended to omit those participants with recent, serious personal traumas. Worker groups were also carefully selected to broaden the applicability of the study findings and to make the account as generalisable and relevant to the field of vicarious trauma as possible. The researcher also attempted to minimise researcher bias by remaining as objective and neutral as possible throughout the process of the handling the data. Well-developed and sought-after quantitative and qualitative analysis software packages were used to assist in the data analyses.

Next, the validity of a scale or questionnaire refers to the degree to which it measures what it is supposed to measure (Rosenthal & Rosnow, 1991). The validity of each of the scales used in the present study, including the self-constructed questionnaire, is also returned to later in this chapter. As for the overall validity of the study, the research design utilised did not depend on only one

method and one type of data, but instead merged quantitative and qualitative data in a complementary way, which is also the precept of mixed methods research. As discussed before, this combination of methods was also believed to somewhat alleviate reactive effects from research participants. Another strategy believed to be useful is for the research to be reviewed meticulously (Onwuegbuzie & Johnson, 2006). These authors explain that the research can be presented to other trained researchers to examine the interpretations made as well as consider the conceptualisations and conclusions reached. In the present study, an array of research auditors in the form of supervisors, an external editor and eventually the examiners, were involved in the research project. It is believed that each of these auditors would have contributed significantly to the quality of the research once the project has reached its final form.

In terms of descriptive validity, the researcher strove towards giving a clear and accurate account and report of the research. Descriptive information was collected and corroborated meticulously. To further increase the descriptive validity herein, great care was taken to express what participants were saying instead of merely focusing on what the author wished to convey, by affording naturally emergent themes considerable attention. This point was discussed in some detail earlier. At the same time, the theoretical validity was also considered at various junctures of the study by ensuring that the theoretical explanation closely fit the data without forcing the data. Internal and external validity and reliability issues were reflected upon at certain intervals in an attempt to improve the author's justification in drawing certain inferences from the data and to improve the degree to which the research findings can be generalised.

2.2.1 Inter-rater reliability.

The level of inter-rater agreement was also gauged in cases where data were categorised according to certain features or objectives. To ascertain inter-rater agreement, 20% of the categorised data along with the objects and descriptions of each category were considered and evaluated by a second rater. The percentage of agreement across the multiple judgements was then calculated to gauge the consistency of these judgements. A high level of agreement (86%) was reached in the present study, whereby the author and the second rater disagreed in 14% of the rated cases. Differences between raters were dealt with by reviewing relevant participant responses alongside rater evaluations. These responses were reconsidered and recategorised accordingly. Finally, throughout the research process, the author also reflected upon the research process and what was evoked at a personal level by the study.

2.3 Reflexivity.

Throughout the research process, the mixed methods approach required of the author to constantly move between an objective and subjective stance. Onwuegbuzie and Johnson (2006) describe this process well by proposing that the mixed methods researcher constantly switches between the quantitative and qualitative lenses. This was a challenging task and it was no surprise to learn that this capability often requires cognitive and empathy training. Onwuegbuzie and Johnson (2006) explain that the researcher, in essence, through an iterative process, creates a third product or viewpoint nested between, but also going beyond, the pure quantitative and qualitative viewpoints.

To be able to accurately interpret the research findings and to create this third viewpoint was no easy feat. Apart from having to oscillate between viewpoints, while staying close to theory and the study objectives, it also required reflexivity, tremendous self-awareness and self-questioning to reflect not only on the research process, but one's own thoughts, actions and influences within this process. The author often had to move beyond personal views, values and biases to re-construct the participant's experience by means of critical consciousness. Cunliffe (2004) states that, in doing so, one often has to negotiate unsettling terrain as one has to suddenly upend one's own basic assumptions, discourse and practices. In line with this statement, the author had to become less complacent and overcome automatic thinking, ways of being and reacting, while simultaneously stretching the mind to see beyond the research process, its framework and pre-suppositions. At times the author had to attempt to walk in the subject's shoes and share their feelings and experiences as well as reflect on these.

At the outset of the study, the author had the good intention of keeping a research diary to document the often-times ambitious and difficult research process. Regrettably, as the research became more challenging, time-consuming and absorbing, these good intentions were unfortunately left by the wayside to make time for the more pressing tasks at hand. However, the process of constant reflection and reflexivity continued and endured.

3 Research Questions

As indicated before, the study was structured around Figley's model of compassion fatigue (2002a). However, the overarching and guiding research question entailed the depth and breadth as well as the nature of vicarious trauma within the worker groups and how participants are affected in various areas of their lives. The research questions collectively attempted to illuminate the nature of vicarious trauma within the sample as well as within each of the worker groups. The overarching

question was broken down into a series of quantitative and the qualitative questions that are offered over the course of the ensuing paragraphs.

3.1 Group comparisons.

The following two research questions were set in search of significant differences between worker groups on the various study variables:

1. Is there a significant difference in the levels of secondary traumatic stress, negative cognitive schemas, empathy, compassion satisfaction and social support between short-term insurance claims workers, trauma counsellors and the control group of holiday booking consultants?

2. Are there significant differences in the negative cognitive schemas, secondary traumatic stress, empathy, compassion satisfaction and social support scores between short-term insurance claims workers with a wellness plan compared to those claims workers without a wellness plan?

3.2 Relationships between variables.

As stated before, there exist traditionally accepted relationships between vicarious trauma and several associated correlates. Research studies involving well-researched groups or those groups more obviously associated with vicarious trauma consistently report on these relationships. The present study wished to determine whether these accepted relationships between the vicarious trauma measures and certain selected correlates hold true within and across the worker groups:

1. Are there significant relationships between secondary traumatic stress, negative cognitive schemas, empathy, compassion satisfaction and social support within and across the worker groups, and what are the nature and strength of these relationships?
2. Is vicarious trauma – being secondary traumatic stress and negative cognitive schemas – explained by empathy, compassion satisfaction and social support in the sample as well as in each of the worker groups?

3.3 Qualitative research questions.

The remainder of the focus rested on the more qualitative data, which allowed for richer, in-depth expressions to develop. These also allowed participants relative freedom to explore some experiences

(Terre Blanche & Durrheim, 1999). Questions were developed which were presented to participants in the form of a self-constructed questionnaire. *Appendix N* presents a copy of the questionnaire.

As stated in the previous chapter, mixed methods research is often characterised by the use of a blend of less extreme versions of quantitative and qualitative methods (Creswell, 2008; Tashakkori & Teddlie, 2003). This feature also extends to the present study. It has to be mentioned here that the self-constructed questionnaire might not be construed as quintessentially qualitative. For instance, some of the questions were not formulated to evoke unrestrained dialogue. Due to the time constraints of the study as well as those imposed upon participants, questions were structured to cover specific issues. Also, a few of the questions required shorter, more concise answers and were leading in the sense that they were devised to gain information on particular issues.

However, a number of open-ended, exploratory questions were included in the questionnaire that qualifies it as being qualitative. Although the questionnaire might not fit a purist definition of a qualitative inquiry, the information rendered is nonetheless verbal and communicative as opposed to numerical or quantitative. Consequently, the term *"qualitative"* is used more loosely in the present study. Also, the self-constructed questionnaire and the data yielded are referred to as *"qualitative"* throughout the thesis. This is done for ease of reference, and even though these might not be qualitative in the strictest sense of the word, it is still the closest fitting definition. The next section gives the reader a sense of the questions as well as the issues that gave rise to certain questions:

1. Did any participants experience recent personal traumas, what was the nature and extent of such trauma and is the person still traumatised?

2. What are participant's perceptions and feelings about working with traumatised clients?

3. What kinds of cases are affecting participants most negatively, how are they affected, what about cases are affecting them and what is the duration of these effects?

4. Are participants able to disengage from client trauma and to what extent?

5. What other difficult life demands did participants have to deal with, how were they affected by these life demands and to what extent?

6. How often do participants fall ill or take sick leave, have participants ever utilised sick leave as a coping mechanism and, if so how often does this happen?

7. Do participants feel that difficulties at work are contributing to illness or to the person taking sick-leave?

8. What else in the work environment has had a negative effect on participants and how are they affected?

9. How are participants supported by their work environment and what can their work environment or employers do to help them cope better with their work demands/environment?

Collectively, the qualitative and quantitative data united to offer a comprehensive and multidimensional view of vicarious trauma and its effects within the population of claims workers compared to trauma counsellors and the control group of holiday booking consultants.

4 Research Sample

Three distinct groups of participants were assessed. The first group consisted of short-term insurance claims workers, referring to those workers who seek to determine the extent of the short-term insurer's liability when a claim is submitted (Ambest, 2011). The claims worker mainly receives formal notice on behalf of the insurer of an insurance claim to follow. This worker corps is usually a collection of various workers each performing specific claims related duties. It typically consists of junior and senior claims clerks or administrators, or what other companies refer to as adjusters, as well as claims managers. This worker corps often extends to also include in-house and independent assessors and loss adjusters who also fall within this broad group.

Although there is no official definition for short-term insurance, the following impressions were formed from the descriptions offered by some of the participating insurers. Firstly, short-term insurance encompasses all types of insurance policies, other than life insurance, and mainly covers the possessions of an individual or business. Short-term insurance policies are valid for a set period of time, most often 12 months. Some short-term insurance polices have been extended to offer liability, funeral, personal accident and accidental death cover.

For the purposes of the study, claims workers were sourced from short-term insurance claims call centres. These claims workers are usually the first line of workers to deal with insurance clients reporting or lodging claims. Some of these workers also answer help-lines from which emergency and assistance services are deployed to offer road-side assistance, including after road accidents, as well as to assist during or after other insured exigencies. Major insurers were approached for their participation and 50 completed batteries of scales/questionnaires were sourced from their claims workers.

Next, trauma counselling organisations that assist clients and victims of trauma from call centres were approached for participation. It was hoped that at least 50 counsellors would participate, but after over a year of imploring, negotiations and multiple meetings with suitable organisations, only 46 usable batteries of scales/questionnaires were sourced from suitable trauma counsellors. Finally, a group of booking consultants from holiday/travel call centres were approached. As they were not expected to customarily deal with traumatised clients, they served as the control group. After just over a year, 48 suitable booking consultants were sourced to participate.

Some of the measures taken to control for extraneous variables are briefly considered. Firstly, all participants were sourced from call-centre environments. There was general consensus that trauma counsellors in direct practice would introduce too many extraneous variables. Moreover, Fisher, Milner and Chandraprakash (2007) who performed a South African call-centre case-study pointed out that call centres are very particular environments in themselves. Methodologically, it seemed more sensible to source all participants from this environment. Also, trauma counsellors were screened carefully to exclude those who perform other forms of trauma work. Personal trauma history was also a deciding factor and those with recent, more serious personal traumas were omitted from the study.

To add further value to the study, the most prominent, well-known and long-standing companies in the short-term insurance, trauma counselling and holiday/travel industries were approached for participation. Even though this made data-collection more challenging, the author felt that data from more important, recognised “major players” within their respective fields of expertise would give an additional edge to the study. It was believed that this approach would further increase the comparability of groups as well as their representativeness to the various fields of expertise within which they operate. All of the organisations that were earmarked are significant, influential and sizeable, with extensive worker corps and huge client bases that operate from Gauteng Province.

5 Data-collection Procedures

The data-collection process spanning a period of 15 months, was a drawn out and often very difficult process to negotiate. The Human Resource Managers of the organisations earmarked for participation were contacted firstly. Then standard information letters for each of the three different industries were e-mailed or faxed to the relevant person/s, expounding the outlines of the study (please see *Appendices C to E*). Follow-up calls were made to the HR managers to firstly request their participation, then to explain and finally arrange the process. In the end, nine organisations agreed to participate – three of the leading short-term insurers, three trauma counselling and three holiday booking agencies. Due to the size of these organisations, negotiations were often complicated by the fact that some of the HR departments were in provinces other than Gauteng.

For instance, in the case of one of the insurers, meetings and negotiations had to be postponed until the HR Officer visited the Gauteng Province from Cape Town. A meeting with the HR Officer was then set up at a location that was accessible to the author, which was tremendously generous and considerate on their part. The lengths some of these organisations went through to assist were genuinely commendable. There were a few other anxiety-provoking hurdles that dragged out the process well beyond the expected time-frame. In a particular case, one of the insurers changed HR Managers when negotiations were almost complete. The author then had to re-negotiate the entire process with the new HR Manager. In another instance, a key gatekeeper left the company which resulted in the entire process coming to a halt until the successor was appointed, settled in and ready to assist. Furthermore, the trauma counsellors proved to be the most difficult out of the three groups to obtain data from. However, despite growing despondency, numerous challenges, hurdles and set-backs, the author persevered.

Upon concluding the negotiations with the HR Managers, the relevant Branch Managers or persons in charge of the actual call centres were then contacted to schedule the next round of introductory meetings. At these meetings, the relevant managers were informed of all aspects of the proposed study. Data-collection was then negotiated and arranged. Data collection was conducted on pre-scheduled dates in private locations allocated by the organisations. Again their generosity, effort and the way in which the author was received was noteworthy. On-site completion of the questionnaire packages were performed in the majority of cases. In some cases, small groups of between three to five workers were relieved of their duties in the call centres to complete the questionnaires. In a few other cases, the questionnaires were distributed to interested candidates, which were completed at their desks between calls. Data collection continued over the course of a

number of days at each organisation, until the negotiated target was reached.

In all the cases described above, the scales/questionnaires were personally handed back to the researcher by participants, thus keeping responses confidential. In the case of all participants, biographical details were obtained by means of *Appendix H*. Before commencing with the completion of the questionnaires, each participant was fully informed of the research aims and the ethics of the study verbally. The author was personally present throughout each data collection session, which gave participants the opportunity to ask questions. In addition, each battery of scales/questionnaires contained a Participant Information Sheet which clearly outlined the nature and purpose of the study in writing (please see *Appendix F)*.

In a few cases, data collection could not be performed on-site. In one case, the author liaised with the founding member of the organisation, who agreed to participate upon condition that the questionnaire packages be left with the organisation, which were then distributed to interested participants in their call centre. Those who volunteered to participate then completed the questionnaires at their desks whenever they had a spare moment, or at home, to ensure uninterrupted service to clients. To guarantee confidentiality of responses, scale/questionnaire packages were furnished with a self-addressed, stamped envelope. Participants then posted their questionnaires upon completion. In another case, an assistant was instructed by the HR Manager to distribute the scale/questionnaire packages to interested candidates. The completed packages were then left in a slotted box by participants, which were then collected by the author at a later date. In these cases, each package also contained an envelope and written request to properly seal the envelope before depositing it into the box, to ensure confidentiality of responses.

To complete the scales and questionnaires involved took approximately 45 minutes to an hour, however, a period of one and a half hours were allotted in the case where participants were allowed to complete the scales in a single sitting. Other participants completed the scales/questionnaires over the course of several days at their desks or at home. To obtain written consent, each participant was asked to complete the Consent Form as per *Appendix G*. Those who preferred to remain anonymous either initialled or signed the document. A few participants refrained from completing the Consent Form altogether, and in these cases, participation was viewed as consent, as all participants were explicitly informed of their right to refrain from participation or to withdraw at any point. To completely conceal the identity of participants and participating organisations, the primary document number generated for each participant by the Atlas.ti software was utilised. Only

the author had access to the completed questionnaires, which were stored in a safe place. Supervisors only viewed spreadsheets or samples of the data.

6 Instruments

The various instruments utilised by the study are considered next. It has to be mentioned here that, as the present study evaluated a number of variables, the length of the instruments was an important deciding factor that had to be weighed carefully to minimise time pressures on the participating organisations.

6.1 Biographical questionnaire (*Appendix H*).

Biographical information was collected from all participants to provide some background on the sample.

6.2 TSI Belief Scale (*Appendix I*).

The Traumatic Stress Institute (TSI) Belief Scale is an 80-item, 6-point Likert-type scale that measures the effects of vicarious trauma on cognitive schemas. The scale is rooted in constructivist self-development theory (McCann & Pearlman, 1990). It focuses on the level of negativity of beliefs about the self, others and the world, following vicarious trauma. The scale consists of ten sub-scales which collectively measure beliefs in five psychological needs areas, in relation to either the self or others. The five needs areas covered are safety, esteem, control, intimacy and trust.

The ten sub-scales are Self-Safety, Other-Safety, Self-Esteem, Other-Esteem, Self-Control, Other-Control, Self-Intimacy, Other-Intimacy, Self-Trust and Other-Trust. Each sub-scale comprises between seven and ten items. These areas collectively examine parts of the person's frame of reference vulnerable to change from vicarious trauma. The authors do not provide cut-off scores and simply state that the higher a score, the more negative cognitive schemas are and the greater difficulty the person expresses to integrate or make sense of traumatic materials (Wiebe, 2001).

The TSI Belief Scale was utilised to measure the levels of negative cognitive schemas in the various worker groups. Of course, in pre-test/post-test or longitudinal studies, this instrument has the power to reveal how a person's cognitive schemas are shaped by trauma exposure. However, as in the case of the present study, these research designs are often not possible, in which case the instrument was used to reveal the present level of negative cognitive schemas of the worker groups in relation to one another.

This instrument was chosen as it was believed that this measure would add a different dimension – that of cognitive changes associated with vicarious trauma – to the study. However, the TSI Belief Scale is an earlier version of the more recently developed Trauma Attachment Belief Scale. The TSI Belief Scale, devised around 1990, was nonetheless opted for as it had been used more prolifically over the years than its successor, including in the South African context (*e.g* Davidson, 2001; Friedland, 1999; MacRitchie, 2006; Martin, 2006). From this prolific use emerged vast amounts of information on the use of the scale, including its psychometric properties (*e.g.* Adams, Matto & Harrington, 2001; Belanger, 1999; Radey & Figley, 2007; Jenkins & Baird, 2002; Kadambi & Truscott, 2004; Van Deusen & Way, 2006).

In 1996, Pearlman reviewed various unpublished studies that utilised this scale, and reported an average internal consistency reliability of .98, with sub-scale reliabilities ranging from .68 to .84 (Schauben & Frazier, 1995). In a more recent study, sub-scale reliabilities ranged from .62 to .83 (Jenkins & Baird, 2002). Concurrent and discriminant validities have been confirmed (Jenkins & Baird, 2002). Strong convergence with general distress was found, but also satisfactory independent shared variance (Jenkins & Baird, 2002). In the present study, Cronbach alphas were calculated for the scale as well as sub-scale items.

This test revealed item 35 of the scale as problematic. This item correlated negatively to the item total and its relationship to other items did not always make sense. The item states the following: "*Some of my happiest experiences involve other people*". It is unclear why participants responded differently to this item. However, it is possible that participants might have responded to different parts of the item. Some might have focused on whether they prefer their happiest experiences to involve others or not. Others might have focused on how often happy experiences involved others.

In the end, it was decided to exclude this item from further analysis as its absence improved the overall item total correlations. For the scale items, sans item 35, a Cronbach alpha of .95 was yielded. Cronbach alphas ranging from .70 to .84 were achieved for the sub-scales, which are quite similar to the alphas reported by Schauben and Frazier (1995) in the previous paragraph.

6.3 Secondary Traumatic Stress Scale (STSS) (*Appendix J*).

This 17-item, 5-point Likert-type scale was devised to measure secondary traumatic stress in those who assist traumatised clients. It measures secondary traumatic stress along the dimensions of frequency of intrusion, avoidance, and arousal symptoms. It was developed by Bride *et al*. (2003)

and several studies have been carried out into its internal consistency and reliability. Clear evidence of convergent, discriminant, and factorial validity was found (Bride *et al*., 2003). Overall high factor inter-correlations confirm that the STSS is a valid, reliable, unidimensional scale (Ting, Jacobson, Sanders, Bride & Harrington, 2004). It was also utilised recently in a South African study (Gwandure, 2007). The use of the STSS in conjunction with the TSI Belief Scale discussed above, is believed to be a sound combination (Hope, 2006). The first covers the cognitive impact of trauma work while the latter focuses on the prevalence and extent of post-traumatic stress disorder or PTSD symptoms from exposure to traumatised individuals.

Traditionally, secondary traumatic stress is measured in two ways: by using an established PTSD measure, or by using a measure specifically developed for secondary traumatic stress (Elwood *et al*., 2010). For the purpose of the study, the STSS, a secondary traumatic stress measure was opted for. The STSS had been used often in secondary traumatic stress studies since its conception (Elwood *et al.,* 2010). Its formulation around PTSD diagnostic criteria has often been highlighted as a strength of the measure (Bride, Hatcher & Humble, 2009).

Several measuring instruments were considered for their suitability. For instance, one very popular instrument is the Compassion Fatigue Self-Test or CFS-T, developed by Figley around 1995. Various revised versions of this scale were most commonly used as they were the first developed to measure compassion fatigue/secondary traumatic stress; however, the CFS-T also assesses burnout (Bride *et al*., 2007). For this reason, this instrument is more than twice the length of the STSS, which made the latter the obvious choice. Finally, the CFS-T has recently fallen out of favour somewhat due to concerns about psychometric problems (Hope, 2006). For instance, Adams *et al*. (2006) specifically called into question the factor validity of the measure.

Furthermore, the wording of the STSS was devised to specifically capture work with traumatised clients as the only traumatic stressor (Bride *et al*., 2007). This was done to minimise the possibility of respondents endorsing items based on a direct experience of traumatisation. Bride *et al*. (2003) further report that the STSS differs from the myriad of other PTSD and secondary traumatic stress measures in that half of the items are stressor-specific, relating to exposure to clients. The other half are not stressor-specific, which relates to the typical negative effects that are associated with PTSD, as indicated by the DSM-IV.

Cronbach alphas were calculated herein. For the scale items, a Cronbach alpha of .93 was established. Cronbach alphas were also calculated for the various sub-scale items which ranged from .80 to .88.

6.4 Interpersonal Reactivity Index (IRI) (*Appendix K*).

The IRI is a 28-item, 5-point Likert-type scale which was designed to measure empathy as a multidimensional construct, which allows for the cognitive as well as emotional aspects of empathy to be explored (Davis, 1980). Empathy is measured along the dimensions of Perspective Taking, Fantasy, Empathic Concern and Personal Distress (Davis, 1980). Empathic Concern and Personal Distress are the affective sub-scales, whereas Perspective Taking and Fantasy are the cognitive sub-scales (Ashraf, 2004). Internal consistency reliability was reported to range from .70 to .78 across the sub-scales. Pulos, Elison and Lennon (2004) reported similar internal consistency reliabilities ranging from .75 to .82 (2004). Canonical analysis provided additional confirmation for the convergent and divergent validity of the IRI (Alterman, McDermott, Cacciola & Rutherford, 2003). It has also been used in the South African context (Harinarain, 2007; MacRitchie, 2006).

Ashraf (2004), who wrote a comprehensive doctoral thesis on the phenomenon and measuring of empathy, reported the Emotional Empathic Tendency Scale or EETS, devised by Mehrabian and Epstein in 1972, to be the most widely used measure in this domain. From research on the EETS, Mehrabian developed the Balance Emotional Empathy Scale or BEES around 1996. In 1982 Bryant developed the Empathy Scale or ES, which is used with some frequency, but it was developed mainly for use with children (Ashraf, 2004). In addition to the scales mentioned thus far, a multiplicity of empathy measures have been around for decades, each having a very valid and interesting approach to empathy.

In the present study, the IRI was opted for as it is considered to be amongst the most widely used instruments for measuring empathy (Pulos *et al*., 2004). The IRI was earmarked because it is a multidimensional measure which also differentiates between affective and cognitive components of empathy (D'Ambrosio, Olivier, Didon & Besche, 2009). Empathy is furthermore measured along dimensions that fit the modern conception of empathy well (D'Ambrosio *et al*., 2009). The IRI measure was further chosen for its capability to determine the effects from engaging with traumatised clients. For instance, the Personal Distress sub-scale yields information specifically on negative effects from empathic engagement which is highly relevant to the study. Also, it consists of only 28 items, which makes the IRI one of the shorter measures to select from. Seeing that the

length of measures was a crucial deciding factor in the present study, the IRI was ideal.

Internal consistency reliability tests for the present study revealed a Cronbach alpha of .74 for the scale items. Cronbach alphas for the sub-scale items ranged from .67 – .80.

6.5 ProQOL R-IV Compassion Satisfaction Sub-scale (ProQOL-CS) (*Appendix L*).

The Compassion Satisfaction sub-scale that was utilised, forms part of a larger 30-item scale. Each item is rated on a 5-point Likert-type scale. The full-length scale was developed by Stamm in 2003 and consists of three discreet ten-item sub-scales, being compassion fatigue, compassion satisfaction and burnout. The full-length instrument yields three separate sets of scores relating to each of the three dimensions and does not offer a composite score. Each sub-scale is believed to be a psychometrically unique unit (Stamm, 2005a). As the proposed study is only interested in looking at the role of the sense of satisfaction with compassion responses, only the compassion satisfaction sub-scale was utilised.

The psychometric properties of the sub-scale have been clearly demonstrated, and an alpha of .87 is reported (Stamm, 2005a). Stamm confirms that the construct validity of the compassion fatigue sub-scale, based on over 200 articles, is well-established. Tests of discriminant and convergent validity have revealed that each sub-scale is in fact a discreet unit, measuring a different construct (Stamm, 2005a). This permitted the use of the Compassion Satisfaction sub-scale on its own. Finally, it was also used quite recently during a doctoral study in the South African context (Smit, 2006).

In Stamm's history of involvement in the advancement of the concepts of compassion fatigue and secondary traumatic stress, she argued that both negative and positive items should be used (Adams *et al*., 2006). As stated before, this approach has long been believed to offer a more balanced view of vicarious traumatisation (Stamm, 2005a). If an individual is interested in the positive aspects of trauma work, the ProQol-CS sub-scale is recommended (Elwood *et al*., 2010). As the study sought to offer a balanced, multifaceted view of vicarious trauma, measuring a positive correlate such as compassion satisfaction, fit well into the framework of the study goals.

Finally, internal consistency reliability tests revealed a Cronbach alpha of .88 for the Compassion Satisfaction sub-scale in the present study.

6.6 Social Support Questionnaire – Short Form (SSQ6) (*Appendix M*).

The SSQ6 is a 12-item, 6-point Likert-type scale which measures the level of perceived social support. Six of the items relate to the number of available supports (Number sub-scale) and another six items refer to the level of satisfaction with the support in a particular situation (Satisfaction sub-scale). Internal consistency reliability has been reported to range from .90 to .93 (Sarason *et al*., 1987). The SSQ6 was validated and the scale correlated strongly with other measures of social support (Sarason *et al*., 1987). For the proposed study, an additional three questions were added to gauge the need, availability and attitude towards formal psychological support. However, these questions did not form part of the SSQ6 and data from these questions were looked at separately. They therefore did not influence the psychometric properties of the SSQ6. Finally, Basedau (2004) reported having used the SSQ6 in a 1999 study within the South African context.

Several measures of social support were looked into for their suitability to the present study. As stated earlier, time was of the essence, and measuring social support is often lengthy and tedious (Sarason *et al.*, 1987). Furthermore, despite a great increase in social support research, there is no clear and efficient criterion for its definition or measurement; however, some literature sources propose certain recommendations (Chronister *et al*., 2006). For one, social support research indicates that measuring perceived support as opposed to actual support is more useful (Basedau, 2004; Sarason *et al*., 1987) Furthermore, the use of multidimensional measures is encouraged when measuring multidimensional constructs, such as social support (Chronister *et al*., 2006).

Sarason *et al*. (1987) developed the SSQ6 in response to the need for a shorter measure, which is a condensed version of the Social Support Questionnaire (SSQ). The SSQ6 is, in cases where administration-time is of the essence, believed to be a valid substitute for the full-length SSQ as it was found to correlate highly with the full-length version (Sarason *et al*., 1987). These authors point out that the SSQ6 can be administered in a matter of minutes and is indicated to be psychometrically sound. In addition, it is considered to be clinically useful to look at the various constituents of social support networks, such as nuclear and extended family, friends, colleagues, acquaintances etcetera, to see who are providing the support (Chronister *et al*., 2006). Unfortunately, few measures tap into all of the various dimensions, often necessitating the use of more than one measure. In the present study, this simply was not a viable option. However, the SSQ6 was further favoured as it offers information on perceptual and structural components, as well as describing the relationships support networks comprise (Chronister *et al*., 2006). As the composition of support networks was also of interest in the present study, the SSQ6 was the obvious choice, especially considering its

briefness and multidimensional nature.

Tests for internal consistency reliability in this study yielded a Cronbach alpha of .84 for the entire scale. For the two sub-scales, Cronbach alphas of .82 and .87 respectively were achieved.

6.7 Self-constructed questionnaire (*Appendix N*).

As stated earlier, a self-constructed questionnaire was developed to further tap into the experiences of participants related to dealings with traumatised clients. The questionnaire contained open-ended as well as a few questions that required shorter, more concise answers. As explained, additional variables of importance were conceptualised and operationalised into questions. Since the test instruments sufficiently covered the areas of secondary traumatic stress, negative cognitive schemas, empathy, compassion satisfaction and social support, the self-constructed questionnaire focused on obtaining more subjective information on the nature of experiences of vicarious trauma specific to each of the worker groups. To reiterate briefly, recent personal trauma history, feelings and effects evoked by client trauma, detachment skills, difficult life demands, sick-leave and work-related illness were some of the issues covered by the questionnaire. How participants are affected and supported by their work environment was also of interest. Each question was devised to effectively elicit the required information.

Content validity was established by formulating items around certain aspects of Figley's model of compassion fatigue (2002a). Furthermore, the principles of questionnaire construction as proposed by Tashakkori and Teddlie (2003) informed the process. For example, care was taken to make sure that the questions closely matched the research objectives. An effort was made to understand the participants by meeting with HR managers prior to data collection and discussing the workers and their work environment at some length. Also, to make sure that interpretations of the responses were maximised, participants were asked for their contact particulars to make clarification of unclear statements possible. Natural and familiar language was used in the questionnaire and care was taken to state questions clearly and succinctly. Questions were kept direct and simple; however, double-barrelled questions were used in cases where participants had to choose between two statements to best describe their typical course of action when dealing with clients. At the end of the process, the author was satisfied that the questionnaire was simple and easy to use.

Seeing that the questionnaire is self-constructed, it was piloted to a small sample of administrative workers prior to the data collection. Participants were asked to answer the questions and to also

restate the questions to see if the essence of each item was clear. A few of the participants were interviewed and the questionnaire items were discussed to make sure that all questions were simple and unambiguous. From the piloting process it was gathered that the questionnaire mostly met the various requirements as outlined herein. It was then further refined and reworked according to the feedback received from the pilot sample. Data capturing is considered next.

7 Data Capturing and Editing

Once the data collection was completed, quantitative 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 software, version 9.3, for analysis. As an extra precaution, frequency tables were performed first to check that all scores were within range and that there were no impossible values or errors.

Response to the self-developed questionnaire on which different forms of content analyses were performed, were captured on Microsoft Word documents. Each document was checked for errors and then imported as a primary document into the Atlas.ti content analysis software, version 6.2. A primary document number, preceded by the letter "P", was assigned to each participant by this software programme. This unique number was also used to serve as a participant number or *nom de plume* to conceal identities. This unique number was used alongside all participant quotations throughout the thesis. In all cases, the unique number is preceded by the worker group to denote which group a participant belongs to.

8 Data Analysis

8.1 Quantitative and qualitative 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 three worker groups, consisting of claims workers, trauma counsellors and holiday booking consultants. Simple statistics were next carried out in terms of the study variables. Distribution analysis was utilised to examine normality and to establish whether parametric statistical procedures were permissible. In the case where parametric assumptions were not met, data were transformed to closer resemble a normal distribution. These transformations, however, are clearly described and then indicated throughout the study. Means, standard deviations and frequencies in terms of the key variables were determined. Statistical analysis was also performed in terms of the biographical variables to determine sample homogeneity. Cronbach Alpha coefficients were calculated for each quantitative

measure to determine internal consistency reliability.

Group comparisons were at the centre of the analyses. To this end, the mean scores of the three worker groups were compared to ascertain whether there were any significant differences between them on the study variables. First, multivariate analysis of variance or MANOVA with effect size was performed on the dependent variables in relation to group. This type of analysis is used to analyse variance when two or more dependent as well as two or more independent variables are used (Rosenthal & Rosnow, 1991). Where there is interest in a number of dependent variables associated empirically and theoretically, as was the case in the present study, the MANOVA is the preferred method (Hassett, 2006). Hasset explains that the MANOVA is furthermore utilised to explore the main as well as the interaction effects of the categorical variable/s on an array of dependent interval variables. To further explore the results of the MANOVA, a series of one-way ANOVAs with effect size were performed. The ANOVA is described as an "*all-purpose*" significance test used to compare two or more groups (Rosnow & Rosenthal, 1996, p. 283).

Next, Pearson *r* correlation tests between the key study variables, being secondary traumatic stress, negative cognitive schemas, empathy, compassion satisfaction and social support were, carried out. This phase of the analysis focused on determining whether certain widely reported relationships between the study variables were true for the sample as well as each of the study groups. The strength and direction of such relationships were recorded. Multiple Regression analyses were then performed to estimate the quantitative effects of the explanatory or causal variables upon selected dependent variables. The dependent variables were the two vicarious trauma measures utilised by the study, being secondary traumatic stress and negative cognitive schemas. In each case, the explanatory variables utilised were empathy, compassion satisfaction and social support.

In addition, both quantitative and qualitative content analyses were performed on the data yielded by the self-constructed questionnaire. Utilising both forms of content analysis is in line with the most recent developments in this area (Stemler, 2001). Firstly, quantitative content analysis involved the frequency counts of units according to which the qualitative data were classified, summarised and tabulated. This approach was followed to express the magnitude of responses within this data. The assumption here is that the words or topics stated most often are sometimes reflective of the most prevalent or pressing concerns and issues (Stemler, 2001). Inferences were made by methodically and objectively identifying specified features of the data (Stemler, 2001). This form of content analysis has several limitations, such as the use of synonyms or the multiple meaning of words. To

curb over-counting, the study looked at words or phrases of interest within context, as suggested by Stemler. *A-priori* categories of interest to the study were developed in advance, after which frequency as well as the intensity of some of these predetermined units was determined. These *a-priori* units related more to aspects of the theoretical model that had been deconstructed for use by the proposed study.

In conjunction to applying the *a-priori* categories to the data, another level of analysis entailed looking at the data without the constraints of predetermined categories (Terre Blanche & Durrheim, 1999). In doing so there is a focus on what the data are naturally saying, and to thus express the emic voice of participants. To this end, there was a focus on emergent themes from which impressions could be formed. Content-based themes were developed inductively through close examination of the data (Wilbraham, 1995). Special attention was given to any interesting statements which stood out or demonstrated unusual or unique positions on the posed matters. Themes were extracted by scrutinising each questionnaire many times over, as it is believed that each reading emits new insight (Terre Blanche & Durrheim, 1999).

9 Ethics

The University of the Witwatersrand's standards of ethics for research with human subjects were adhered to at all times. The identity of each participant and organisation was protected by strict privacy and materials pertaining to each were treated with the utmost integrity, respect and responsibility. Confidentiality was maintained whereby only the author had access to raw data, and the research supervisors viewed captured and coded data as well as samples of data used to determine inter-rater reliability.

Quotations from the self-constructed questionnaires were used sporadically, but anonymity was afforded at all times as no names or any identifying information was used. The primary document number generated by the analysis software for each participant was used to conceal their identities in all cases where quotations were taken from the data for use. Participants were clearly informed that their decision whether to participate or not, would not have any bearing or pose any risk to their employment. Each person was asked to sign or initial the participation consent form. Participants were asked to provide their names and contact details for clarification purposes only. However, participants were given the option to refrain from disclosing these details if they wished. A number of participants also chose not to sign or even initial their participation consent forms and, as stated before, the mere fact of their attending the voluntary data collection sessions and filling in the

questionnaires were viewed as indications of consent.

Participants reserved the right to withdraw from the study at any time. Participating organisations as well as individual participants did not run any risk of being singled out, portrayed negatively, or identified in any way. Questions contained in the scales and the self-constructed questionnaire were formulated with great care as not to be harmful, insulting or unnecessarily intrusive. Any participant who wished to obtain professional counselling was advised to contact the Centre for the Study of Violence and Reconciliation or Lifeline, as they offer gratis professional trauma counselling. All research data will be stored safely for the compulsory six year audit/verification period specified by the university, after which it will be destroyed. No identifying information will be used in the final report or any articles published from the research.

CHAPTER SIX: RESEARCH RESULTS

Results from Quantitative Measures

As discussed before, Figley's model was deconstructed into its eleven constituent parts, after which data were collected on each element. Please refer to *Figure 1* on page 60 for a copy of the model. *Appendix A* gives a bird's-eye view of how the model was covered by the quantitative and qualitative legs of the study and indicates other areas investigated. This diagram also informs which quantitative measures were utilised. Quantitative statistical analyses were used to examine the data from the scales. Firstly, internal consistency reliability of the various scales employed by the study was discussed under the methods chapter. This chapter discusses simple and descriptive statistics results which are presented first, followed by the analyses of results that are organised around each of the research questions.

1 Biographical Variables

Frequency distributions of all of the biographic variables were utilised to check for any outliers and impossible values. All scores were within range. Items of each scale were checked in the same fashion and all scores were again found to be in range.

1.1 Sample composition.

The sample comprised a total of 144 participants. For the purpose of the study, the sample was subdivided into three different worker groups of which 50 were short-term insurance claims workers, 46 trauma counsellors and 48 holiday booking consultants. Of the sample, 22% were male and 78% female. As can be seen from these figures, the worker populations consulted in the study were mostly from female-dominated industries, especially for the trauma counselling and holiday booking consultancy firms. This did not pose a problem seeing that, due to the limited scope of the study, gender was not a variable looked at.

Next, the race categories of each worker group are briefly considered. Even though racial categorization is a very sensitive issue, the study asked participants to specify their race for statistical purposes. Participants were explicitly informed of the purpose of this action. Of the sample, 30% (*N*=41) were black, 37% (*N*=53) were white, 23% (*N*=33) were coloured and 12% (*N*=17) were Indian. Next, 18% (*N*=26) were younger than 25, 42% (*N*=61) were between the ages of 25 to 30 years, and 17% (*N*=24) were between 31 and 35 years of age. Only 10% (*N*=14) were between 36 and 40 years old, and the remaining 13% (*N*=19) were older than 40.

Table 1. Descriptive Statistics: Biographical Variables

		Claims Workers (*N*=50)		Trauma Counsellors (*N*=46)		Holiday Booking Consultants (*N*=48)	
VARIABLE		FREQUENCY	PERCENT	FREQUENCY	PERCENT	FREQUENCY	PERCENT
Gender	Male	20	40.00	3	6.52	9	18.75
	Female	30	60.00	43	93.48	39	81.25
Age	Younger than 25	12	24.00	10	21.74	4	8.33
	25-30 years	25	50.00	14	30.43	22	45.83
	31-35 years	8	16.00	5	10.87	11	22.92
	36-40 years	4	8.00	4	8.70	6	12.50
	41-45 years	-	-	4	8.70	2	4.17
	45-50 years	-	-	4	8.70	1	2.08
	Older than 50	1	2.00	5	10.87	2	4.17
Years of Service	0-1 year	10	20.00	15	32.61	3	6.25
	2-4 years	29	58.00	14	30.43	18	37.50
	5-8 years	3	6.00	9	19.57	17	35.42
	9-12 years	7	14.00	1	2.17	9	18.75
	13-16 years	1	2.00	1	2.17	1	2.08
	17+ years	-	-	6	13.04	-	-
Race	Black	15	30.00	11	23.91	15	31.25
	White	6	12.00	28	60.87	19	39.58
	Coloured	23	46.00	3	6.52	7	14.58
	Indian	6	12.00	4	8.70	7	14.58

Of the sample, 19% (*N*=28) had less than two years of service in their current worker roles, 43% (*N*=61) had between two and four years of service, while 20% (*N*=29) had between five and eight years of service in their current worker roles. Only 12% (*N*=17) of participants had between nine and twelve years of service, while the remaining six percent (*N*=9) had more than twelve years of service in their current worker roles. Participants were also asked to state their actual years of service, of which the sample average came to approximately five years and eight months.

Furthermore, participants were asked whether their employment was full-time or part-time. This question was asked to ensure that no participants performed additional trauma work that might introduce extraneous variables. All participants who declared their employment to be part-time listed administrative or sales positions as their additional employment. A few of the trauma counsellors were tertiary students. For the descriptive statistics for each worker group, please see

Table 1. As can be gathered from this table, each person was required to select biographical information in terms of predetermined categories with the exception of years of service. For each of the worker groups, the actual years of service averages were four years for claims workers, six years for trauma counsellors and approximately five and a half years for holiday booking consultants.

Finally, considering that the notion *group* – claims workers, trauma counsellors and holiday booking consultants – constitutes the primary independent variable, it was deemed to be of some interest to establish whether the three groups were equivalent in terms of the biographical variables. To this end, Chi-square tests for independence were performed on age, years of service, gender and race, utilising a five percent significance level.

1.2 Group differences.

A very large percentage of the cells of the Chi-square tests had expected frequencies of less than five, which were rectified by combining certain categories. This action addressed the problem, as there was a sufficient proportion of expected frequencies over five in each of the analyses after problematic categories were collapsed. Firstly, the seven age categories were collapsed into five, being younger than 25, 25-30 years, 31-35, 36-40 and 41+ years. Secondly, the six categories for years of service were reduced to five, being zero to one year of service, two to four years, five to eight years, nine to 12 years and 13+ years of service.

The Chi-square tests of independence did, however, detect significant group differences for each of the biographical variables ($p<0.05$) being gender, age, years of service and race. The author acknowledges that these group differences might have influenced the study results. However, due to the constraints of the study, these differences could not be explored, but are nonetheless considered briefly. For one, the groups are significantly different in terms of gender. Although all three worker populations are female-dominated, the group of claims workers comprised significantly more males, whereby 20 of the total of 50 participants were male. The group of trauma counsellors consisted of the least number of males – only three out of a group of 46. It has been suggested that gender may interact with exposure to traumatic material and might contribute to trauma-related symptoms (Pearlman & Mac Ian, 1995). However, due to the great variety of variables examined by the study, gender differences were not elected as an area of interest.

Also, claims workers presented with the youngest population of workers, where 74% were under the age of 30 compared to 52% of trauma counsellors and 54% of holiday booking consultants. Theorists propose that newer, more inexperienced workers usually present with more serious difficulties from dealing with client traumata (Sexton, 1999). Therefore, the claims workers might be at greater risk for negative outcomes, which makes this group especially important to explore in terms of vicarious trauma. Furthermore, there also seems to be more career longevity in the group of trauma counsellors and booking consultants. This could be due to the fact that trauma counselling is often described as a "*calling*", and that people are mostly drawn to this profession by a desire to be a helper. It is believed that those who feel drawn to a particular vocation might possibly also stay in the profession for longer.

Greater career longevity could also be due to the fact that trauma counsellors invest a lot of their time and financial resources in obtaining the necessary education to perform this work, which could likely lead to them feeling compelled to stay in the profession for longer. It is also speculated that booking consultants might have longer careers seeing that dealings with their clientele centre on more optimistic, positive experiences. As suggested by the biographical variables, claims workers have the highest staff turnover rates out of the three groups, which could be attributed to the negative effects from dealing with traumatised individuals.

Furthermore, as reflected in *Table 1*, the racial make-up of each group was significantly different. The trauma counsellor group was predominantly white, which could be accredited to the fact that they are from a socio-economic segment that is usually more financially capable of undertaking the required tertiary education. Racial make-up has been indicated to play a role in the prevalence of secondary traumatic stress (Stamm, 2010).

Therefore, gender, age and racial differences might all have affected the study results. Research into less explored areas, such as biographical differences, has been identified as an important and much needed area of study (Figley, 2003; Stamm, 2010). However, the present study was exploratory in nature and focused on variables most often associated with vicarious trauma. Finally, *Table 2* below presents the descriptive statistics for the biographical variables after categories were collapsed as outlined on the previous page. *Table 3* reflects the Chi-square results.

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

		Claims Workers (*N*=50)		Trauma Counsellors (*N*=46)		Holiday Booking Consultants (*N*=48)	
VARIABLE		FREQUENCY	PERCENT	FREQUENCY	PERCENT	FREQUENCY	PERCENT
Age	Younger than 25	12	24.00	10	21.74	4	8.33
	25-30 years	25	50.00	14	30.43	22	45.83
	31-35 years	8	16.00	5	10.87	11	22.92
	36-40 years	4	8.00	4	8.70	6	12.50
	41+ years	1	2.00	13	28.27	5	10.42
Years of Service	0-1 year	10	20.00	15	32.61	3	6.25
	2-4 years	29	58.00	14	30.43	18	37.50
	5-8 years	3	6.00	9	19.57	17	35.42
	9-12 years	7	14.00	1	2.17	9	18.75
	13+ years	1	2.00	7	15.21	1	2.08

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

VARIABLE	DF	CHI-SQUARE VALUE
Gender	2	16.0382**
Years of Service (collapsed)	8	38.1146***
Age (collapsed)	8	21.7995*
Race	6	38.3938***

p<0.01* ** *p<0.001* * *p<0.0001*

1.3 Distribution analysis.

1.3.1 The TSI Belief Scale.

The TSI Belief Scale was used to measure the prevalence of negative cognitive schemas. After the appropriate items had been reverse scored, the 80-item scale was summed and items means were calculated. As stated under the methods section of this paper, Cronbach analysis revealed item 35 of this scale to be problematic, which was subsequently dropped from all further analyses. Next, distribution analysis was performed on the scale without item 35. It is perhaps useful to mention here that most researchers consider data to be within the normal range or to present with an approximately normal shape if skewness and kurtosis values fall between -1.0 and +1.0 (Huck, 2012). The distribution analysis histogram for the total scale revealed a slightly platykurtik bell-shaped curve with kurtosis of -0.136. The total scale distribution was slightly skewed to the right

with a skewness coefficient of 0.428. This falls within the normal range, which warranted the use of parametric statistics.

A high score on this scale as well as on each of the ten sub-scales suggests greater negativity in cognitive schemas within five needs areas in relation to the self and others. These needs areas are Safety, Trust, Esteem, Intimacy and Control. High scores on the sub-scales also signify greater difficulty in integrating or making sense of experiences of vicarious traumatisation (Wiebe, 2001). Next, the items of the total scale were divided into the ten sub-scales: Self-Safety, Other-Safety, Self-Esteem, Other-Esteem, Self-Control, Other-Control, Self-Intimacy, Other-Intimacy, Self-Trust and Other-Trust. Each individual's score on each of these sub-scales was found by averaging the relevant items. Distribution analysis was again performed on each of the sub-scales, sans item 35, and the score distributions, kurtosis and skewness coefficients of six of the sub-scales were within normal range. However, in the case of the remaining four sub-scales, violations of skewness and/or kurtotsis were revealed.

In the case of the Self-Esteem sub-scale, the tail of the distribution pointed towards the upper end of the score continuum, which means the distribution was positively skewed. Therefore, the bulk of scores were grouped around the lower end of the score continuum. A lower score generally indicates healthier, more sound and helpful beliefs within the particular needs area. The skewness coefficient was 1.070 with kurtosis of 2.274. The Other-Esteem sub-scale was skewed in a similar way, which indicated somewhat positive and unaffected beliefs in this area. The skewness coefficient was 0.994 with kurtosis of 1.156 which was not quite within the normal parameters. The Other-Control sub-scale was also positively skewed, indicating that beliefs in this area were unperturbed to some extent and relatively positive. The skewness coefficient was 1.050 with kurtosis of 1.807. The Self-Intimacy sub-scale presented with a skewness coefficient of 0.855 and kurtosis of 1.074. The skewed sub-scales are revisited under the part of this chapter that deals with the cleaning and transforming of data.

1.3.2 The STS Scale.

The STS Scale was utilised to measure secondary traumatic stress. None of the items in this scale require reverse scoring. The 17-item scale was summed into a total scale and item means were calculated. The distribution analysis histogram for the total scale presented a slightly leptokurtik bell-shaped curve with kurtosis of 0.293. The total scale distribution was also slightly skewed to the right with a skewness coefficient of 0.796. This falls within the normal range, which permits

the use of parametric statistics. A high score on this scale indicates high levels of secondary traumatic stress, while a lower score signifies lower levels and fewer associated symptoms. The total scale is composed of three sub-scales, being Intrusion, Avoidance and Arousal. High scores on either of these sub-scales indicate a high prevalence in intrusion, avoidance or arousal symptoms respectively. Distribution analysis was performed on each of the sub-scales and the score distributions, kurtosis and skewness coefficients were found to be within the normal range.

1.3.3 The IRI Scale.

The IRI Scale was used in the present study to investigate empathy. The appropriate items were reverse scored and the 28-item scale was summed and the average item mean calculated. The distribution analysis histogram for the total scale presented with a leptokurtik bell-shaped curve with kurtosis of 1.012. The total scale distribution was only slightly skewed to the right with a skewness coefficient of 0.133. Even though the kurtosis was relatively high, the scale was taken as falling within the normal range. A high score on the IRI scale indicates that the person possesses a large capacity to empathise. A low score suggests that the person does not have a propensity or the capacity to empathically engage with others.

Reflective of the notion that empathy comprises of a set of closely related constructs, the total scale can be summed into four sub-scales: Personal Distress, Fantasy, Empathic Concern and Perspective Taking. A high score on each of the sub-scales confirms a greater propensity or capacity in each of the four areas represented by each sub-scale. For example, a high Perspective Taking score indicates that persons have a large capacity or proclivity to project themselves into the position of another or to adopt another's viewpoint. A low Fantasy score, for instance, indicates that persons either do not have the capacity or the inclination to fantasize, identify with fictional characters or imagine themselves into hypothetical situations. Such individuals usually prefer to stay firmly grounded in reality and the practical world. A high Personal Distress score involves high levels of anxiety, discomfort and distress evoked by the negative experiences and distress of others. Distribution analysis on each of the sub-scales confirmed that all score distributions, kurtosis and skewness coefficients were within normal range.

1.3.4 The ProQOL-CS sub-scale.

This sub-scale was utilised to investigate compassion satisfaction. Items in this sub-scale do not require reverse scoring and the ten-item scale was summed and the average item mean calculated. The distribution analysis histogram for the total scale presented a slightly leptokurtik bell-shaped

curve with kurtosis of 0.244. The total scale distribution was somewhat skewed to the left with a skewness coefficient of -0.845. This falls within the normal range for parametric statistics. A high score on this sub-scale suggests that the person derives pleasure and positive reinforcement from performing a chosen job, as well as a sense of confidence that they are performing the work well (Stamm, 2010). A low score indicates the opposite – that the person does not experience the particular work to be pleasurable or satisfying, and might feel overwhelmed and even depressed as a result.

1.3.5 The SSQ6 Scale.

Finally, the SSQ6 Scale was utilised to measure social support. This scale does not require any reverse scoring and the 12-item scale was summed and the average item mean calculated. The distribution analysis histogram for the total scale presented a slightly leptokurtik bell-shaped curve with kurtosis of 0.354. The total scale distribution was slightly skewed to the left with a skewness coefficient of -0.170. This falls within the normal range, which permitted the use of parametric statistics.

The total scale is composed of two sub-scales. The first is the Social Support Satisfaction sub-scale which refers to the level of satisfaction/dissatisfaction persons have with their current support systems. For the Social Support Satisfaction sub-scale, the distribution was hugely skewed to the left with a skewness coefficient of -2.273. The kurtosis was very high with a value of 6.508. In the present study, almost all participants were very satisfied with the perceived availability of support, irrespective of how big or small their support networks were. For this sub-scale, item scores range from one to six and the median of nearly each item was found to be six. Therefore, the majority of participants leaned towards the high satisfaction end of the scale, which accounted for the exceedingly skewed distribution.

The other sub-scale is that of the Social Support Number sub-scale, which refers to the perceived size and availability of the respective supports. The score distribution of the Social Support Number sub-scale was within the normal range. The distribution analysis histogram for this sub-scale scale presented a slightly platykurtik bell-shaped curve with kurtosis of -0.172. The distribution was also slightly skewed to the right with a skewness coefficient of 0.560. For this sub-scale, participants were required to indicate the relative size of their perceived support network.

1.4 Data cleaning and transformation.

As explained earlier, item 35 of the TSI Belief Scale was identified to be problematic by the Cronbach analysis and was subsequently dropped from all further analyses. Furthermore, four of the TSI Belief sub-scales were dramatically skewed, as also pointed out previously. To correct the skewness, the sub-scale data in question were transformed. A logarithm transformation was used in SAS to transform the data and to bring the data closer to a normal distribution. This log instruction was applied to the skewed sub-scales being Self-Esteem, Other-Esteem, Other-Control and Self-Intimacy. This logarithmic transformation resolved the skewness issues of all four sub-scales concerned.

Furthermore, the Social Support Satisfaction sub-scale discussed earlier also presented with dramatic skewness and kurtosis that could not be improved. The logarithm transformation failed to bring the scale closer to a normal distribution. Dichotomising the data would also not have remedied the problem as there were too few scores on the lower end of the scale to warrant this approach. Very importantly, the *total* SSQ6 Scale presented with a normal distribution as well as skewness and kurtosis within the normal range, as pointed out earlier. Therefore, the total scale could still be used for the analysis. Only when the total scale was divided into the two sub-scales did one of the two sub-scales become problematic. The Social Support Number sub-scale did not present with problematic skewness and could therefore also be used for analysis. Only the Social Support Satisfaction sub-scale was dramatically skewed and omitted from further analysis.

2 Analysis of Variance

Multivariate analysis of variance or the MANOVA procedure was the first step of the analysis which focused on differences among the three worker groups on all of the measures utilised by the study. This procedure was chosen because of its power to detect group differences along a whole host of dependent variables. Also, the MANOVA procedure makes fewer assumptions about the data, making it quite robust (Brace, Kemp & Snelgar, 2009). Finally, results from the MANOVAs performed were further explored by performing a series of one-way ANOVAs to address each of the study variables. The first research question is stated below, results are discussed and group differences are then considered one variable at a time.

2.1 Research question one:

Is there a significant difference in the levels of secondary traumatic stress, negative cognitive schemas, empathy, compassion satisfaction and social support between short-term insurance

claims workers, trauma counsellors and the control group of holiday booking consultants?

The MANOVA procedure was the first step in answering the above research question. The first MANOVA, which focused on significant group differences on the various scales, emerged as significant, as displayed in *Table 4*.

Table 4. MANOVA Result: Individual Scales (Secondary Traumatic Stress, Negative Cognitive Schemas, Empathy, Social Support and Compassion Satisfaction) by Group

INDEPENDENT VARIABLE		VALUE	DF	F
Group	Wilk's Lambda	0.66	2:141	12.20*

* $p<0.0001$

A significant difference was detected between the claims workers and trauma counsellors ($p<0.0001$), as well as between the claims workers and holiday booking consultants ($p<0.0001$) with respect to secondary traumatic stress, negative cognitive schemas, compassion satisfaction and social support. The MANOVA procedure was then repeated on the various sub-scales utilised to further explore group differences. Of course, the compassion satisfaction measure does not present any sub-scales, whereas only one of the two social support sub-scales were usable, and further MANOVAs were not therefore performed in these cases. Significant differences were detected between claims workers and trauma counsellors, as well as between the claims workers and holiday booking consultants on the negative cognitive schema, secondary traumatic stress and empathy sub-scales respectively ($p<0.0001$; $p<0.01$; $p<0.0001$). No significant differences were detected between the claims workers and trauma counsellors on any of the scales or sub-scales. *Tables 34* to *36* of *Appendix O* present the MANOVA results for the sub-scales.

To further explore the group differences detected by the MANOVAs, a one-way ANOVA was performed on each of the variables expressed by research question one. It has to be mentioned here that the likelihood of the Type I error escalates in cases where multiple comparisons are made. However, Pearlman and Mac Ian (1995), who used a multiple comparisons approach to vicarious trauma, stated that this approach is appropriate in cases where research is at an early stage. For instance, if research is exploratory, involves new areas of research or looks at unknown populations, which are mainly the case for the present study, these authors feel that performing a series of

ANOVAs is warranted. In their opinion, taking this risk opens up a whole host of future research possibilities and generates new areas for investigation (Pearlman & Mac Ian, 1995). In the present study, this risk was accepted. It was felt, in line with these authors' sentiments, that performing multiple comparisons would be both useful and informative.

To this end, a one-way analysis of variance or ANOVA was performed on each of the dependent variables, being negative cognitive schemas, secondary traumatic stress, empathy, compassion satisfaction and social support, to unearth any significant group differences. The independent variable in each case was group, these being claims workers, trauma counsellors and holiday booking consultants. For all of the analysis of variance tests, the mean of each scale's items was used instead of the summed scale means. A five percent significance level was utilised and Tukey Kramer post-hoc (multiple) analyses were also computed in each case. As stated before, four of the ten negative cognitive schema sub-scales had to be transformed to correct the high skewness and kurtosis, and the transformed mean of the *t* items was used in these cases.

A summary of the ANOVA procedures is provided in *Tables 6, 9, 11, 13* and *15,* presenting the results for each of the scales and its various sub-scales. The descriptive statistics of the scales and sub-scales are presented for each group in *Tables 5, 8, 10, 12* and *14.*

2.1.1 Group differences in secondary traumatic stress.

The fist one-way ANOVA revealed a significant difference in the levels of secondary traumatic stress among the three worker groups ($p<0.0001$). *Table 5* provides the descriptive statistics for each worker group and *Table 6* presents the ANOVA results for the Secondary Traumatic Stress Scale as well as the sub-scales.

Table 5. Descriptive Statistics: Secondary Traumatic Stress Scale (STSS) and Sub-scales by Group

	Claims Workers			**Trauma Counsellors**			**Holiday Booking Consultants**		
DEPENDENT VARIABLE	**N**	**MEAN**	**SD**	**N**	**MEAN**	**SD**	**N**	**MEAN**	**SD**
Secondary Traumatic Stress	50	2.47	0.74	46	1.81	0.58	48	1.60	0.58
Intrusion Sub-scale	50	2.36	0.75	46	1.77	0.69	48	1.48	0.60
Avoidance Sub-scale	50	2.45	0.82	46	1.85	0.63	48	1.64	0.57
Arousal Sub-scale	50	2.62	0.82	46	1.78	0.63	48	1.68	0.68

Table 6. One-way ANOVA Results: Secondary Traumatic Stress Scale (STSS) and Sub-scales by Group

DEPENDENT VARIABLE	DF	SS	F	GROUP COMPARISON ♀
Secondary Traumatic Stress	2:141	20.23	24.67*	(M_1^a; M_2^b; M_3^b)
Intrusion Sub-scale	2:141	19.78	21.13*	(M_1^a; M_2^b; M_3^b)
Avoidance Sub-scale	2:141	17.39	18.46*	(M_1^a; M_2^b; M_3^b)
Arousal Sub-scale	2:141	25.74	24.83*	(M_1^a; M_2^b; M_3^b)

* $p<0.0001$

♀ M_1 = Claims workers; M_2 = Trauma counsellors; M_3 = Holiday Booking Consultants
(Group means with the same letter were not significantly different)

Firstly, the post-hoc analysis indicated a significant difference in secondary traumatic stress between the claims workers and trauma counsellors, as well as between the claims workers and holiday booking consultants. No significant difference was observed between the trauma counsellors and holiday booking consultants. As indicated by the scale means presented in *Table 5*, the claims workers exhibited the highest secondary traumatic stress scores (M=2.47) followed by the trauma counsellors (M=1.81) and holiday booking consultants (M=1.60).

Furthermore, the sub-scales, being Intrusion, Avoidance and Arousal, each also presented with significant differences among the three worker groups ($p<0.0001$). These results are summarised in *Table 6*. On all three sub-scales, the significant differences were between claims workers and trauma counsellors, as well as between claims workers and holiday booking consultants. There were again no significant differences detected between the trauma counsellors and holiday booking consultants. The claims workers presented with the highest Intrusion sub-scale score (M=2.36), followed by the trauma counsellors (M=1.77) and holiday booking consultants (M=1.48).

For the Avoidance sub-scale, the claims workers also presented with the highest scores (M=2.45), followed by the trauma counsellors (M=1.85) and holiday booking consultants (M=1.64). Similarly, for the Arousal sub-scale, the claims workers again presented with the highest scores (M=2.62), followed by the trauma counsellors (M=1.78) and holiday booking consultants (M=1.68). This means that, out of the three worker groups, the claims workers exhibited significantly higher overall levels of secondary traumatic stress as well as significantly higher levels of intrusion, avoidance and arousal symptoms.

Furthermore, looking more closely at the Secondary Traumatic Stress Scale means provides additional information on this variable. Bride (2007) provides severity recommendations for further interpretation based on normative data collected from several studies over time. According to these recommendations, a total score of less than 28 indicates little or no secondary traumatic stress. A score of 28 to 37 points towards mild levels of secondary traumatic stress. From 38 to 43 is indicative of moderate levels, whereas the field from 44 to 48 indicates high levels. A score of more than 49 points towards severe levels of secondary traumatic stress.

A summary of the severity categories for each worker group is presented in *Table 7*. The average secondary traumatic stress score for claims workers was 42, which falls within the moderate category. The average score for trauma counsellors was 31, pointing towards mild levels of secondary traumatic stress. Finally, the average score for holiday booking consultants was 27, which falls within the little or no secondary traumatic stress category. As can also be seen from *Table 7*, claims workers scored consistently higher in terms of secondary traumatic stress and presented with a much greater score range compared to the other two worker groups. Claims workers also presented with the fewest participants in the milder categories as well as the most participants in the higher secondary traumatic stress categories.

Table 7. Severity Categories for Secondary Traumatic Stress

	Claims Workers (*N*=50)	**Trauma Counsellors (*N*=46)**	**Holiday Booking Consultants (*N*=48)**
MINIMUM	17	17	17
MAXIMUM	80	55	30
Little or No (<28)	12%	50%	63%
Mild (28 - 37)	22%	24%	19%
Moderate (38 - 43)	22%	15%	10%
High (44 - 48)	16%	7%	4%
Severe (>49)	28%	4%	4%
GROUP AVERAGE	42 (moderate secondary traumatic stress)	31 (mild secondary traumatic stress)	27 (little or no secondary traumatic stress)

2.1.2 Group differences in negative cognitive schemas.

As per *Table 9*, the one-way ANOVA procedure revealed a significant difference in the levels of negative cognitive schemas between the group of claims workers, trauma counsellors and holiday booking consultants ($p<0.0001$).

Post-hoc analysis indicated a significant difference between the claims workers and trauma counsellors, as well as between claims workers and holiday booking consultants. Again, no significant difference was observed between trauma counsellors and holiday booking consultants. As per the scale means displayed in *Table 8,* claims workers presented with the highest overall levels of negative cognitive schemas (M=2.71) followed by the holiday booking consultants (M=2.22) and trauma counsellors (M=2.18).

Table 8. Descriptive Statistics: Negative Cognitive Schemas (TSI Belief Scale) and Sub-scales by Group

	Claims Workers			**Trauma Counsellors**			**Holiday Booking Consultants**		
DEPENDENT VARIABLE	**N**	**MEAN**	**SD**	**N**	**MEAN**	**SD**	**N**	**MEAN**	**SD**
Negative Cognitive Schemas	50	2.71	0.57	46	2.18	0.38	48	2.22	0.45
Self-Safety Sub-scale	50	2.52	0.72	46	2.10	0.65	48	1.97	0.56
Other-Safety Sub-scale	50	3.17	0.59	46	2.29	0.59	48	2.39	0.72
Self-Esteem Sub-scale#	50	1.92	0.59	46	1.55	0.38	48	1.62	0.48
Other-Esteem Sub-scale#	50	2.89	0.76	46	2.46	0.47	48	2.48	0.54
Self-Control Sub-scale	50	2.79	0.82	46	2.22	0.58	48	2.34	0.81
Other-Control Sub-scale#	50	2.98	0.36	46	2.30	0.23	48	2.12	0.54
Self-Intimacy Sub-scale#	50	2.53	0.75	46	2.11	0.69	48	2.23	0.79
Other-Intimacy Sub-scale	50	2.58	0.88	46	2.15	0.50	48	2.04	0.63
Self-Trust Sub-scale	50	2.27	0.70	46	2.09	0.57	48	2.25	0.68
Other-Trust Sub-scale	50	3.49	0.92	46	2.63	0.67	48	2.80	0.84

 # Data were transformed but this table contains untransformed data. Please see Appendix P for the transformed descriptive statistics

Table 9. One-way ANOVA Results: Negative Cognitive Schemas (TSI Belief Scale) and Sub-scales by Group

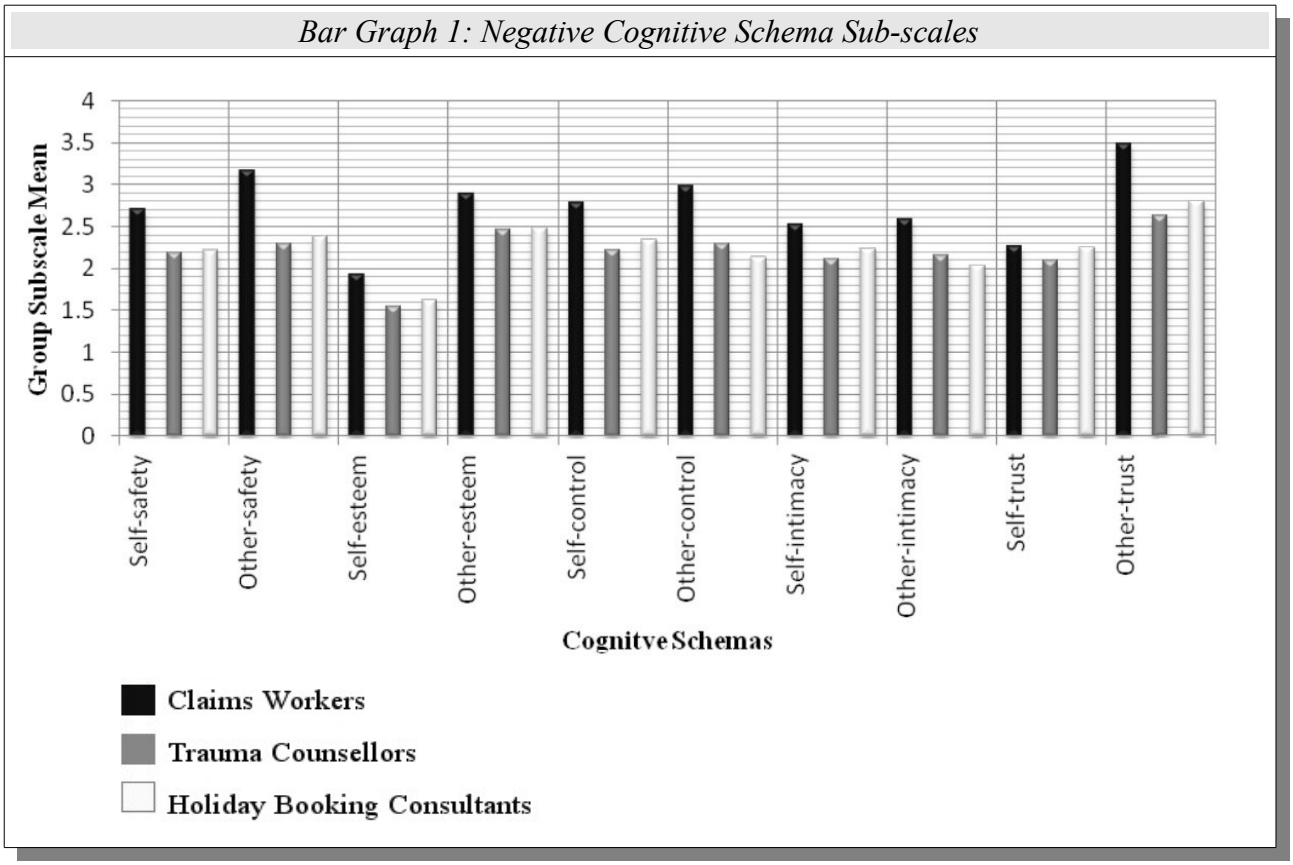
DEPENDENT VARIABLE	DF	SS	F	GROUP COMPARISON ♀
Negative Cognitive Schemas	2:141	8.62	18.70****	(M_1^a; M_2^b; M_3^b)
Self-Safety Sub-scale	2:141	8.15	9.70****	(M_1^a; M_2^b; M_3^b)
Other-Safety Sub-scale	2:141	22.78	27.85****	(M_1^a; M_2^b; M_3^b)
Self-Esteem Sub-scale#	2:141	1.11	7.04**	(M_1^a; M_2^b; M_3^b)
Other-Esteem Sub-scale#	2:141	0.68	6.93**	(M_1^a; M_2^b; M_3^b)
Self-Control Sub-scale	2:141	8.66	7.70***	(M_1^a; M_2^b; M_3^b)
Other-Control Sub-scale#	2:141	2.58	14.86****	(M_1^a; M_2^b; M_3^b)
Self-Intimacy Sub-scale#	2:141	0.82	4.01*	(M_1^a; M_2^b; M_3^b)
Other-Intimacy Sub-scale	2:141	7.93	8.20*	(M_1^a; M_2^b; M_3^b)
Self-Trust Sub-scale	2:141	0.84	0.98 (NS)	(M_1; M_2; M_3)
Other-Trust Sub-scale	2:141	20.35	15.02****	(M_1^a; M_2^b; M_3^b)

Data were transformed * $p < 0.05$ ** $p<0.01$ *** $p<0.001$ **** $p<0.0001$

♀ M_1 = Claims workers; M_2 = Trauma counsellors; M_3 = Holiday Booking Consultants
(Group means with the same letter were not significantly different)

Results for the various sub-scales, being Self-Safety, Other-Safety, Self-Esteem, Other-Esteem, Self-Control, Other-Control, Self-Intimacy, Other-Intimacy, Self-Trust and Other-Trust, also indicated group differences. The results and descriptive statistics for the sub-scales are also included in *Tables 8* and 9. Furthermore, the sub-scale means for each of the worker groups are depicted visually by means of *Bar Graph 1*.

Bar Graph 1: Negative Cognitive Schema Sub-scales



For the Self-Safety sub-scale, there was a significant difference in scores between claims workers and trauma counsellors, as well as between claims workers and holiday booking consultants (p=0.0001). This was also the case for Other-Safety (p<0.0001). For the Self-Esteem sub-scale, there was again a significant difference in scores between the claims workers and trauma counsellors, as well as between claims workers and holiday booking consultants (p=0.0012). A similar result was achieved for Other-Esteem (p=0.0013), Self-Control (p<0.001) and Other-Control (p<0.0001). Significant differences in scores were also observed for Self-Intimacy (p=0.0203) as well as Other-Intimacy (p=0.0004).

Interestingly, there was no significant difference in scores between the three worker groups for Self-Trust (p=0.3795); however, the Other-Trust sub-scale showed a significant difference in scores (p<0.0001). In all the cases expounded here, the significant difference in scores was between claims workers and trauma counsellors as well as between claims workers and holiday booking consultants. The only exceptions were in terms of Self-Safety and Self-Trust. Of course, as stated earlier, there was no significant difference in Self-Trust scores. For Self-Safety, there was only a significant difference between the claims workers and trauma counsellors. To reiterate, there was

never any significant difference in scores between trauma counsellors and holiday booking consultants, and means on the scale as well as sub-scales remained close together for these two groups at all times.

To summarise, the claims workers presented with the highest levels of negative cognitive schemas. As can be seen from *Bar Graph 1*, the claims workers also consistently scored higher on each of the sub-scales. Although there were no significant differences between the trauma counsellors and holiday booking consultants, the trauma counsellors had the second highest scores and holiday booking consultants the lowest scores for Self-Safety, Other-Esteem, Other-Control and Other-Intimacy. However, in the case of Other-Safety, Self-Esteem, Self-Control, Self-Intimacy, Self-Trust and Other-Trust, the holiday booking consultants scored second highest, followed by the trauma counsellors with the lowest scores, which was interesting. It is believed that the different patterns of results are attributable to the very different types of client groups served by each of the worker groups. For instance, the beliefs of claims workers and trauma counsellors are impinged upon by the distinctly different types of trauma presented by their clients most often, a point which is further elucidated in the next chapter. On the other hand, holiday booking consultants are affected by anger and maltreatment from clients.

2.1.3 Group differences in empathy.

The one-way ANOVA did not reveal any significant difference in empathy scores between the three worker groups (p=0.6273). The results are summarised by *Table 11* and the descriptive statistics for each worker group by *Table 10*.

Table 10. Descriptive Statistics: Empathy (IRI) Scale and Sub-scales by Group

	Claims Workers			**Trauma Counsellors**			**Holiday Booking Consultants**		
DEPENDENT VARIABLE	**N**	**MEAN**	**SD**	**N**	**MEAN**	**SD**	**N**	**MEAN**	**SD**
Empathy	50	3.31	0.35	46	3.32	0.31	48	3.26	0.37
Perspective Taking Sub-scale	50	3.44	0.50	46	3.82	0.51	48	3.66	0.57
Empathic Concern Sub-scale	50	3.91	0.56	46	3.92	0.45	48	3.98	0.52
Personal Distress Sub-scale	50	2.72	0.64	46	2.25	0.59	48	2.47	0.73
Fantasy Sub-scale	50	3.16	0.72	46	3.31	0.60	48	2.92	0.72

Table 11. One-way ANOVA Results: Empathy (IRI) Scale and Sub-scales by Group

DEPENDENT VARIABLE	DF	SS	F	GROUP COMPARISON ♀
Empathy	2:141	0.11	0.47 (NS)	(M_1; M_2; M_3)
Perspective Taking Sub-scale	2:141	3.61	6.48**	(M_1^a; M_2^b; M_3^b)
Empathic Concern Sub-scale	2:141	0.14	0.27 (NS)	(M_1; M_2; M_3)
Personal Distress Sub-scale	2:141	5.41	6.29**	(M_1^a; M_2^b; M_3^b)
Fantasy Sub-scale	2:141	3.61	3.84*	(M_1; M_2^a; M_3^b)

* $p < 0.05$ ** $p < 0.01$

♀ M_1 = Claims workers ; M_2 = Trauma counsellors; M_3 = Holiday Booking Consultants
(Group means with the same letter were not significantly different)

However, significant differences for the various sub-scales, being Perspective Taking, Empathic Concern, Personal Distress and Fantasy, were revealed. For Perspective Taking, a significant difference was detected between the claims workers and the trauma counsellors (p=0.0020). Interestingly, trauma counsellors presented with the highest levels of Perspective Taking (M=3.82) compared to the claims workers who presented with the lowest levels (M=3.44). Next, no significant difference was detected for Empathic Concern (p=0.7623).

For Personal Distress, there was a significant difference in scores between the claims workers and trauma counsellors (p<0.01). Claims workers presented with the highest levels of Personal Distress (M=2.72) whereas the trauma counsellors presented with the lowest levels out of the three worker groups (M=2.25). A significant result was also achieved for the Fantasy sub-scale (p=0.0238) and the post-hoc analysis revealed a significant difference in scores between trauma counsellors and holiday booking consultants. Interestingly, for the Fantasy sub-scale, the trauma counsellors presented with the highest scores (M=3.31) and the holiday booking consultants scored the lowest out of the three worker groups (M=2.92), with the claims workers falling between these two scores (M=3.16).

2.1.4 Group differences in compassion satisfaction.

A one-way ANOVA detected significant group differences in compassion satisfaction scores (p=0.0008). *Table 13* displays the ANOVA results, whereas *Table 12* presents the descriptive statistics for each of the worker groups.

Table 12. Descriptive Statistics: Compassion Satisfaction (ProQOL-CS) Sub-scale by Group

	Claims Workers			Trauma Counsellors			Holiday Booking Consultants		
DEPENDENT VARIABLE	**N**	**MEAN**	**SD**	**N**	**MEAN**	**SD**	**N**	**MEAN**	**SD**
Compassion Satisfaction	50	4.01	0.65	46	4.49	0.53	48	4.32	0.65

Table 13. One-way ANOVA Results: Compassion Satisfaction (ProQOL-CS) Sub-scale by Group

DEPENDENT VARIABLE	DF	SS	F	GROUP COMPARISON ♀
Compassion Satisfaction	2:141	5.63	7.47*	(M_1^a; M_2^b; M_3^b)

* $p<0.001$

♀ M_1 = Claims workers; M_2 = Trauma counsellors; M_3 = Holiday Booking Consultants
(Group means with the same letter were not significantly different)

Post-hoc analysis revealed a significant difference between claims workers and trauma counsellors, as well as between claims workers and holiday booking consultants. Again, no significant difference was detected between the trauma counsellors and holiday booking consultants. The trauma counsellors presented with the highest levels of compassion satisfaction (M=4.49), whereas the claims workers presented with the lowest levels (M=4.01). This means that, out of the three workers groups, the claims workers experience the least compassion satisfaction and the trauma counsellors derive the most compassion satisfaction from the work they perform.

2.1.5 Group differences in social support.

The reader is reminded that the total SSQ6 scale presented with a distribution within normal range. So did the Social Support Numbers sub-scale, which measures the size of the person's social support network. However, the remainder of the two sub-scales, which measures the level of satisfaction with social support, was found to be problematic and was thus excluded from the analysis.

The one-way ANOVA revealed significant group differences in Social Support scores ($p<0.0001$). *Table 15* presents the ANOVA results and *Table 14* the descriptive statistics. Post-hoc analysis revealed a significant difference between the claims workers and trauma counsellors, as well as between the claims workers and holiday booking consultants. The holiday booking consultants presented with the greatest levels of social support (M=4.71) and the claims workers with the lowest

levels out of the three worker groups (*M*=4.02). Once again, there was no significant difference in scores between trauma counsellors (*M*=4.65) and holiday booking consultants.

Similarly, the one-way ANOVA also revealed a significant difference in Social Support Number scores (*p*=0.0005). Post-hoc analysis detected a significant difference between the claims workers and trauma counsellors, as well as between claims workers and holiday booking consultants. Again, no difference was detected between the trauma counsellors and holiday booking consultants. In this case, the trauma counsellors presented with the largest number of social supports (*M*=3.78) and claims workers with the smallest number out of the three groups (*M*=2.70).

Table 14. Descriptive Statistics: Social Support (SSQ6) Scale and Sub-scales by Group

	Claims Workers			**Trauma Counsellors**			**Holiday Booking Consultants**		
DEPENDENT VARIABLE	**N**	**MEAN**	**SD**	**N**	**MEAN**	**SD**	**N**	**MEAN**	**SD**
Social Support	50	4.02	0.81	46	4.65	0.99	48	4.71	0.77
Social Support Number Sub-scale	50	2.70	0.75	46	3.78	0.69	48	3.61	0.60
Social Support Satisfaction Sub-scale	Omitted from the analysis								

Table 15. One-way ANOVA Results: Social Support (SSQ6) Scale and Sub-scales by Group

DEPENDENT VARIABLE	**DF**	**SS**	**F**	**GROUP COMPARISON ♀**
Social Support	2:141	14.33	9.68**	(M_1^a; M_2^b; M_3^b)
Social Support Number Sub-scale	2:141	32.70	7.98*	(M_1^a; M_2^b; M_3^b)
Social Support Satisfaction Sub-scale	Omitted from the analysis			

* $p<0.001$ **$p<0.0001$ ♀ M_1 = Claims workers; M_2 = Trauma counsellors; M_3 = Holiday Booking Consultants (Group means with the same letter were not significantly different)

2.2 Research question two.

The final research question regarding group differences poses the query as to **whether there are significant differences in the negative cognitive schemas, secondary traumatic stress, empathy, compassion satisfaction and social support scores between short-term insurance claims workers with a wellness plan compared to those claims workers without a wellness plan?**

For this part of the analysis, scores from the insurer with the longest running wellness plan was compared to scores from the insurer with no wellness plan. At the time of the data collection, one of the three participating insurers confirmed to *not* yet having a wellness plan available for their claims workers. Although they had recently implemented such a programme, it was not yet fully operational and workers had therefore not yet started to reap the benefits of their wellness programme. The second claims organisation had had a wellness plan in place for five years, whereas the third had implemented their plan seven years before, qualifying them as the insurer with the longest running plan.

It has to be mentioned here that, at the outset of the study, there was uncertainty as to whether wellness plans might factor into the study. It was only during negotiations with the insurers for their participation that the possible effects from wellness plans became a confirmed issue. The author recognises that it is impossible to estimate whether the group differences detected are a function of the wellness plan or merely a reflection of differences in organisational climates. However, it was nonetheless felt that it would be interesting to investigate the possible impact of wellness programmes on claims workers.

To gauge for group differences, a one-way ANOVA was performed on the claims workers with the longest running wellness plan (*N*=16) and those without an operational wellness plan (*N*=10). The variables used for the analysis are the two vicarious trauma measures, being negative cognitive schemas and secondary traumatic stress, as well as empathy, compassion satisfaction and social support. The descriptive statistics as well as the results of the ANOVA procedure for the two groups are reflected in *Tables 16* and 17.

Table 16. Descriptive Statistics: Individual Scales by Group

	Claims Workers (Longest Running Wellness Plan)			**Claims Workers** (No Wellness Plan)		
DEPENDENT VARIABLE	**N**	**MEAN**	**SD**	**N**	**MEAN**	**SD**
Negative Cognitive Schemas	16	2.44	0.57	10	2.94	0.50
Secondary Traumatic Stress	16	2.04	0.56	10	3.14	0.45
Empathy	16	3.26	0.46	10	3.57	0.19
Compassion Satisfaction	16	4.46	0.37	10	3.69	0.37
Social Support	16	4.25	0.85	10	3.57	0.74

Table 17. One-way ANOVA Results: Individual Scales by Group

DEPENDENT VARIABLE	DF	SS	F
Negative Cognitive Schemas	1:25	1.58	5.35*
Secondary Traumatic stress	1:25	7.46	27.05**
Empathy	1:25	0.60	4.10 (NS)
Compassion Satisfaction	1:25	3.67	26.34**
Social Support	1:25	2.85	4.28*

* $p<0.001$ ** $p<0.0001$

Firstly, the ANOVA did not detect significant differences between the two groups of claims workers for empathy ($p=0.05$). However, a significant difference was detected in the case of both vicarious trauma measures: Firstly, a difference in the prevalence of negative cognitive schemas was detected between the two groups ($p<0.05$) as well as a significant difference in secondary traumatic stress scores ($p<0.0001$).

Next, a significant difference in compassion satisfaction scores was also detected ($p<0.0001$). Finally, the ANOVA also revealed a difference in social support scores between the two groups ($p<0.05$). Although these results should be interpreted circumspectly, they seem to indicate that those workers with access to a wellness plan expressed lower levels of vicarious trauma, as well as higher levels of compassion satisfaction and social support compared to those without a wellness plan.

3 Correlation Tests

Next, Pearson *r* correlation tests were carried out to establish whether there are any relationships between the study variables as well as to ascertain the strength and direction of these relationships. The third research question focuses on correlations between the study variables within the sample, as well as within each of the worker groups. To this end, the different study variables were investigated in relation to one another in the sample. Next, the different study variables were investigated in relation to the two vicarious trauma measures – those of secondary traumatic stress and negative cognitive schemas – within each of the worker groups.

The two vicarious trauma measures were also investigated in relation to one another. This part of the analysis focuses on the traditionally accepted relationships between key variables that are reported to exist within well-researched groups. The aim was to establish whether these

relationships also held true for each of the worker groups. To further investigate the group correlation results, Fisher's *z* was calculated to establish whether there are any significant differences between the correlation coefficients for the different worker groups. These results are presented under the ensuing headings, each dealing with different combinations of variables.

A five percent significance level was set for all correlation tests. As explained under the data cleaning section, data were transformed to meet parametric assumptions and any problematic items were omitted from the ensuing analysis. The descriptive statistics are presented in *Table 18* for the sample and *Table 20* for the worker groups. The correlation test results are summarised in *Table 19* for the sample and *Table 21* for the worker groups.

Table 18. Descriptive Statistics: Scale Item Means

DEPENDENT VARIABLE	N	MEAN	SD	MEDIAN	MINIMUM	MAXIMUM
Secondary Traumatic Stress	144	1.97	0.74	1.85	1.00	4.71
Negative Cognitive Schemas	144	2.38	0.53	2.30	1.34	3.97
Empathy	144	3.30	0.35	3.28	2.21	4.28
Compassion Satisfaction	144	4.27	0.64	4.40	2.10	5.00
Social Support	144	4.45	0.91	4.42	2.50	6.42

Table 19. Pearson Correlation Results – Sample Data

Pearson Correlation Coefficients, *N* = 144					
	Secondary Traumatic Stress	**Negative Cognitive Schemas**	**Empathy**	**Compassion Satisfaction**	**Social Support**
Secondary Traumatic Stress	1.00				
Negative Cognitive Schemas	.61**	1.00			
Empathy	.17*	.14	1.00		
Compassion Satisfaction	-.54**	-.42**	.17*	1.00	
Social Support	-.40**	-.54**	-.05	.33**	1.00

** p<0.05 **p<0.0001*

Table 20. Descriptive Statistics: Scale Item Means by Group

Claims Workers						
DEPENDENT VARIABLE	**N**	**MEAN**	**SD**	**MEDIAN**	**MINIMUM**	**MAXIMUM**
Secondary Traumatic Stress	50	2.47	0.74	2.44	1.00	4.71
Negative Cognitive Schemas	50	2.71	0.57	2.77	1.43	3.97
Empathy	50	3.31	0.36	3.30	2.21	3.96
Compassion Satisfaction	50	4.01	0.65	4.10	2.10	5.00
Social Support	50	4.02	0.81	4.08	2.50	6.42
Trauma Counsellors						
	N	**MEAN**	**SD**	**MEDIAN**	**MINIMUM**	**MAXIMUM**
Secondary Traumatic Stress	46	1.81	0.58	1.65	1.00	3.23
Negative Cognitive Schemas	46	2.18	0.38	2.20	1.34	3.21
Empathy	46	3.32	0.31	3.28	2.75	3.96
Compassion Satisfaction	46	4.49	0.53	4.65	2.80	5.00
Social Support	46	4.65	0.99	4.92	1.42	6.42
Holiday Booking Consultants						
	N	**MEAN**	**SD**	**MEDIAN**	**MINIMUM**	**MAXIMUM**
Secondary Traumatic Stress	48	1.60	0.58	1.35	1.00	3.35
Negative Cognitive Schemas	48	2.22	0.45	2.20	1.34	3.47
Empathy	48	3.26	0.37	3.27	2.46	4.28
Compassion Satisfaction	48	4.32	0.65	4.50	2.60	5.00
Social Support	48	4.71	0.77	4.54	3.33	6.67

Table 21. Pearson Correlation Results - Worker Group Data

	Claims Workers (*N*=50)	**Trauma Counsellors (*N*=46)**	**Holiday Booking Consultants (*N*=48)**	**Claims Workers (*N*=50)**	**Trauma Counsellors (*N*=46)**	**Holiday Booking Consultants (*N*=48)**
	Secondary Traumatic Stress			**Negative Cognitive Schemas**		
Negative Cognitive Schemas	.53**	.46*	.48**	1.00	1.00	1.00
Empathy	.30**	.07	.10	.18	.05	.17
Compassion Satisfaction	-.71**	-.37*	-.32*	-.58**	-.30*	-.50
Social Support	-.31**	-.23	-.34*	-.62**	-.40*	-.34*

3.1 Research question three.

Is there a significant relationship between secondary traumatic stress, negative cognitive schemas, empathy, compassion satisfaction and social support within and across the worker groups, and if so, what are the nature and strength of these relationships?

The Pearson *r* correlation test revealed the following relationships between the study variables, as displayed in *Table 19*:

A significant strong correlation (r=.61) was detected between secondary traumatic stress and negative cognitive schemas. This implies that those with higher levels of secondary traumatic stress also exhibited more negative cognitive schemas and vice versa. A significant but low correlation (r=.17) was observed between levels of empathy and secondary traumatic stress, which implies that an increase in levels of empathy is associated with an increase in secondary traumatic stress and vice versa. There was, however, no significant relationship between empathy and negative cognitive schemas.

A significant strong negative correlation (r=-.54) was uncovered between compassion satisfaction and secondary traumatic stress, which means that an increase in compassion satisfaction is related to a diminution in the levels of secondary traumatic stress and vice versa. Furthermore, a significant moderate negative correlation (r=-.42) was observed between compassion satisfaction and negative cognitive schemas. This confirms that, the more satisfied workers are with their work and their compassion response, the fewer negative cognitive schemas are likely to develop.

Next, a significant but low correlation was observed between compassion satisfaction and empathy (r=.17), meaning that an increase in empathy coincides with an increase in compassion satisfaction. A significant moderate negative correlation (r=-.40) was found between social support and secondary traumatic stress, implying that an increase in social support is associated with a decrease in secondary traumatic stress and vice versa. Similarly, social support demonstrated a significant strong inverse correlation (r=-.54) to negative cognitive schemas, signifying that an increase in social support relates to a decrease in negative cognitive schemas and vice versa. No significant correlation was found between empathy and social support; however, it was interesting to see that the direction of the relationship between these two variables was nonetheless inverse. Finally, a significant medium correlation was found between social support and compassion satisfaction (r=.33), meaning that higher levels of social support occurred alongside higher levels of

compassion satisfaction and vice versa.

The ensuing set of sub-headings focuses on correlations within each of the study groups between the two vicarious trauma measures and each of the study variables. To reiterate, the purpose herein was to establish whether the accepted relationships proposed by most vicarious trauma theorists also held true for each of the worker groups.

3.1.1 Vicarious trauma and empathy.

This part of the discussion examines the theoretical notion that empathic engagement can increase vicarious trauma outcomes. To reiterate, the two vicarious trauma constructs utilised are secondary traumatic stress and negative cognitive schemas. The Pearson *r* correlation test results are summarised for the worker groups in *Table 21*. The correlation test revealed a significant moderate relationship between empathy and levels of vicarious trauma, however, only for the group of claims workers (r=.30) and only in relation to the secondary traumatic stress measure. A similar relationship was not observed for the trauma counsellors or the holiday booking consultants. Negative cognitive schemas showed no significant relationship with empathy for either of the three worker groups.

3.1.2 Vicarious trauma and social support.

The following section explores the theoretical belief that social support can decrease vicarious trauma outcomes. Interestingly, a significant relationship between social support and the two vicarious trauma measures – secondary traumatic stress and negative cognitive schemas – was observed in the claims workers and holiday booking consultants. These results are presented in *Table 21*. Secondary traumatic stress presented with a significant moderate inverse correlation to social support (r=-.30), whereas negative cognitive schemas showed a strong inverse relationship with social support (r=-.62) for the claims worker group.

No relationship was observed between social support and secondary traumatic stress for the group of trauma counsellors. However, a significant moderate inverse relationship was observed between social support and negative cognitive schemas for the trauma counsellors (r=-.40). The group of holiday booking consultants presented with a significant moderate negative relationship between social support and secondary traumatic stress as well as between social support and negative cognitive schemas (r=-.34).

These results indicate that those claims workers and holiday booking consultants who possessed greater levels of social support showed fewer negative cognitive schemata as well as lower levels of secondary traumatic stress. Similarly, those trauma counsellors who are supported well showed a lower prevalence in negative cognitive schemas. However, Fisher's *z* analysis, displayed in *Table 38* of *Appendix Q* did not indicate a significant difference between the correlations for each of the worker groups.

3.1.3 Secondary traumatic stress and negative cognitive schemas.

The two vicarious trauma measures were investigated to determine whether there is a relationship between the two constructs within each of the worker groups**.** The Pearson *r* correlation test did indeed uncover a strong positive relationship between secondary traumatic stress and negative cognitive schemas for all three of the worker groups as outlined in *Table 21*. In the claims worker group, the observed relationship was strong (r=.53). With respect to the trauma counsellors, the relationship between secondary traumatic stress and negative cognitive schemas was also significant but moderate (r=.46). The group of holiday booking consultants presented with a similar relationship between secondary traumatic stress and negative cognitive schemas (r=.48). These results indicate that participants with high secondary traumatic stress scores were also likely to present with high levels of negative cognitive schemas. However, Fisher's *z* analysis, outlined by *Appendix Q*, did not indicate a significant difference between the correlations for each of the worker groups.

3.1.4 Vicarious trauma and compassion satisfaction.

The final part of the Pearson *r* correlation analysis explored the theoretical notion that compassion satisfaction can reduce vicarious traumatisation. Significant correlations were in fact revealed, which are summarised in *Table 21*. As expected, the observed relationship between compassion satisfaction and the two vicarious trauma measures was inverted in each case. This indicates that the higher the compassion satisfaction, the less pronounced secondary traumatic stress and negative cognitive schemas are. The claims worker group presented with a significant strong inverted correlation (r=-.58) between compassion satisfaction and secondary traumatic stress, as well as an equally strong inverse relationship between compassion satisfaction and negative cognitive schemas (r=-.71).

For the trauma counsellors, the same inverse relationship between compassion satisfaction and secondary traumatic stress was observed (r=-.30), as well as between compassion satisfaction and

negative cognitive schemas (r=-.37); however, only to a moderate extent. In the group of holiday booking consultants, compassion satisfaction showed a significant moderate negative correlation with secondary traumatic stress (r=-.32). No significant relationship was observed between compassion satisfaction and negative cognitive schemas for the holiday booking consultants (r=-.05).

Finally, Fisher's z analysis indicated that there were significant differences in the magnitude of the correlations for the different worker groups. The correlations between secondary traumatic stress and compassion satisfaction showed a significant difference between the group of claims workers and trauma counsellors (z=-2.36) as well as between the claims workers and holiday booking consultants (z=-2.66). In each case, the correlations were strongest for the group of claims workers. There was, however, no significant difference in the correlations between the trauma counsellors and holiday booking consultants.

For the correlations between negative cognitive schemas and compassion satisfaction, the Fisher z analysis indicated a significant difference between claims workers and holiday booking consultants (z=-2.94). Again, the correlation was strongest for the claims workers whereas it did not reach significance for the holiday booking consultants. Finally, no significant difference in the correlations was detected between the claims workers and trauma counsellors as well as between the trauma counsellors and holiday booking consultants.

3.2 Research question four.

The fourth research question looks at vicarious trauma in relation to certain predictor or explanatory variables:

Is vicarious trauma – in terms of secondary traumatic stress and negative cognitive schemas – explained by empathy, compassion satisfaction and social support in the sample as well as in each of the worker groups?

A Multiple Linear Regression analysis was performed with a five percent significance level to estimate the quantitative effects of the explanatory or causal variables upon the dependent or criterion variables, being the two vicarious trauma measures. Multiple Regression is a statistical technique that allows one to predict the score on one variable – the dependent or criterion variable – on the basis of scores on a number of other variables referred to as explanatory or predictor

variables (Brace *et al*., 2009). To answer this question, it is broken down into four different parts, as indicated by the ensuing headings.

3.2.1 Predictor variables for secondary traumatic stress – sample data.

The first part of the question entails whether the first vicarious trauma measure, that of secondary traumatic stress, is explained by empathy, compassion satisfaction and social support in the sample. To answer this part of the research question, a Multiple Linear Regression was performed on secondary traumatic stress as the dependent variable.

Multicollinearity was detected and a high conditioning index of 28.42 was yielded. The latter indicated outliers and influences that diverged greatly from the overall pattern of data. A scatter plot of the Cook's D Influence statistic was examined to identify these outliers and influences. The bulk of scores fell between 0.03 on the *y* axis (being outliers) and 0.07 on the *x* axis (being scale influence or leverage) of the plot. Scores falling outside these mass score parameters were considered to be outliers or having undue influence, and were eliminated from further regression analyses. A total of 13 observations were eliminated, therefore utilising only 131 of the original 144 observations. Next, Linear Selection Regression was repeated on the remaining 131 observations.

The conditioning index remained unchanged and a Stepwise Regression was opted for as the best course of action. A Stepwise Regression is a hierarchical method which enters the variables into the model in sequence and assesses the value of each of these variables (Brace *et al*., 2009). Due to the intercollinearity between the explanatory variables, establishing the hierarchy of importance or contribution of each explanatory variable was deemed to be a useful approach herein.

The Stepwise Regression resulted in all three predictor variables being entered into the model. This model was significant ($F(3,127)=40.53$; $p<0.0001$) with an R-Square value of 0.489, which translates to 49% of secondary traumatic stress being explained by a combination of empathy, compassion satisfaction and social support.

It is important to mention here that the more observations used with Multiple Regression analysis, the more stable regression parameters become. The final number of observations used for the regression analysis herein, being 131, is a very modest study size by most standards. The probability of the estimate differing from the true value of the underlying parameter could be elevated in smaller samples (Sykes, 1993). However, in the present study, the ideal number of observations

required for Multiple Regression analysis was well exceeded. As a general rule of thumb, the number of observations, or participants, should exceed the number of explanatory variables used by tenfold, or reach a ratio of 10:1. (Brace *et al*., 2009). Therefore, more than 30 participants would be required, which was comfortably exceeded in the present study, which utilised 131 observations. However, some authors specify a ratio as high as 40:1 to be more desirable, which would require at least 120 observations when using three explanatory variables (Brace *et al*., 2009). Again, the 131 observations used exceeded even the 40:1 ratio.

The final Stepwise model to emerge from the analysis contained all three predictor or explanatory variables, being empathy, compassion satisfaction and social support. The results are summarised in *Table 22*. Firstly, the Beta value offers a measure of how strongly each of the predictor variables influences the criterion or dependent variable (Brace *et al*., 2009). The larger the standardised parameter estimate or Beta value, the larger the effect of the predictor variable on the criterion variable.

Table 22. Regression Results: Secondary Traumatic Stress (Dependent Variable)

EXPLANATORY VARIABLE	DF	PARAMETER ESTIMATE	STANDARD ERROR	*t* VALUE	STANDARDISED PARAMTER ESTIMATE
Intercept	1	2.83	0.59	4.81	0
Social Support	1	-0.15	0.58	-2.66*	-0.18
Compassion Satisfaction	1	-0.67	0.82	-8.18**	-0.56
Empathy	1	-0.81	0.15	5.34**	0.35

* $p<0.05$ ** $p<0.0001$

As can be seen from the standardised parameter or Beta values displayed in *Table 22*, compassion satisfaction was the most powerful explanatory variable in the model (β=-0.56), followed by empathy (β=0.35) and finally social support (β=-0.18), being the least powerful predictor. This result means that compassion satisfaction, or lack thereof, contributes most to secondary traumatic stress. Empathy was the second strongest explanatory variable in the model, which means that more empathy and deeper empathic engagement are associated with higher levels of secondary traumatic stress. Social support was found to contribute least strongly to secondary traumatic stress, which means that social support still has an impact upon secondary traumatic stress, but least so out of the

three predictor variables.

3.2.2 Predictor variables for secondary traumatic stress – worker group data.

The second part of research question four entails the notion of whether secondary traumatic stress is explained by empathy, compassion satisfaction and social support in each of the worker groups. To answer this part of the question, the Stepwise Regression analysis was repeated for each of the worker groups, summarised in *Table 23*.

Table 23. Regression Results by Group: Secondary Traumatic Stress (Dependent Variable)

Claims Workers					
EXPLANATORY VARIABLE	**DF**	**PARAMETER ESTIMATE**	**STANDARD ERROR**	***t* VALUE**	**STANDARDISED PARAMTER ESTIMATE**
Intercept	1	3.66	0.84	4.39	0
Compassion Satisfaction	1	-0.84	0.11	-7.66***	-0.70
Empathy	1	0.65	0.19	3.33**	0.31
(Social Support was not a significant predictor for this group)					
Trauma Counsellors					
EXPLANATORY VARIABLE	**DF**	**PARAMETER ESTIMATE**	**STANDARD ERROR**	***t* VALUE**	**STANDARDISED PARAMTER ESTIMATE**
Intercept	1	2.98	0.90	3.31	0
Compassion Satisfaction	1	-0.64	0.15	-4.23***	-0.62
(Social Support and Empathy were not a significant predictors for this group)					
Holiday Booking Consultants					
EXPLANATORY VARIABLE	**DF**	**PARAMETER ESTIMATE**	**STANDARD ERROR**	***t* VALUE**	**STANDARDISED PARAMTER ESTIMATE**
Intercept	1	1.93	0.92	2.09	0
Compassion Satisfaction	1	-0.37	0.13	-2.75**	-0.41
Empathy	1	0.67	0.27	2.45*	0.36
(Social Support was not a significant predictor for this group)					

** $p<0.05$ ** $p<0.0001$*

For this part of the analysis, the number of observations per group exceeded the 10:1 ratio at all times, and the number of observations used was never less than the required 30. The regression analysis yielded very interesting results that are mainly in line with what existing theory points to.

As can be surmised from *Table 23*, different predictor variables had different significance and power within the various worker groups.

For the claims worker group, the model was significant ($F(2,43)=38.11$; $p<0.0001$). An *R*-Square value of 0.639 was yielded, which means that 64% of secondary traumatic stress is explained by compassion satisfaction and empathy. Surprisingly, social support did not strengthen the model and was dropped from the Stepwise analysis. Compassion satisfaction was the most powerful explanatory variable for secondary traumatic stress (β=-0.70), followed by empathy (β=0.31). This means that those claims workers with the least compassion satisfaction experienced the most secondary traumatic stress and vice versa. Also, those workers who expressed more empathy and engaged more deeply with clients also showed greater levels of secondary traumatic stress and vice versa.

For the trauma counsellors, the model was also significant ($F(2,39)=8.96$; $p<0.001$). An *R*-Square value of 0.314 was yielded, which means that 31% of secondary traumatic stress is explained by compassion satisfaction. Empathy did not reach significance (p=0.09) and social support was dropped from the analysis as it did not strengthen the model. Compassion satisfaction emerged as the strongest predictor for secondary traumatic stress (β=-0.62).

Finally, for the holiday booking consultants, the model was significant ($F(3,39)=5.38$; $p<0.01$). An *R*-Square value of 0.292 was yielded, which means that 29% of secondary traumatic stress is explained by compassion satisfaction and empathy. Social support did not reach significance in the model (p=0.05). Compassion satisfaction was the most powerful explanatory variable (β=-0.41), followed by empathy (β=-0.36). This result means that compassion satisfaction contributed most to secondary traumatic stress. Empathy was the second strongest explanatory variable in the model, which means that more empathy and deeper empathic engagement is associated with higher levels of secondary traumatic stress. For all three worker groups, social support did not exert a strong influence on secondary traumatic stress scores.

3.2.3 Predictor variables for negative cognitive schemas – sample data.

The third part of the fourth research question entailed whether negative cognitive schemas – the second vicarious trauma measure – are explained by empathy, compassion satisfaction and social support in the sample. In response to this part of the question, a Stepwise Regression was performed with negative cognitive schemas as the dependent variable. The model reached significance ($F(3,127)=42.02$; $p<0.0001$) with an *R*-Square value of 0.498, which translates to 50% of negative

cognitive schemas being explained by the explanatory or predictor variables, being compassion satisfaction, empathy, and social support. What makes the result even more interesting is the fact that social support played a very important role in explaining negative cognitive schemas, which was not the case for secondary traumatic stress.

Table 24. Regression Results: Negative Cognitive Schemas (Dependent Variable)

Claims Workers					
EXPLANATORY VARIABLE	**DF**	**PARAMETER ESTIMATE**	**STANDARD ERROR**	***t* VALUE**	**STANDARDISED PARAMTER ESTIMATE**
Intercept	1	2.63	0.43	6.16	0
Social Support	1	-0.26	0.04	-6.15***	-0.42
Compassion Satisfaction	1	-0.28	0.06	-4.74*	-0.32
Empathy	1	0.64	0.11	5.77**	0.37

* $p<0.05$; ** $p<0.001$; *** $p<0.0001$

Firstly, as displayed in *Table 24*, social support was the most powerful explanatory variable for negative cognitive schemas (β=-0.42). This means that social support had the strongest impact on negative cognitive schemas, suggesting that the less social support persons have, the more prone they are to develop negative cognitive schemas about the self, others as well as the world. Empathy emerged as the second strongest predictor for negative cognitive schemas (β=0.37). This indicates that more empathy as well as a deeper empathic connection with traumatised individuals is associated with a greater prevalence in negative schemas and vice versa. Finally, compassion satisfaction emerged as the least powerful explanatory variable in the model (β=-0.32) which indicates that compassion satisfaction still has an impact upon negative cognitive schemas, but to the least extent out of the three predictor variables.

3.2.4 Predictor variables for negative cognitive schemas – worker group data.

The final part of the fourth research question, which also concludes this chapter, entailed whether negative cognitive schemas – the second vicarious trauma measure – is explained by empathy, compassion satisfaction and social support in each of the worker groups. To answer this part of the research question, a Stepwise Regression analysis was performed for each worker group, of which the results are summarised in *Table 25*.

Table 25. Regression Results by Group: Negative Cognitive Schemas (Dependent Variable)

Claims Workers					
EXPLANATORY VARIABLE	**DF**	**PARAMETER ESTIMATE**	**STANDARD ERROR**	***t* VALUE**	**STANDARDISED PARAMTER ESTIMATE**
Intercept	1	4.04	0.77	5.24	0
Social Support	1	-0.29	0.07	-4.27**	-0.42
Compassion Satisfaction	1	-0.43	0.09	-4.69**	-0.45
Empathy	1	0.46	0.16	2.76*	0.27
Trauma Counsellors					
EXPLANATORY VARIABLE	**DF**	**PARAMETER ESTIMATE**	**STANDARD ERROR**	***t* VALUE**	**STANDARDISED PARAMTER ESTIMATE**
Intercept	1	2.50	0.43	5.82	0
Social Support	1	-0.21	0.07	-2.89*	-0.42
(Compassion Satisfaction and Empathy were not significant predictors for this group)					
Holiday Booking Consultants					
EXPLANATORY VARIABLE	**DF**	**PARAMETER ESTIMATE**	**STANDARD ERROR**	***t* VALUE**	**STANDARDISED PARAMTER ESTIMATE**
Intercept	1	0.94	0.69	1.36	0
Social Support	1	-0.27	0.07	-3.68**	-0.45
Empathy	1	0.79	0.19	4.12**	0.50
(Compassion Satisfaction was not a significant predictor for this group)					

* $p<0.05$ ** $p<0.0001$

For the claims workers, the model was significant ($F(3,42)=22.71$; $p<0.0001$). The *R*-Square value expressed was 0.618, which means that 62% of negative cognitive schemas were explained by empathy, compassion satisfaction and social support. Compassion satisfaction was the most powerful predictor of negative cognitive schemas (β=-0.45), followed by social support (β=-0.42) and empathy (β=0.27). This means that compassion satisfaction and social support had the strongest influence on negative cognitive schemas. Therefore, those who experience less compassion satisfaction and have less social support are more prone to develop negative cognitive schemas. Empathy also had an influence on negative cognitive schemas, but least so out of the three predictor variables.

In the case of the trauma counsellors, the model was also significant ($F(1,40)=8.89$; $p<0.01$). An *R*-Square value of 0.181 was achieved, which means that 18% of negative cognitive schemas are explained by empathy, compassion satisfaction and social support. In this case, social support (β=-0.32) emerged as the most powerful predictor for negative cognitive schemas (β=0.36). This means that, in trauma counsellors, a lack of social support is associated with greater negativity in their cognitive schemas. Interestingly, neither compassion satisfaction nor empathy strengthened the model and both were subsequently dropped from the Stepwise analysis.

Finally, for the group of holiday booking consultants, the model was significant ($F(2,40)=14.15$; $p<0.0001$). An *R*-Square value of 0.414 was yielded, which means that 41% of negative cognitive schemas were explained by empathy, compassion satisfaction and social support. Empathy was the strongest explanatory variable for negative cognitive schemas (β=0.50), followed by social support (β=-0.45). This means that those holiday booking consultants who express more empathy and engage more deeply with clients also experience greater negativity in their cognitive schemas and vice versa. Also, those with less social support are more prone to developing negative cognitive schemas and vice versa. For the group for holiday booking consultants, compassion satisfaction did not strengthen the model and was subsequently dropped from the Stepwise analysis.

The next chapter reports the results yielded by the self-constructed questionnaire that presented a mix of open and closed-ended questions to participants.

"Not everything that can be counted counts, and not everything that counts can be counted" (Albert Einstein, 1879 - 1955).

CHAPTER SEVEN: RESEARCH RESULTS

Quantitative and Qualitative Content Analysis Results

Content analysis was utilised to forge a connection between quantitative and qualitative data. To reiterate, data were collected around Figley's model of compassion fatigue (2002a) as well as additional concepts of importance to the study. As explained, the applicability of each model component to the administrative context was gauged by focusing on a group of short-term insurance claims workers. A bio-psychosocial framework enabled the study to systematically explore effects of vicarious trauma at the intrapersonal, interpersonal, social and organisational levels of functioning.

Results were constructed into etic and emic viewpoints. *Appendix R* provides an overview of these two positions. The etic voice involved themes the study wished to unearth and was structured around the remaining components of Figley's model not yet covered by the quantitative instruments, as well as some themes of interest. For this purpose, *a-priori* themes were developed in advance and applied to the qualitative data. By contrast, the emic voice represents what participants wished to impart and was honoured by allowing the data to speak unrestrainedly, focusing on themes that emerged spontaneously from the data. Results are sporadically illustrated by utilising verbatim quotations to exemplify points in participants' own words.

To construct the etic voice, deductive themes stemming from the research questions or theory were utilised. As stated before, some of these themes relate to theory on the progression of secondary traumatic stress/compassion fatigue depicted by the remaining elements of Figley's model. These are detachment, level of empathy, personal trauma history, difficult life demands and exposure to suffering. Next, the theme of illness – especially work-related – was explored in response to the theoretical notion that vicarious trauma has certain health implications. Absenteeism as a result of illness as well as from utilising sick-leave as a coping strategy was considered. Positive effects postulated by theorists to sometimes emanate from trauma work were also explored. This information supplemented the quantitative data on a sense of satisfaction expressed by Figley's model. Examples of emotional contagion were also presented.

Also, the language utilised by participants in response to questions was analysed in search of further emotional effects. Feelings emanating from dealing with traumatised clients were deliberated as well as attitudes towards professional counselling as formal support. To illustrate the permeating nature of vicarious trauma, effects within the interpersonal domain were captured. The social domain received attention whereby non-work-based support was examined. The etic voice concluded with a small needs assessment. The role and nature of work-based support were explored as well as levels of satisfaction with support provided. Participants discussed disparities between their work circumstances and what they need from their work environment. Theory played an important part throughout the etic voice; however, the theoretical significance of themes is only deliberated in the next chapter. This tier of the analysis mainly involved quantitative content analysis whereby frequency of applied themes was recorded to reveal direction and strength of opinion.

The emic voice was constructed by unearthing spontaneously emergent themes which include work effects and challenges, other sources of stress as well as additional emotional effects and challenges. The themes expressed by the emic voice might be of less significance within the theoretical framework of the study, but are nonetheless important – especially to the worker context and in promoting inside-outside legitimation. Also, each emic theme unlocked a new area of possible future research, increasing their noteworthiness. However, the theme of self-care, a point of great theoretical significance to the study, emerged spontaneously from various portions of the data. Conjointly, the information presented attempts to illuminate the nature of vicarious trauma within the worker groups, and how these experiences shape attitudes, behaviour and work-lives.

It has to be mentioned that this chapter is voluminous, and that tables are used intermittently to make results clearer. The rationale was to re-examine the data until an intuitive point of saturation was reached, and the material offered nothing more to promote understanding (Terre Blanche & Durrheim, 1999). A large number of themes were included as they emerged pertinently, thus signifying their felt importance. Other information was included for interest's sake or to offer insight into the typical work-lives of each worker group. For instance, even though the group of holiday booking consultants acted as a control group, results from this group are nonetheless included to contrast and elucidate certain points and to honour the emic voice. Not all the points covered here are developed further by the discussion. Only information of significance within the theoretical boundaries of the study received further attention, and information from this chapter was drawn upon sporadically to illustrate and corroborate.

1 The Etic Point of View

1.1 Figley's model components.

As stated before, Figley's model was deconstructed into its constituent parts, after which data were collected on each element. Please refer to *Figure 1* on page 60 for Figley's model and a brief discussion of each element. To reiterate, elements relating to empathy, sense of satisfaction and compassion fatigue/secondary traumatic stress were covered by the quantitative measures as discussed in the previous chapter. The remaining model elements were systematically covered by this chapter or added information to supplement the data yielded by the quantitative measures. *Appendix A* offers a bird's-eye view of how the model was covered by the quantitative and qualitative legs, and also indicates which other areas were investigated. This figure also reflects which quantitative measures were utilised as well as some of the major themes investigated in relation to each element. This part of the discussion is loosely structured around the remaining model elements, after which it then focuses on other areas of importance. The first model component under consideration is that of detachment.

1.1.1 Detachment.

The general ability to disengage from client traumata or difficult cases was gauged. Responses were sorted according to the level of success with which detachment was illustrated, derived from participant responses to questions eight and nine of the self-constructed questionnaire (*Appendix N*). Inter-rater reliability achieved for these categories was discussed in chapter five. Three categories were developed:

Effective disengagement: participants do not dwell on cases, and can move on to the next client, even after an emotionally trying case. They are able to successfully leave work matters at work.

Partial disengagement: participants can disengage from cases with some success. However, more severe cases tend to linger and trouble participants away from work.

Poor disengagement: participants disengage from cases poorly and cases often plague participants away from work.

Claims workers generally demonstrated the least effective disengagement out of the three groups. Only 34% *disengage effectively* from trauma cases, 50% *disengage partially* whereas 16% *disengage poorly*. Of the trauma counsellors, 46% *disengage effectively*, 48% *disengage partially*

whereas only six percent demonstrated *poor disengagement* from client traumata. Holiday booking consultants demonstrated the most effective disengagement. Firstly, four percent stated that they do not deal with trauma cases and omitted related questions. *Effective disengagement* was illustrated by 71% of this group. However, they referred to instances involving client anger, antagonism and discourtesy. Their responses confirmed the rarity of trauma exposure in this group, but nonetheless illustrated that their work context is not without emotional challenge. *Partial disengagement* was demonstrated by 15% and ten percent stressed that they generally *disengage poorly* from client emotions.

Interestingly, six percent of the sample described rituals they routinely follow to signify the transition from work to personal time. These rituals seem to prevent work issues from entering into their private lives and vice versa. Four trauma counsellors described such rituals, including meditation, artistic expression, self-hypnosis, compartmentalising of work-issues as well as mindful visualisation of placing work matters to rest at the end of each work-day.

None of the claims workers described such practices. Three holiday booking consultants described closing a notional door in the mind whenever they close the door to their office or home, barring related cares. A fourth holiday booking consultant described how she routinely uses daily commutes to decompress and work through troubling issues. These rituals all seem to facilitate mindfulness and clear role boundaries. These rituals seem to serve participants well as they either showed effective or partial disengagement from client emotions. Figley's model components relating to empathy are deliberated on next.

1.1.2 Level of engagement/empathy.

In addition to the data yielded by the empathy measure, level of empathic engagement was also considered alongside the ability to disengage from client emotions, discerned from responses to questions seven, eight and nine of *Appendix N*. *Table 26* presents a summary of the results and chapter five provides the inter-rater reliability. Three categories were developed:

Connecting deeply: participants focus on client experiences and their emotional state. Clients are allowed to take the lead and discuss their ordeal in as much depth and breadth as they wish to. Throughout this ventilation process, participants offer comfort and empathy. Once the client has said all he/she needs to participants move on to work matters.

Connecting somewhat: participants connect with clients briefly, offering comfort and empathy. However, participants remain in charge of the process and actively steer towards work once the client has had some opportunity to ventilate.

Focusing on work: participants avoid connecting with clients emotionally, focusing mainly on work. They aim is to attain the necessary information and to deal with the work at hand as swiftly as possible. They do not dwell on what happened to clients but more on speedy service delivery.

Table 26. Level of Empathic Engagement with Traumatised Clients

	Claims Workers	**Trauma Counsellors**	**Holiday Booking Consultants**	
CATEGORY	**Trauma**	**Trauma**	**Anger**	**Trauma**
Connect deeply	**42%**	**59%**	**19%**	**4%**
Effective disengagement	28%	41%	78%	-
Partial disengagement	43%	52%	11%	50%
Poor disengagement	29%	7%	11%	50%
Connect somewhat	**38%**	**37%**	**46%**	
Effective disengagement	37%	47%	77%	
Partial disengagement	53%	47%	14%	
Poor disengagement	10%	6%	9%	
Focus on work	**20%**	**4%**	**27%**	
Effective disengagement	40%	100%	76%	
Partial disengagement	60%	-	15%	
Poor disengagement	-	-	8%	
Do not deal with trauma	-	-	**4%**	

Of the claims workers, 42% *connect deeply* with clients. Of this 42%, 28% disengage effectively from client traumata, 43% disengage partially, whereas 29% disengage poorly. Next, 38% of the claims workers *connect somewhat* with clients. Of this 38%, 37% disengage effectively, 53% disengage partially and ten percent disengage poorly. Finally, 20% of claims workers avoid forging a connection, *focusing on work*. Of this 20%, 40% disengage effectively, 60% disengage partially and none of the claims workers from this category disengaged poorly.

Of the trauma counsellors, 59% *connect deeply*. A deeper connection is somewhat expected as counselling, by design, centres upon forging empathic and therapeutic alliances with clients. Of this 59%, 41% disengage effectively from client trauma, 52% disengage partially and seven percent disengage poorly. Next, 37% of the trauma counsellors *connect somewhat* with clients. Of this 37%, 47% disengage effectively, 47% disengage partially whereas six percent demonstrated *poor disengagement*. Surprisingly, four percent of the trauma counsellors avoid forging a connection with clients, *focusing on work*. Looking at this data more closely, these counsellors also reported emotional numbness. However, they generally disengage from client traumas effectively.

Finally, responses from the holiday booking consultants were again reflective of their unique emotional challenges and the relative absence of traumatised clients. As can be seen from *Table 26,* they generally connect less deeply with clients and demonstrated the best ability to dissociate from client emotions, in their case being anger and antagonism. Their ability to disengage from actual cases that involved client trauma, however, proved to be much less effective.

Four percent of the holiday booking consultants discussed encounters with traumatised clients. One of these two participants was upset for several days following the encounter, which happened two years prior to data collection. The fact that she readily recalled the incident after two years had passed, shows that the client's trauma had had quite an impact. The other participant also showed considerable perturbation following the encountering with the traumatised client. The incident happened three weeks prior to the data collection, at which time she stated that she was still being affected. The model component of personal trauma is discussed next.

1.1.3 Personal trauma history.

Of the entire sample, 39 experienced a recent personal trauma ranging from death of a loved one, to violent crime, surgery, accidental injury, divorce, unemployment of a spouse, ending of a significant relationship and the loss of a cherished animal companion. Four percent of the sample suffered more than one recent trauma. As these events randomly happen to us all from time to time, participants with recent traumas were not excluded from the study, unless they indicated persisting moderate or severe trauma.

Interestingly, a theoretically significant theme spontaneously emerged from the data. Even though participants were only asked to divulge and rate recent traumas, a number of participants later observed how personal trauma impinged upon their ability to assist traumatised clients. Of the

claims workers, eight percent acknowledged that their own traumas impeded their ability to assist. Of this eight percent, half observed how similar client traumas reignited their own traumatic memories, inducing much more distress than other unrelated types of trauma.

Most likely due to their psychology training, trauma counsellors expressed a far greater awareness of the compounding role of personal trauma. By comparison, 24% discussed this issue, of which 42% described how their unresolved traumas were triggered by similar client experiences. Some trauma counsellors described how their levels of secondary traumatic stress were heightened while others felt that their emotional reactions and instrumental responses toward clients had been influenced. Finally, four percent of the holiday booking consultants stated that personal traumas complicated their ability to assist difficult clients. Difficult life demands proposed by Figley's model are investigated next.

1.1.4 Difficult life demands.

The levels of difficulty of life demands described by participants were not evaluated, but rather how they were perceived to impact upon stress levels, well-being and the ability to deal with clients. Of the claims workers, 26% had not recently experienced any difficult life demands. Of this 26%, 31% reported that working with traumatised clients was the only real source of work-stress and the remaining 69% were spared recent challenging life demands. However, 72% of this group experienced recent disruptions that impinged upon their ability to cope with client traumata. A further two percent of claims workers who experienced difficult life demands reported these to have had an overall positive effect/outcome.

Of the trauma counsellors, 26% had not recently faced difficult life demands. Of this 26%, 35% found client trauma to be the only significant source of work-stress, whereas 65% were fortunate not to have encountered recent difficult life demands. However, 56% of trauma counsellors stated that recent life challenges added to the stresses of dealing with client crises. A further 18% recently experienced difficult life demands, but felt that these had an overall positive effect/outcome.

Finally, of the holiday booking consultants, 48% had not recently been faced with challenging life demands. Of this 48%, 13% acknowledged that work-pressure and irate clients posed the only real sources of stress and 87% were fortunate not to have experienced any difficult life demands. Another 52% admitted that difficult life events had invariably impinged upon their lives recently, of which 67% found these challenges to have added to their work-stress. They reported the most

positive effects by far, whereby 33% of this group reported difficult life demands to have had a positive outcome. The final component of Figley's model, that of exposure to trauma, is examined next, and is aimed at also creating a sense of the typical work-lives of the three worker groups.

1.1.5 Exposure to suffering.

Exposure to suffering was gauged by considering the more serious cases participants had been called upon to deal with. How long ago these cases had been as well as how long participants was affected by them, was also examined in order to elucidate the nature of exposure to trauma.

1.1.5.1 Types of cases.

This section aims to offer the reader a glimpse into the types of cases participants sometimes have to deal with. The reasoning in this is that, the more traumatised clients are, the greater the likelihood is that they will exert an effect on workers. Question two of the self-constructed questionnaire – as per *Appendix N* – prompted participants to describe a case that had affected them most. Incidents were categorised and their frequencies recorded. The results are displayed in *Table 27* and cases are listed from most to least severe.

For claims workers and trauma counsellors, trauma cases were prolific, revealing an array of sometimes disturbing events. It was striking that some cases claims workers dealt with, although less frequently, were as serious as cases encountered by trauma counsellors. Although cases might generally be more varied and less severe, cases described nonetheless offered some sense of the challenges faced by both worker groups.

Holiday booking consultants mostly described maltreatment from out-of-control clients, punitive action or loss of income which was highly reflective of their work environment. Only two holiday booking consultants described actual trauma cases – one involving a terminally ill client, and another a fearful client in an abusive relationship.

Furthermore, claims workers do not usually encounter cases involving sexual or emotional abuse, which is to be expected within their frame of work. However, they encounter a disturbing number of rape survivors. As stated previously, crimes are often succeeded by violent acts, a tendency that was clearly visible in the data. Interestingly, claims workers encountered the most survivors of violent attacks and torture as well as cases involving death compared to trauma counsellors. For instance, claims workers discussed cases resulting in death on ten occasions as opposed to trauma

counsellors who dealt with death six times.

Table 27: Types of Traumatising Cases Dealt With

	Claims Workers	Trauma Counsellors	Holiday Booking Consultants
Rape	6	13	-
Violent attack/torture	3	-	-
Sexual abuse	-	7	-
Case involving death ***(murder, death from illness)***	3	2	-
Accident resulting in death *(road accidents, burning to death, drowning)*	7	4	-
Suicide	3	3	-
Violent crime *(burglary with victims present, hi-jacking, armed robbery, hostage taking)*	18	6	-
Abuse *(Physical/mental abuse of a person or child, abusive relationships)*	-	6	1
War situation	-	1	-
Wrongful imprisonment	-	1	-
Accident involving serious injury	6	-	-
Terminal/serious illness	1	2	1
Neglect *(child or elderly person)*	1	1	-
Accident	2	-	-
Poverty	-	1	-
Prostitution	-	1	-
Case leading to punitive action	-	-	6
Case leading to loss of income	-	-	4
Rude/angry client	-	-	21

It was surprising to find that claims workers encountered suicide cases as often as trauma counsellors. Astonishingly, one claims worker described persuading a client not to take his own life over a severe uninsured loss that he could not come to terms with. This was unexpected as one would not associate claims workers with suicide cases at all. Yet, out of the 50 claims workers, 6% encountered cases where property loss or damage resulted from suicide, attempted suicide or where clients contemplated suicide over losses. Also, claims workers dealt with more than double the number of violent crimes than did trauma counsellors. Furthermore, only the claims workers described incidents involving serious injury. *Table 27* clearly indicates the severity of cases that

claims workers do on occasion deal with. One only expects trauma counsellors to deal with cases of this nature and seriousness, which made this section eye-opening. Next, participants were asked how long ago these cases occurred.

1.1.5.2 Length of time ago.

The reasoning to apply this theme was that the longer ago cases had occurred, the greater the effect they might have had if participants were still readily recalling them. Of the claims workers, 46% recalled cases that had happened under a year ago and 30% discussed a case that had happened over a year ago. Of this 30%, 47% described cases that were one year ago, whilst 53% referred to cases that dated back more than a year. The remaining 24% of this group did not give usable answers. They either did not give a time, stated that they were generally a not affected by cases or instead responded with answers like "*It happens every now and then*"; "*I hear about it weekly*" or "*We handle such cases often.*"

For the trauma counsellors, 52% described cases that happened less than a year ago and 24% spoke about cases dating back more that a year. Of this 24%, 46% spoke about cases they handled around a year ago and 54% spoke about cases that dated back further. The remaining 24% of this group did not give usable answers. They either did not report a time, stated that they were normally not affected by cases or responded with answers like "*Every so often*"; "*It happened a while ago*" or "*I can't recall at the moment*".

Of the Holiday booking consultants, only 14% answered related questions. Of this 14%, the majority of participants spoke of abuse from irate clients, or having to cope with disrespect and discourteousness. Only four percent of the control group dealt with a traumatised client. To summarise, the results presented above do not necessarily relate back to theory. However, they indicate that trauma counsellors experience trauma cases most frequently with 52% of cases being less than a year ago, followed by claims workers with 46% for the same period. It also shows that participants seem to be affected by cases for quite some time. It is argued that, if someone recalls a case that happened several years ago, it means that the case still stands out as a particularly traumatising event. Claims workers and trauma counsellors recalled cases that dated back several years with similar frequency. This means that both these worker groups equally often experience difficulties to forget more severe cases. The following section looks at the duration of effects from these more severe cases.

1.1.5.3 Duration of effects.

Participants were asked how long they were affected by the case they chose to talk about.

Table 28: Duration of Effects of a Severe Case

	Claims Workers	Trauma Counsellors	Holiday Booking Consultants
Not affected	4%	-	42%
Affected for duration of call	-	-	6%
Affected a while after the call	22%	22%	8%
Affected 1 day	4%	4%	2%
Affected a few days	18%	30%	2%
Affected 1 week	6%	4%	-
Affected a few weeks	4%	4%	-
Affected 1 month	4%	11%	-
Affected a few months	8%	6%	4%
Affected 6 months	6%	-	2%
Affected 1 year	-	2%	-
Still affected	18%	11%	8%

Six percent of the claims workers either could not recall a trauma case or how long ago the case was. As per *Table 28,* four percent of the claims workers, despite the severity of cases, were unaffected. Another 22% were affected for a while after the call, but resumed work shortly thereafter and 22% were affected for one to a few days. Ten percent experienced effects for one to a few weeks. Another 12% reported effects lasting between one and a few months, whereas six percent experienced effects for six months. A further 18% were still affected whenever they thought about the case, dealt with a similar case, or encountered reminders around the office.

Next, four percent of the trauma counsellors either could not recall a trauma case, or how long ago the case was. Another 22% experienced effects for a short while after the call, but resumed work a short while later whereas 34% felt affected for one to several days. Eight percent experienced effects for one to a few weeks and 17% reported effects that lasted one to several months. Four percent reported effects that lingered for around a year. Finally 11% of the trauma counsellors were still affected by the case when thinking about it, when dealing with a similar case or when stumbling upon reminders around the office.

Only 75% of the holiday booking consultants answered the question, whereas the rest reported that they do not deal with trauma cases, thus omitting related questions. Of this group, only four percent spoke of a trauma case. One of the holiday booking consultants was affected for several months, whereas the other worker described still being affected by the particular case. These results showed that the effects from the two trauma cases were quite lasting. The majority of the remaining participants spoke about how they were affected by angry, discourteous clients, and a few reported that they were generally not affected by difficult cases. Continuing the focus on the etic view, the attention shifts to other themes of importance to the study, being sick-leave, illness and resultant absenteeism.

1.2 Other important *a-priori* themes.

Theory continues to play an important part in the ensuing themes, which will be illustrated more clearly in the next chapter.

1.2.1 Sick-leave as a coping strategy.

Participants were asked whether they had ever taken sick-leave because of feeling overwhelmed or in need of a break. Of the claims workers, 54% responded with a resounding "*No*" or "*Never*". Of this 54%, four percent admitted to having seriously considered doing so. As many as 46% admitted to having taken sick-leave as a means to cope. One person stated that 90% of sick-leave taken was aimed at escaping work pressures. Two persons admitted to doing so more often than they cared to admit. One person admitted to excessive alcohol consumption, which contributed to absences from work.

Of the trauma counsellors, 78% had never taken sick-leave for any other reason than being ill. Of this 78%, eight percent did feel tempted to do so. However, 22% had taken sick-leave because they could not face stresses at work. Finally, 83% of the holiday booking consultants had never taken sick-leave to cope. Of this 83%, seven percent had toyed with the idea. Only 17% had taken sick-leave as a means to cope.

1.2.2 Stress and illness.

Participants were next asked whether they had taken sick-leave due to illness in the past six months, and whether work-stress might have contributed to their illness. Of the claims workers, 18% stated not to have taken any sick-leave recently. Therefore, 82% had taken sick-leave during this period, of which 54% felt that work-stress did not contribute in any way. However, 46% felt that work-

stress played a role in their illness. A person commented that stress at work had had a serious impact on her health and that she was ill so often that her annual sick-leave quota was depleted, forcing her to take personal leave for recuperation. One person stated that stress at work was partly responsible for a failed pregnancy. Another person reported that, although she had not taken sick-leave, the stress of dealing with clients in crisis contributed to her weight spiralling out of control.

For the trauma counsellors, 39% confirmed not having taken sick-leave in the past six months. Therefore, 61% did take sick-leave during this period, of which 70% maintained that work-stress did not contribute to them falling ill. However, 30% felt confident that work-stress did play a part. Of the latter 30%, 27% felt run-down or burnt out, believed their immunity to be compromised, thus making them susceptible to infection. One person suffered a health-scare that was unequivocally stress-related. Of the holiday booking consultants, 48% had not taken any sick-leave in the past six months, whereas 52% had done so. Of this 52%, 88% felt that work-stress did not play a part in their illness. However, 12% felt certain that stresses at work had contributed.

Moreover, the theme of a decline in health also emerged in unrelated parts of the data, discussed by 14% of the claims workers who were convinced that work-pressures were partly to blame. They described weight-gain, chronic fatigue, restlessness and feeling run down. Four percent reported trouble sleeping.

Similarly, a decline in health cropped up in unrelated parts of the data for 13% of the trauma counsellors. Some mentioned issues similar to those raised by claims workers, whereas others described specific problems such as stress-related back-pain and elevated blood-pressure. They too felt that work-stresses contributed. Six percent of trauma counsellors reported difficulties in falling or staying asleep. In contrast, despite functioning in a high-pressure environment, holiday booking consultants did not discuss health issues again. Next, the focus of the analysis shifts towards underlying attitudes and feelings on certain subjects.

1.3 Assessment of feelings and attitudes.

Firstly, attitudes towards professional counselling were gauged. As stated previously, most claims workers had access to counselling via wellness programmes. The data were used to form an idea of the level of utilisation and perceived usefulness of this resource.

1.3.1 Attitudes towards counselling/therapy.

Firstly, the three participating trauma organisations all have counselling services and supervision available to their counsellors. In one particular case, monthly massages are also made available. Two of the three participating insurers had had wellness programmes for between five and seven years, including counselling, whereas the third insurer had recently introduced their programme. However, at the time of data collection, it was not fully operational. None of the holiday booking consultancy firms indicated having wellness programmes.

Of the claims workers, 80% knew of the counselling available to them, although, six percent reported that the service was completely inaccessible. Constantly having to forego counselling appointments due to conflicting work schedules or staff shortages made the service unobtainable. One participant commented that their employer arranged a group counselling session once, and nothing since. Interestingly, 20% had no knowledge of this service. Of those aware of the service, 10% felt that they would not benefit from counselling, whereas 76% believed that they would gain greatly. The remaining 14% expressed ambivalence about the benefits of counselling. A total of 82% of the claims workers indicated that they would use the counselling service should they need it and seemed to draw a sense of security from the knowledge that the service was there. Eight percent would not make use of the service, and ten percent expressed uncertainty about whether they would.

For the trauma counsellors, 75% were aware of the counselling available to them. As many as 79% believed that they would benefit from counselling and 79% acknowledged that they would seek counselling if need be. Interestingly, four percent stated that they would only use the service if confidentiality was guaranteed, or if a counsellor could be seen privately. Eight percent were in counselling at the time or in the recent past. Interestingly, eight percent of the trauma counsellors believed that they would not gain from counselling, two percent were unsure if they would benefit or seek assistance, and ten percent admitted that they would not seek counselling. Alarmingly, 21% of the trauma counsellors were unaware of the counselling available to them.

Finally, even though holiday booking consultants do not deal with traumatised clients, they showed a surprising level of interest in work-related counselling. Of this group, 46% believed that they would benefit and 39% would seek counselling. High levels of stress and pressure, dealing with difficult client groups or even burnout are most likely the motivating factors that facilitated the high level of interest. Feelings evoked by client traumata are considered next.

1.3.2 Feelings evoked by traumatised clients.

This section focuses on the feelings described by participants in relation to working with traumatised clients. The direction and intensity of reported feelings are also considered. Finally, instances that evidenced the occurrence of emotional contagion, a theoretically significance concept, are also presented.

1.3.2.1 Direction and intensity of feelings.

Statements were viewed within context and judged by collectively considering all of the responses relating to client traumata, being questions one to nine of *Appendix N*. *A-priori* codes were formulated to indicate direction as well as strength of emotions or effects described. The results are summarised in *Table 29* and inter-rater reliability is discussed in chapter five. Seven categories were developed:

Strongly negative: the person experiences mostly negative emotions/effects that are quite strong/intense and lasting. The person's functioning is affected negatively. Emotional numbness falls under this category, because it is a negative result that is generally believed to impair certain areas of functioning.

Moderately negative: the person experiences reasonably negative emotions/effects that are moderately intense and lingers somewhat. The person's functioning may be disrupted to some extent, but only for a short while.

Slightly negative: the person experiences some negative emotions/effects but they are transient and abate quickly. The person does not seem to experience any positive emotions/effects to counterbalance the negative.

Neutral: the person can remain neutral and help effectively without getting caught up in client emotions. A fairly equal mix of negative and positive emotions/effects is experienced that dissipates quickly. This code was also assigned to cases where negative emotions discussed were not related to traumatised clients, or where participants stated that they do not deal with traumatised clients.

Slightly positive: the person experiences slightly positive emotions/effects of a transient nature. Intermittent negative emotions/effects are reported but experiences lean more towards positivity.

Moderately positive: the person experiences reasonably positive emotions/effects that are somewhat lingering. Few negative emotions are reported.

Strongly positive: the person experiences mostly positive emotions/effects that are quite intense and lasting. No negative emotions/effects are reported – the person does not seem to be affected by client trauma/emotions.

Table 29: Feelings About Working with Traumatised Clients at a Glance

	Claims Workers	Trauma Counsellors	Holiday Booking Consultants
Strongly negative	-	11%	-
Moderately negative	28%	15%	2%
Slightly negative	38%	22%	15%
Neutral	32%	41%	81%
Slightly positive	-	7%	-
Moderately positive	2%	2%	-
Strongly positive	-	2%	2%

None of the claims workers experienced *strongly negative* emotions/effects from working with traumatised clients. *Moderately negative* emotions/effects were reported by 28%. The majority of participants, tallying to 38%, experienced *slightly negative* emotions/effects. Finally, 32% are able to remain *neutral* and able to help effectively. None of the participants experienced *slightly positive* effects, although two percent indicated *moderately positive* emotions/effects. None of the claims workers experienced *strongly positive* emotions/effects from helping traumatised clients.

Of the trauma counsellors, 11% reported *strongly negative* emotions/effects. *Moderately negative* effects were reported by 15%, and 22% reported *slightly negative* emotions/effects. Those able to remain *neutral* and help effectively tallied to 41% and seven percent reported *slightly positive* effects/emotions. Two percent experienced *moderately positive* effects, and another two percent reported *strongly positive* effects/emotions from helping traumatised clients.

Finally, holiday booking consultants do not customarily deal with traumatised clients. Their responses indicated how they are affected by antagonism, anger and discourteousness. Results for this group are also presented in *Table 29*. However, seeing that booking consultants interact with clients around a positive subject, that of holiday and travel, it was expected that they would report more positive effects. Interestingly, no-one from this group reported *slightly positive* or *moderately positive* effects, and only two percent experienced *strongly positive* emotions/effects.

In summary, 66% of claims workers reported experiencing negative emotions/effects of varying degrees from dealing with traumatised clients. Of the trauma counsellors, 48% reported a similar negative experience. Although this is considerably less compared to the claims workers, trauma counsellors experienced negative outcomes of the greatest *intensity* out of the three groups. Holiday booking consultants were least affected by their clients, whereby only 17% reported purely negative outcomes. Claims workers are least efficient and impervious to trauma as only 32% were able to remain neutral during client interactions, compared to 41% of trauma counsellors and 81% of the holiday booking consultants. Surprisingly, the largest percentage of participants to report positive emotions/effects – being 11% – consisted of trauma counsellors. Only two percent of the booking consultants reported positive effects.

1.3.2.2 Positive outcomes.

Next, positive outcomes from dealing with traumatised clients that emerged from unrelated sections of the data are considered.

Of the claims workers, an additional six percent described positive outcomes ranging from personal growth, a deeper understanding of life, a deeper appreciation for their own good fortune, to a deep sense of fulfilment. Also, 20% of claims workers reported positive outcomes, despite experiencing their work to be negative. This polarity between consistently negative experiences resulting in a positive outcome was interesting. To give a few examples, one claims worker stated that dealing with traumatised clients had made her stronger and more resilient. Another stated having mastered valuable life-skills that she would not have acquired otherwise. One person reported dramatic intellectual and emotional growth from doing this work. It was quite surprising to see how, after explaining at great length how negative and unpleasant dealing with traumatised clients is, they nonetheless have a passion for their work and derive positive outcomes from it.

Of the trauma counsellors, 24% described a positive outcome. The same polarity between negative experiences resulting in positive outcomes was observed in 15% of this group. One person reported that, although counselling is draining and instils feelings of aggression, he nonetheless derives great satisfaction from his work. Another person stated that she was a richer, more empathic person for it. Others admitted looking forward to coming to work and deriving a deep sense of fulfilment. Another person stated that, although counselling was mostly a grim experience, she had gained invaluable experience in her field of study. Finally, a trauma counsellor reported that client traumata interspersed with her own traumas have matured her, changed her way of thinking about life and instilled a desire to seek joy.

Finally, 21% of the holiday booking consultants experienced their work as overall positive, sharing in people's dreams and excitement, being in a positive atmosphere and experiencing pleasure from being around colleagues who are like family. Some expressed a sense of confidence and competence from their work while others described enjoyment and satisfaction. However, a polarity between negative experiences resulting in positive outcomes was not observed. Next, the theoretically significant theme of emotional contagion is considered.

1.3.2.3 Emotional contagion.

Whilst analysing feelings evoked by dealing with traumatised clients, evidence of emotional contagion emerged. The majority of participants explained how they work hard to maintain emotional distance from clients. However, a large percentage of participants specifically described instances where their feelings mirrored those of clients. To reiterate, the content analysis primary document number is used alongside quotations to conceal identities. Of the claims workers, 14% reported feeling, to varying degrees, what their clients were feeling. Here are a few statements from claims workers to exemplify this point:

P71: *"I would feel as if it happened to me."*

P82: *"My heart would ache as if I was in that situation as well."*

P85: *"I imagine myself in their situation and think if it were me."*

P90: *"I usually feel what they are feeling e.g. panic, fear, grief, shock etc."*

P96: *"I feel a little bit of what they are feeling."*

Of the trauma counsellors, 19% described instances of experiencing emotions parallel to those of clients:

P21: *"[I] feel the person's vulnerability."*

P22: *"[I] kept putting myself/my daughters in her shoes."*

P35: *"[I] felt like I was drowning with him."*

Holiday booking consultants showed the greatest levels of emotional contagion, in responding to anger with anger. Firstly, 30% of this group stated that they did not deal with traumatised clients. Of the 70% that responded to the questions, 23% of the holiday booking consultants admitted to mirroring client emotions involuntarily and regularly:

P103: *"It [what I feel] is all very much dependent on how the client reacts. [A client] coming through screaming and shouting and not calming down, and my back goes up and I go into defensive mode."*

P106: *"[An angry client] makes me irritated and angry."*

P130: *"It only makes me angry when people shout."*

Next, the language utilised by participants to describe client interactions is focused on.

1.4 Analysis of language.

Language utilised by participants to convey feelings evoked by traumatised clients was categorised next. Firstly, use of emotionally charged language was delved into. Secondly, the use of words expressing fear and vulnerability were unearthed.

1.4.1 Emotionally charged language.

Language utilised by the three worker groups evoked by dealings with clients is summarised in *Table 30.*

Table 30: Analysis of Language – Use of Emotionally Laden Language

Claims Workers (83 counts)	Trauma Counsellors (81 counts)	Holiday Booking Consultants (48 counts)
Words expressing horror (Inhuman, brutal, cruel, devastated, ordeal, hate, horrified, evil, sick) …..... 9	Words expressing horror (Inhuman, brutal, cruel, devastated, ordeal, hate, horrified, evil, sick) 10	Words describing distaste.....2
Shocked/panic/shook up.....6	Shocked/panic/shook up.....4	Hurt.....2
Unable to focus/work.....4	Physically ill... 1	Trapped/caught up.....2
Unable to handle emotionally.....1	Overwhelmed.....2	Difficult/difficult to stay calm.....4
Completely lost control (from trauma).....1	Angry.....14	Negative effect on mood.....3
Haunted/nightmare.....2	Haunted.....1	Angry.....7
Anxiety/uneasy/nervous/worry.....10	Anxiety/uneasy/nervous.....2	Nightmare.....1
Cried.....1	Flashback.....3	Worry/nervous/dread.....3
Wanted to cry.....2	Depressed.....2	Self doubt.....1
Felt bad/affected badly.....8	Fed up/tired/disillusioned..... 3	Wanted to cry.....1
Upset.....4	Upset.....5	Felt bad/affected badly.....3
Numb/detached.....1	Numb/detached.....4	Upset.....2
Emotionally taxing/draining/drowning.....3	Emotionally taxing/draining/drowning.....8	Emotionally distant 5
Helpless/powerless.....5	Helpless/powerless.....5	Demotivated.....4
Emotional/deeply touched.....5	Emotional.....5	Helpless.....1
Sad/sorrow.....13	Sad/sorrow.....11	Emotional.....1
Heartbroken/heartache/heart goes out.....7	Heartbroken/heartache/heart goes out.....1	Emotionally intense.....2
Frustrated/irritated.....2	Distrustful.....3	Heart goes out.....1
		Frustrated.....1

The language and emotional expressions used by claims workers and trauma counsellors were reasonably similar, mostly indicating what emotions were evoked and how client stories affected them. Most strongly worded cases expressed horror over client ordeals. Holiday booking consultants mostly described emotions elicited by difficult clients. Their most strongly worded instances expressed hurt and resentment over maltreatment.

Interestingly, the trauma counsellors expressed the most anger and outrage, mostly directed at perpetrators. Holiday booking consultants expressed the second most anger resulting from client anger. The claims workers expressed more instances of shock. They also were most often unable to continue work or resume focus after a severe case. For example, one person physically trembled and had to be excused from work temporarily. Another described losing control and having to be excused for 30 minutes. Shock was also expressed, though to a lesser extent by the trauma counsellors. For example, one trauma counsellor felt physically ill and unable to focus. Another admitted to being forced to refer some of her cases to colleagues after a particularly trying case.

Sorrow and heartache over client ordeals were expressed most often by claims workers. They also described three instances of crying or being close to tears. One holiday booking consultant also described having to suppress tears after unfair treatment from a client. The trauma counsellors most often felt overwhelmed, emotional, upset and drained. They also reported the most emotional numbness whereas the holiday booking consultants described the most emotional distance in coping with anger and outrage. Interestingly, the claims workers experienced far more anxiety, unease and worry than the other two groups. Finally, only the trauma counsellors experienced depression and described the largest incidences of flashbacks or feeling "haunted". The frequency of expressions of fear is considered next.

1.4.2 Language expressing fear.

Words indicating fear, such as "scared", "scary", "afraid", "fear" and so forth were recorded. Firstly, the claims workers expressed fear 21 times. Surprisingly, trauma counsellors only used fearful expressions three times and holiday booking consultants twice. Statements expressing vulnerability, cautiousness and unease were also recorded. Of claims workers 18% simultaneously expressed fear and a sense of vulnerability, whereas 17% of trauma counsellors described feeling vulnerable. Finally, two percent of the holiday booking consultants experienced heightened feelings of vulnerability after encountering actual traumatised clients.

1.5 The reach of vicarious trauma.

Results on the effects of vicarious traumatisation have thus far mainly been structured around intrapersonal concepts gauging effects on psychological and physiological levels. Next, effects in the interpersonal domain of functioning are focused on.

1.5.1 The permeating effects of vicarious trauma.

At the outset, it was explained that a bio-psychosocial approach to vicarious trauma is taken. The many intrapersonal effects described thus far have interpersonal implications that often reach into other areas of functioning. This section considers some of these effects.

1.5.2 Effects beyond the person.

Interpersonal difficulty was a significant theme, involving 17% of the sample. Participants described effects from their work, including constant agitation, moodiness, depression and feeling stressed, with great regularity. Of the claims workers, 20% described how these effects impacted upon relationships. One person described feeling cold and disinterested in her family after a difficult day at work, while others described increased conflict with loved ones. Another claims worker described resentment from family for spending so much time at work. One person admitted to only being genuinely happy when she was by herself, causing her to become increasingly distant and withdrawn. These claims workers agreed that the stress of working with clients in crisis, exposure to their trauma as well as long hours at work were fuelling interpersonal difficulties.

Similarly, 15% of the trauma counsellors reported relationship problems stemming from work-stress and secondary traumatic stress. They also described conflicts and how their moods and agitation impacted upon family and friends. One person described resentment from family and friends for always putting work before them. Another described how she was progressively withdrawing from everyone, just wanting to be left alone. Yet another person felt that constantly seeing the negative side of life makes it hard for her to relate to others. She felt alone and doubted whether friends and family would ever understand the difficulties her work involved.

Of the holiday booking consultants, 17% described how feelings of irritation and stress affected personal relationships. However, they attributed these difficulties to working long hours, being in a high-pressure environment and from being bullied by displeased clients. They released pent-up anger and frustration on loved ones, neglected family and friends and mostly avoided social situations. One person described how belligerent clients dampened her feelings of self-worth and

her desire to be around people.

An associated difficulty that also emerged was that of finding balance. Eight percent of the claims workers expressed difficulty in finding a balance between work and private life. Of the trauma counsellors, 13% described similar difficulties as well as not allowing problems in one area to contaminate the other. Another four percent described how their work had forced them to draw a clear separation for the sake of self-preservation and harmony at home. Finally, holiday booking consultants also often described how their work-lives overtook their personal lives. The next area of functioning to be looked at is the social domain.

1.6 The social realm.

In continuation of a bio-psychosocial approach, the social realm of functioning is considered. This part of the analysis looks at social support from a different angle to complement the quantitative data on this important variable.

1.6.1 Characteristics of support networks.

Participants were asked to list zero to nine persons they could typically turn to under difficult circumstances. These were tallied to achieve insight into the composition of the support network of the total sample. *Appendix M* contains the questions utilised to collect this data.

Interestingly, as many as 2810 persons are involved in supporting the 144 participants. The composition of the social support networks is summarised in *Table 31*.

Holiday booking consultants presented with the largest support network, followed by trauma counsellors. Claims workers presented with dramatically fewer supports. In all three worker groups, the largest part of the network consisted of family, followed by friends and romantic partners. Out of the three groups, trauma counsellors presented with noticeably more friends. Surprisingly, only 37 of the 144 participants listed co-workers as supports. Of the total network of 2810 individuals, less than one percent is dedicated to colleagues, supervisors, managers and employers. However, the holiday booking showed the most camaraderie and collegial support. The support network of the trauma counsellors showed slightly more diversity by including nine more unconventional supports, as opposed to five from claims workers and three from holiday booking consultants. Finally, trauma counsellors presented with noticeably fewer romantic partners.

Table 31: Social Support Network Composition

	Claims Workers ***N*=50**	**Trauma Counsellors** ***N*=46**	**Holiday Booking Consultants** ***N*=48**
Support Categories			
Family (nuclear) Family (extended) Family (in law) Family	385 50 10 **445**	408 40 24 **472**	533 40 23 **596**
Friends	183	391	265
Romantic/life partner	162	138	150
Colleagues Employer Co-workers	30 5 **35**	31 2 **33**	68 8 **76**
No-one	14	7	1
God Church figure Religious supports	5 1 **6**	- 1 **1**	1 4 **5**
Mentor	5	1	-
Therapist	-	5	-
Pets	-	1	2
Day mother	-	-	1
Domestic helper	-	1	-
Art teacher	-	1	-
Total supports	**850**	**1051**	**1096**

Sadly, 10% of the sample reported that they had no-one to turn to during trying times. The claims workers reported the most instances of not having any support. Surprisingly, very few references were made to religion as a support. Only four percent of the sample acknowledged leaning upon their faith and of the total network of 2810 persons, religious figures occupied only 0.43%. The next section looks at the work environment as well as work-based support.

1.7 The work environment.

In continuation of a bio-psychosocial stance, the work domain was investigated. Vicarious trauma occurs in the work-place and therefore support, interpersonal relationships, additional sources of stress and suggested improvements are considered within this context. This section is almost a needs assessment, highlighting areas of undue pressure and strain. This information is valuable as disparities between present circumstances and worker needs are illuminated. This information can be particularly useful when in the planning of organisational improvement, training, education and service enhancement. This information also indicates how resources can be best directed to

ameliorate work stresses.

1.7.1 Work-based support.

Participants were asked how their work contexts supported them. Responses were coded according to the level of satisfaction and the level of regard for the work-based support. Inter-rater reliability is considered in chapter five. Four categories were developed:

High regard/level of satisfaction: participants expressed a high regard/level of satisfaction for the support from the work context. This category describes personal benefits that go beyond merely receiving managerial support, adequate supervision or a job providing a means to an end.

Moderate regard/level of satisfaction: participants expressed a moderate regard/level of satisfaction for the support from the work context. This includes the support mechanisms one would expect to receive from the work environment such as supportive managers, adequate supervision and financial security.

Little regard/satisfaction: participants expressed little regard/satisfaction for the support from the work context. They receive some support but not nearly what they need.

No regard/satisfaction: participants described the support from the work context to range from unsatisfactory to non-existent.

From the claims worker group, 16% showed a high regard/level of satisfaction:

> P48: *"It makes me a stronger person, making it easy for me to deal with real life traumas when faced with them."*

> P62: *"It helps me to grow and understand life. I view everything from a different perspective now."*

Another 40% of claims workers expressed a moderate regard/level of satisfaction:

> P51: *"The availability of EAP (Employment Assistance Programme) when you need it."*

P54: *"Financially, and it takes the mind off."*

P64: *"Exercises the brain. Makes me think out of the box."*

P75: *"Managers and supervisors are always available to assist."*

P78: *"I have a 9 - 5 which doesn't look so bad."*

P86: *"It supports me financially and allows me to expand my friendship base."*

P89: *"My supervisor helped me when I was without a car – she arranged a lift for me once or twice."*

Next, 12% of claims workers expressed little regard/satisfaction, finding the support not nearly adequate:

P59: *"In this regard, they don't. Unless it starts affecting your work performance. They do arrange counselling sessions, but these are limited due to calls queuing (customers), staffing shortages, etc."*

P70: *"They provide counselling, but not so much though."*

P80: *"It tries at times."*

P88: *"My supervisor is very kind and understanding. She can't do much to help me, but knowing that she cares and understands makes me feel a little better."*

Finally, 32% of the claims workers felt that they were not supported by their work context:

P55: *"It does not. It's every man for himself."*

P56: *"I'm not sure it does."*

P67: *"It very rarely does. Most of it comes from my side to push yourself to stay motivated."*

P83: *"Not even once."*

P84: *"They are working on it."*

Next, of the trauma counsellors, 28% expressed a high regard/high level of satisfaction:

P01: *"It provides a solid, consistent foundation that is reliable and dependent, and has great staff."*

P10: *"People are all here for the same reason and it is very comforting and inviting."*

P25: *"Good monthly massages. Management who are friendly and approachable if you've got problems that need to be addressed."*

P28: *"Massage once a month – love that! Reasonable supervisors."*

P39: *"Good supervision. The experiences make me a stronger, better person."*

Another 48% of the trauma counsellors expressed a moderate regard/level of satisfaction:

P05: *"Earns an income."*

P06: *"Providing advice and support."*

P07: "*Giving me experience in my field of study."*

P23: *"Supplying and income and socialising with colleagues."*

P34: *"Supportive manager. Good Listener."*

P36: *"Open door policy for discussion and presenting grievances."*

Of the trauma counsellors, 13% felt that they received a little support but not nearly enough:

P17: *"6 sessions of counselling are offered to us but this is nowhere near enough."*

P18: *"I think the mechanisms are there but I don't feel comfortable accessing them."*

P20: *"Very little. We need more support at work. Colleagues provide comic relief and make the job here worthwhile."*

P31: *"Don't see any reasonable support in terms of pressure. There is support only in guidance regarding what to do with cases."*

P44: *"Managers are very accessible and helpful. But, they can only do so much. Putting yourself and your needs (even in crisis) ahead of clients is frowned upon. I try to cut back for the sake of my health, but it is not welcomed."*

Another 11% of the trauma counsellors felt that their work context did not support them:

P16: *"In not way at all."*

P19: *"Feel a lack of support because focus is on pleasing our clients."*

P22: *"They don't. Would have to motivate for support."*

For the holiday booking consultants, 15% expressed a high regard/level of satisfaction:

P97: *"I love being around friendly people who can give me good guidance and will assist if I ask for help. The general manager checks up on us individually every day and it's nice to compete against each other for incentives (feels like a big family)."*

P117: *"I have a very nice boss – he is a very positive person and good to be around as he always focuses on the good no matter how bad a situation might look."*

P121: *" I work very hard, but I feel that management "has my back" at all times. My boss knows me and he knows the kind of person I am. He has never taken an agent's word over mine. He knows I work hard and will never be dishonest about what has happened. He has never let me down so far."*

Another 52% of the holiday booking consultants expressed a moderate regard/level of satisfaction:

P99: *"When I am really behind I do get assistance. But also being a senior I do get more freedom on the decision making with the problem files."*

P105: *"[Managers] supply information about the product so we can sell with confidence."*

P106: *"Pays my bills. Provides learning."*

P110: *"Managers are always available and willing to help."*

P118: "*People at work are generally nice – I enjoy working with them."*

P144: *"Money to get by."*

Eight percent of the holiday booking consultants expressed little regard/satisfaction, finding the support inadequate:

P114: *"Not nearly enough!"*

P119: *"Management is nice but bulldogs without teeth – they can't do a lot to lessen our work burden/stress load."*

P132: *"I used to work on commission only at a previous company which was stressful. Now at least I get a basic + commission. We still lose commission for mistakes/slow business, but it is less stress than commission only jobs."*

P139: "*Managers are always available and willing to help."*

Finally, 25% of the holiday booking consultants felt that they were not supported by their work context:

> P98: *"Outbound, being in a call centre, you don't have time for anything, not even to eat. Immediate stress to catch up with admin during your lunch or after hours."*
>
> P115: *"It doesn't really – so I end up focusing on keeping clients happy and doing my work well."*
>
> P116: *"Not a lot – management is too demanding."*
>
> P141: *"It doesn't do anything in particular."*

For ease of comparison, the results for the three different groups are summarised by *Table 32* below.

Table 32. Level of Satisfaction/Regards for Support from the Work Context at a Glance

	Claims Workers	**Trauma Counsellors**	**Holiday Booking Consultants**
High regard/level of satisfaction	16%	28%	15%
Moderately regard/level of satisfaction	40%	48%	52%
Little regard/level of satisfaction	12%	13%	8%
Dissatisfaction/no support	32%	11%	25%

To further emphasise the importance of social support, the theme of work-based support emerged yet again elsewhere in the data. This time, the theme emerged as an expressed need. However, this topic is returned to later.

1.7.2 Sources of stress from the work environment.

In continuation of gauging needs, difficulties and interpersonal problems in the work domain, participants were asked what else in their work context affected them negatively. The various categories that emerged are summarised by *Table 33*.

Table 33: Other Sources of Work-related Stress

	Claims Workers	Trauma Counsellors	Holiday Booking Consultants
Nothing else – only trauma/rude clients (48 counts)	16	16	16
Unrealistic workload (31 counts)	3	14	13
Inefficient management (30 counts)	14	9	8
Inefficient colleagues (14 counts)	1	6	7
Insufficient remuneration (10 counts)	7	-	3
Unrealistic expectations (9 counts)	4	4	1
Work-stress causing conflict/problems at home (10 counts)	4	3	3
Cold/impersonal work atmosphere (8 counts)	2	6	-
No acknowledgement/appreciation (7 counts)	3	3	1
Financial penalties (5 counts)	-	-	5
Mundane aspects of work (4 counts)	1	3	-
Gossip (3 counts)	2	-	1
Negative atmosphere (3 counts)	-	-	3
Office politics (abuse of power) (3 counts)	1	1	1
Travel to work/traffic/road works (3 counts)	1	2	-
Feeling of not belonging (2 counts)	1	-	1
Constant changes in work environment (1 count)	-	-	1
Not being able to help client (1 count)	-	1	-
Punitive actions (1 count)	-	-	1
Struggling to find balance (1 count)	1	-	-

Of each of the three worker groups, 32% felt that trauma cases/difficult clients were the only real sources of stress. Next, 30% of the trauma counsellors and 27% of the holiday booking consultants opined that workload was unrealistic. Trauma counsellors found the constant pressure of the immediacy and urgency of client problems to be unrelenting and very demanding. By contrast, only six percent of the claims workers reported workload to be unmanageable. This does not imply that claims workers do not have a heavy workload, the importance of workload was simply surpassed by other issues.

A prominent topic to emerge was that of inefficient management. Claims workers articulated this problem most often, involving 28% of this group. Most felt that management style created additional stress. They found that management was unresponsive to their needs, focusing almost always on client needs. Favouritism and lack of leadership were also clear obstacles. Next, 19% of

the trauma counsellors underlined inefficiencies from management. Differences in management style were obvious as participants either found managers to be domineering and punitive about trivialities, or not to offer any support. The first leaves workers feeling stifled, whereas the second instils feelings of isolation. Of the holiday booking consultants, 17% found the management style to be stressful. They described managers to be disagreeable, unapproachable or their actions to be inequitable. The purpose was not to criticise any of the organisations, but to point out that management style is the third highest source of stress affecting around 21% of the sample.

Next, the trauma counsellors and booking holiday consultants expressed gripes with colleagues. Trauma counsellors mainly felt disconnected from colleagues, criticised their attitude, lack of responsibility or having to rely on undependable colleagues. They found these problems to hamper solidarity and teamwork. The holiday booking consultants mainly felt that the inattention and errors on the part of colleagues created conflict and added to the workload.

Of the three groups, the claims workers most frequently flagged remuneration as a problem. Although participants confided their financial difficulties, they nevertheless expressed gratitude for having employment. However, they felt that remuneration was not in line with the self-sacrifice of dealing with traumatised individuals, and 14% were struggling financially, feeling that they were not salaried at their worth.

Although expressing gratitude, 17% of the holiday booking consultants also raised the issue of compensation from two different perspectives. Six percent experienced a constant financial bind and felt that remuneration was insufficient, when measured against responsibility and workload. They mostly also do not receive compensation for overtime. The topic of financial penalties for mistakes and slow business emerged a second time, involving 11% of this group. Two of the three participating organisations employ this system, which seems to pose a constant source of anxiety and worry to workers.

Next, a cold and impersonal work atmosphere and lack of acknowledgement were aired a number of times. Negativity, gossip, office politics and a sense of not belonging also seemed to sour the work atmosphere. An unexpected topic was the stress generated by mundane aspects of work that leave participants feeling demotivated. Two percent of the sample described stress from the long commutes to work and back.

1.7.3 Suggested improvements for the work environment.

The ensuing themes that emanated from this section of the data conclude worker needs as well as the etic voice. Participants were prompted to suggest how the work context can better support them, to alleviate work stresses and improve interpersonal relationships within this domain.

Firstly, 21% of the sample were satisfied with the support efforts from their respective industries. One percent refrained from making any suggestions as they felt this to be futile. The remaining 78% of workers made various instrumental suggestions on what would help them to cope better with secondary traumatic stress and other stressors from the work environment. These themes are presented by order of their magnitude.

1.7.3.1 Distribution of workload.

Of the sample, 26% made various suggestions regarding workload. Of the claims workers, a total of 16% criticised workload, of which 88% suggested more realistic goals and a more evenly distributed workload. The remaining 12% felt that more staff was needed. Of the trauma counsellors, 17% discussed workload and 13% believed their organisations to be understaffed. Of this 13%, 54% felt that employing administrative staff would greatly assist, as time spent on administration could be used to counsel more individuals. Assisting clients and performing administration accurately were more than they can cope with. The remaining 46% suggested that more counsellors would even out the workload. An additional four percent suggested a more manageable workload and more realistic goals.

Of the three groups, the holiday booking consultants responded most frequently to workload whereby 44% commented on the issue. Another 28% suggested a more evenly distributed workload or more realistic expectations. They felt that they had to work unreasonably long hours without compensation to stay afloat. An additional 14% proposed that more administrative staff would equalise the workload. Finally, another two percent of the holiday booking consultants felt that a greater variety of tasks would be a welcome change to offer inspiration and heighten interest.

1.7.3.2 Management style.

As previously discussed, management style was flagged by 21% of the sample as the third highest source of stress. Alongside these reports also came several suggestions. Of the claims workers, 28% raised the issue, with 16% proposing more effective communication and a less impersonal approach. Another 12% called for reasonable and understanding managers. By contrast, only nine

percent of the trauma counsellors offered suggestions, firstly calling for more understanding, reasonable managers. Of the holiday booking consultants 12% responded, with six percent calling for better interrelations, more effective communication and a less impersonal approach. The remaining six percent asked for more reasonable and empathic managers. Two percent of the claims workers felt that management should follow through on promises regarding permanency of employment and two percent of holiday booking consultants felt the same about interdepartmental transfers. Another one percent of the sample suggested that management take action against inefficient colleagues.

1.7.3.3 Financial improvements.

As pointed out earlier, 18% of the sample felt remuneration to be inadequate. The overall feeling was that they should be salaried at their worth. For instance, 20% of claims workers, seven percent of trauma counsellors and 13% of holiday booking consultants appealed for fairer remuneration. However, a few other interesting suggestions emerged. Six percent of the claims workers and two percent of holiday booking consultants suggested incentives for meritoriousness to increase productivity, instil healthy competition and to keep staff motivated. Finally, the theme of the dreaded financial penalty system emerged yet again, whereby eight percent of the holiday booking consultants called for the abolition of this system as it caused undue stress.

1.7.3.4 Improved work-based support.

Participants again expressed a need for improved work-based support. The theme of regard/satisfaction with work-based support was discussed earlier. However, specific suggestions on how to improve work-based support were made. Firstly, participants called for improved work-based support, involving 12% of the sample. Of the claims workers, 14% suggested that debriefing or counselling should be more readily available. More support in general and consideration from management about the difficulties of dealing with clients in crisis were proposed by six percent. Some suggested group debriefings as they found sharing with colleagues to be particularly useful. Claims worker P59 shared these thoughts:

> *"They used to arrange sessions for the whole call centre to attend (in groups), where you just"de-stress", talk about bad cases or clients you've had and learn how to deal with it in better ways. They should do that again. Since they stopped those sessions, the overall stress levels of the staff seem to be <u>a lot</u> higher."*

Of the trauma counsellors, 13% expressed a need for more supervision, debriefing and counselling. One trauma counsellor suggested an on-site therapist for this purpose. Only four percent of the holiday booking consultants requested more general support from their managers. Holiday booking consultant P103 made this suggestion:

> *"Take more notice of what the people sitting making the sales and the money need, it's often something very small that will make the biggest difference."*

1.7.3.5 Equipment and training.

Of the claims workers, four percent felt that faster, more up-to-date computer equipment would improve the speed of service delivery and the overall technological capacity of the organisation. Another four percent made statements regarding the benefits of training. In addition, a few claims workers suggested that better trained, more skilled management, would offer a sounder platform. Of the trauma counsellors, two percent felt that better headsets would make the number of hours spent on the telephone less challenging. Finally, eight percent of the holiday booking consultants felt that they, and especially newer staff, would benefit greatly from continued training.

1.7.3.6 Community and cohesion.

The need for a greater sense of community among staff was expressed a total of eleven times in the amalgamated data. Four percent of the claims workers stated that team-building activities and bonding opportunities would greatly enhance their sense of community. This need was expressed by 15% of the trauma counsellors who found their work to be very isolating. They welcomed team-building opportunities and increased social contact, within but also away from the work environment. Some suggested changes in the office set-up to make workers more visible to one another, to combat feelings of isolation. Four percent of the holiday booking consultants called for team-building activities to improve group cohesion and camaraderie.

1.7.3.7 Modification of the environment.

Seven percent of the sample, involving mostly trauma counsellors and the holiday booking consultants, called for a less rigid and less punitive work environment. These participants agreed that a friendlier atmosphere with fewer restrictions and more focus on the contributions they make would reduce stress. They believed that a happier, more flexible atmosphere would cultivate a sense of well-being and enjoyment of the workplace.

2 The Emic Point of View

Thus far, the etic viewpoint was promoted. A few themes that emerged spontaneously were discussed, that intermittently typified the emic voice. However, this portion of the data is dedicated solely to honouring the insider perspective. To this end, data were not manipulated, focusing on what participants wished to contribute. As discussed before, honouring emergent themes concomitantly improves inside-outside legitimation of the study. To reiterate, both etic and emic viewpoints need to be utilised to ensure accurate and authentic descriptions and explanations derived from the data (Onwuegbuzie & Johnson, 2006). As stated before, inside-outside legitimation refers to the extent to which the researcher balances both viewpoints (Barnes, 2012).

2.1 Themes emerging from the trauma topic.

Whilst coding information relating to feelings about client traumata, the ensuing themes emerged spontaneously, reflecting what participants chose to discuss.

2.1.1 Work effects and challenges.

A few claims workers responded to other stressors from their work environment when prompted to talk about experiences with traumatised clients. Reflective of the rarity of trauma cases, a large percentage of holiday booking consultants nonetheless utilised the opportunity to express issues pertinent to their context. As stated before, even though data from the control group are less important, it was felt that, in pursuit of the emic voice, statements from this group also had to be honoured. The strongest theme to emerge was that of client attitude.

2.1.1.1 Client attitude.

A significant portion of participants chose to talk about client attitude when asked to consider feelings evoked by client trauma. They instead shared thoughts on rudeness, disrespect and belligerence from clients. They described behaviours such as insults, uncontrolled anger, profanities, maliciousness, and in some cases, blasphemy. Two percent of the claims workers discussed poor client attitude, which they found more distressing than client traumata.

Of the holiday booking consultants who did respond to the questions, four percent dealt with actual traumatised clients, referred to previously. One involved an upset client fearing reprisal from an abusive partner over a forfeited deposit, and the other a terminally ill client who booked what was probably her last holiday. However, the remaining 76% chose to opine that client attitude was the most prominent source of work-related stress. Poor attitude mostly involved clients, but also

intermediaries in the industry who make travel arrangements on their behalf. A few of them seem to abuse their position of power, whereas the majority appear to be inimical due to their own stresses. These intermediaries were by no means portrayed unfavourably or with disrespect by participants, some holiday booking consultants simply conveyed feelings of defencelessness, discouragement and even trepidation when having to deal with some of these intermediaries.

2.1.1.2 Loss of income.

The fear of loss of income was very important to holiday booking consultants and emerged three times from different sections of the data. In the latter case, eight percent discussed the anxiety and stress provoked by monetary penalties as opposed to client traumata.

2.1.1.3 Punitive action.

When asked to talk about client trauma, two percent of the claims workers chose to describe their fear of punitive actions from management instead. This theme emerged even more strongly for the holiday booking consultants whereby 12% expressed constant worry over this issue.

2.1.1.4 Workload and pressure to perform.

Eight percent of the claims workers chose to talk about the constant pressure to perform in conjunction with heavy workload, instead of how traumatised clients affect them. Two percent of the holiday booking consultants followed the same line.

2.1.2 Other sources of stress.

Finally, a reasonable percentage proceeded to elaborate on other sources of work-related stress. Eight percent of the claims workers responded, not to client trauma, but to the tediousness of dealing with traumatised individuals. They found the time it takes to calm the client down, having to repeat everything, as well as traumatised clients refusing to follow procedures, to be stressful. An additional four percent of the claims workers described how slow computers added to the challenges of speedy assistance. Four percent of the holiday booking consultants again discussed stress generated by inattentive colleagues. Finally, two percent of the holiday booking consultants talked about the stress of adjusting to a new position in a new city.

2.1.3 Emotional effects and challenges.

As the next step, the data relating to working with traumatised clients were re-examined for striking emergent themes.

2.1.3.1 Death.

When asked to describe cases that affected them most, a considerable percentage of participants described cases involving death. This theme emerged from various contexts and appeared a total of 42 times, involving 29% of the sample. Of the claims workers, a startling 52% talked about death – either of a client, colleague, or a loved one. Of this 52%, 58% spoke about how dealing with an accident, crime or suicide leading to a client's death affected them. Eight percent spoke about how the death of a client touched upon their personal fears. Another 34% discussed difficulties of moving on from the death of a colleague or loved one. Below are examples of statements from the claims workers about dealing with claims involving death:

> P59: *"While speaking to her, her brother and sister passed away and her mother was critical. It affected me in a bad way, I placed myself in her shoes and then totally lost control of my emotions. I was unable to work for about 30 mins afterwards."*

> P89: *"She was desperate – her husband had died in a car accident and her policy was cancelled. She screamed and cried that she was going to commit suicide. Her desperation and panic upset me. I felt very sorry for her and did not know what to do."*

> P90: *"An elderly man was attacked in his house and tortured. He was burned with a hot iron and kicked and beaten. He died in the hospital the next day. I was horrified and felt deeply sad. I nearly started crying when I heard about it."*

> P91: *"Woman drove over child accidentally, killing the child. The woman being so upset upset me as well."*

The following statements from claims workers exemplify how the death of a client impacted upon their personal fears:

> P48: *"I have a child of my own and would be devastated if that would happen to me."*

> P65: *"It made me think what I would do if it was me and how would I have handled it..."*

Finally, the following are some statements from claims workers about difficulties to move beyond the death of a colleague or a loved one:

> P61: *"Friend passing on. Emotionally stressed, not in control, helpless."*

> P86: *"The death of my grandmother. I could not focus on anything for about 3-6 months after her passing. My eyes were open by I wasn't home."*

For the trauma counsellors, 30% discussed death of which 63% described how dealing with a case involving death affected them, exemplified by the following:

> P04: *"[Dying] child with AIDS in very bad condition. Very difficult for me. Overwhelming emotions. Stressful feelings, exhaustion."*

> P25: *"Kept on thinking about the conversation with the client and visualised the accident. These came back as flashbacks. The way in which the pedestrian died..."*

> P41: *"A mother who lost her baby – baby got burnt with hot water while mother was at work. Baby died in hospital before mother could get there. My heart went out to this mother – I felt very sad for her."*

The next statements are from the remaining 37% of trauma counsellors, who described the difficulties of overcoming the effect of a death in their personal lives:

> P27: *"One very close friend passed away 3 weeks ago. Made me stress, emotional and worried."*

> P30: *"I've had to cope with a lot of difficulties in my life – divorce, lost a child etc. A lot of it affected all aspects of my life – it changed my way of thinking about life."*

Of the holiday booking consultants, only four percent discussed death. One person discussed how dealing with a dying client touched upon her own fears:

P143: *"Client finding out she does not have long to live – diagnosed with cancer/tumour. It made me realise how short life is – how easily life can change. It scared me."*

Another holiday booking consultant described how the death of someone in her personal life affected her:

P122: *"My elderly neighbour was murdered a few days ago – that was quite difficult to deal with. It upset me and made me very sad... It just was a huge shock and it occupied my thoughts a lot."*

2.1.3.2 Disappointment in mankind.

Feelings of disappointment in mankind emerged quite strongly from the sample, especially for the trauma counsellors and claims workers. This spontaneously emergent theme bears theoretical significance, which will be considered in the next chapter. Firstly, 20% of the claims workers expressed an overall sense of loss of respect for mankind. Their statements described mankind to be brutal, cruel, inhuman and sick. Below are some of the statements from claims workers:

P55: *"...it was only a child."*

P63: *"I feel heartbroken – to see what the world has become."*

P64: *"The cruelty of mankind."*

P75: *"The brutality and inhuman treatment of an innocent, defenceless woman."*

P90: *"I feel sick and ashamed at being a human being."*

This theme was especially prominent for trauma counsellors, whereby 39% expressed anger and sadness over the inhumanity and suffering caused by mankind:

P03: *"I became angry at society for permitting people who perform these acts to continue living."*

P22: *"I felt devastated that some people have so little humanity."*

P28: *"...that people are able to perpetrate so much evil on someone else."*

P33: *"...how cruel a human being can be."*

P34: *"Adults causing life-long damage to a child."*

P45: *"...the fact that these predators destroy lives for their own fun and enjoyment."*

Finally, the holiday booking consultants did not demonstrate a sense of disappointment in mankind.

2.1.3.3 A need to do more.

A need to do more to help emerged strongly for claims workers, whereby 24% wanted a larger skills-set to better assist traumatised clients, often feeling helpless or paralysed in the face of severe traumas. They communicated a need for training specifically in dealing with clients in serious distress. They expressed a desire to offer services beyond merely indemnifying losses, wanting to do more for the client's emotional state. They described how they often do not know how to handle situations, wanting to reach out to the distressed person, but not knowing how to. Comments from one claims worker stood out whereby the person admitted that, due to an inadequate skills-set, panic is experienced when having to deal with serious cases.

2.1.3.4 Frequency of trauma.

A large number of claims workers and some trauma counsellors made reference to the frequency of trauma. In the case of claims workers, 20% of participants expressed concerns over the frequency with which they encounter trauma. Of this 20%, six percent stated that they have somehow adapted, become desensitised or that they have grown accustomed to hearing the many trauma reports. The remaining 14% expressed a continued struggle to cope with the many trauma cases laid before them, exemplified by a comment from claims worker P63:

"*I am still affected because this happens every day. When do I really get over it?"*

Of the trauma counsellors, 11% expressed worry over the frequency of trauma, concerned about how the many cases were affecting them. Secondary traumatic stress, emotional numbing and feeling blasé were described as well as worries over these effects. Trauma counsellor P27 described concern over distrust she noticed in herself:

"I work a lot with abused women and children. This sometimes makes me very negative towards men. It changed my perceptions. Makes me distrust men, which I worry about."

2.1.3.5 Staying strong.

Consciously staying strong for the client's sake emerged quite strongly for claims workers and trauma counsellors. Firstly, 20% of the claims workers described instances where they had to suppress their own strong emotions or hide their distress in order to be strong for clients. Next, 32% of the trauma counsellors made similar statements; however, they mostly discussed the *importance* of being able to put aside your own feelings and to remain calm to offer more effective counselling. Interestingly, four percent of the trauma counsellors described the opposite. They had to immerse themselves in the client's pain to counteract emotional numbness and to enable a connection with clients.

2.1.3.6 Guilt.

Guilt appeared in various forms. It emerged most strongly for claims workers involving 18% of this group. Six percent struggled to cope with client guilt over having caused an accident or having failed to protect loved ones. Another four percent felt guilty over their own good fortune in the wake of client traumas. One claims worker described feeling guilty every time she experienced joy in the days following a severe trauma case. Another person admitted to flurries of goodwill towards strangers stemming from guilt after dealing with a lonely, aged client. Four percent experienced guilt after conveying crushing news to clients about claim repudiations. Another four percent felt guilty for not being able to financially provide for loved ones.

Guilt emerged from four percent of the trauma counsellor group. For instance, one counsellor experienced guilt over the poor living conditions of clients she had recently dealt with. Another responded deeply to a client's feelings of guilt for having failed to protect her daughter from an attacker. Finally, six percent of holiday bookings consultants spoke about guilt. One person expressed guilt about releasing her pent-up stress and frustration on her husband. Two participants expressed guilt over not being accessible to loved ones, either due to work obligations or from constantly feeling overworked and exhausted.

2.1.3.7 Going beyond the call of duty.

This theme emerged from the claims worker group only. Reports of going beyond what duties call for were made by 12% of claims workers. For example, one person gave her personal contact

details to a client in an old-age facility with the explicit instructions to contact her if she needed anything. Another person was extremely concerned about a client who was taken by hi-jackers. After an entire week of not being able to get the client out of her mind, she finally contacted his spouse who informed her of his murder. Disturbing incidents prompted these workers to reach out to clients in their personal capacity. As heart-warming as it might be, the distress of these workers was palpable.

2.1.3.8 Religion as a coping mechanism.

Instances where the person indicated drawing strength from religion were considered. Of the claims workers, eight percent confided their religion to be a significant source of support. Two percent of holiday booking consultants mentioned leaning upon faith to offer comfort to distressed clients. No reference to religion was made from the trauma counsellors.

2.1.3.9 Alone in their hour of need.

This was a striking theme whereby some claims workers were distressed by clients being completely alone during a desperate situation. Eight percent described being upset by the client not having someone with them during a traumatic event to offer comfort or guidance. For instance, one claims worker felt upset over a client who was ostracised by her family to face her ordeal alone, after having been raped by burglars. Two claims workers described clients contacting their emergency line from burning vehicles, with no-one on the scene to assist. In both cases, claims workers had to talk the clients through the hysteria and panic of trying to find escape whilst waiting for emergency services to arrive. One client suffered serious burns but finally escaped whereas the other client did not. Their ordeals were heard by the two claims workers who took their calls. Needless to say, they were in shock after these experiences and deeply distressed. The next section looks at a very important topic that emerged strongly, which also concludes this chapter.

2.2 Other important emergent themes.

The theme of self-care, a point of theoretical significance to the study, also surfaced spontaneously from various portions of the data. This was a surprising discovery as none of the questions posed by the self-constructed questionnaire pertained to self-care.

2.2.1 Self-care.

Throughout this thesis, the importance of self-care was emphasised. The theoretical significance of this point is deliberated on in the next chapter.

A significant number of participants spontaneously described how they neglected themselves by placing client needs ahead of their own, while others expressed a need for self-care. A total of 28% of the claims workers voiced these issues. Of this 28%, 36% expressed a need for better self-care. They described feeling over-extended, stressed and exhausted from working with clients in crisis. They were only able to take personal leave when their work schedules permitted as opposed to when they needed it. Some participants felt that being allowed a few minutes after a difficult call to regroup before launching into the next caller's crisis would make a marked difference. Another 64% described instances where they knowingly disregarded themselves, pushing themselves beyond their limit.

Self-care and self-neglect emerged equally prominently for trauma counsellors, voiced by 27%. Of this 27%, 33% felt that they should be granted leave when they needed it instead of when work schedules permitted. They similarly believed that a few moments to decompress after a difficult call would greatly help and agreed that better self-care would improve their efficiency and overall level of service. Finally, 67% described instances where they neglected themselves for work.

Even though holiday booking consultants do not deal with traumatised clients, 29% of this group also discussed self-care and self-neglect. Of this 29%, 66% expressed a pressing need for better self-care, to alleviate the long hours and ceaseless work schedules. Finally, 34% described continuously neglecting themselves to attend to pressing work matters. Unrealistic time management goals, very long hours and workers getting home late at night leave them with very little personal time.

The discussion on self-care concludes this chapter. The next chapter will winnow these results by only delving into those issues that are significant within the theoretical framework of the study. As stated earlier, the information outlined in this chapter will also be borrowed from selectively to exemplify or emphasise certain points.

"*He who loves practice without theory is like the sailor who boards ship without a rudder and compass and never knows where he may cast*" (Leonardo da Vinci, 1452-1519).

CHAPTER EIGHT: DISCUSSION

Quantitative and Qualitative Results Discussion

1 Summary of Research Aims and Findings

The overarching aim of the research was to enrich, contextualise and expand on the experiences of claims workers within their unique context and to reach a deeper understanding of the nature and challenges of vicarious trauma in administrative populations of workers.

Quantitative measures were utilised to pursue the overarching aim and to respond to the research questions expressed by the study. Data from these measures were used to explore differences between claims workers – the main focus of the study – and trauma counsellors – a well-researched vicarious trauma population – as well as a control group of holiday booking consultants. Analysis of variance revealed significant differences for secondary traumatic stress, negative cognitive schemas, compassion satisfaction and social support. No group differences were detected for empathy, or the Empathic Concern sub-scale of this measure; however, the Perspective Taking, Personal Distress and Fantasy sub-scales yielded significant results. Trauma counsellors showed the greatest capacity to empathise whereas claims workers experienced significantly greater levels of personal distress from empathic engagement with traumatised clients.

For secondary traumatic stress – the first vicarious trauma measure – claims workers presented with the highest scores, whereas the control group of holiday booking consultants were least affected. Further group differences were detected for the sub-scales, these being Intrusion, Avoidance and Arousal, with claims workers exhibiting significantly more symptoms in all three areas. Negative cognitive schemas – the second vicarious trauma measure – were most prevalent for claims, with the control group once again showing the least effects. Claims workers also exhibited significantly greater negativity of cognitive schemas on nine of the ten sub-scales, with Self-Trust being the only sub-scale not reaching significance. Significant group differences were also revealed in the levels of perceived social support, including the size of support networks. The majority of participants expressed a high level of satisfaction with their perceived social support, irrespective of the size of their support networks. Finally, vicarious trauma was also found to affect those claims workers with a wellness plan less than those without.

Correlations within and across the worker groups confirmed traditionally accepted associations between the study variables, in relation to one another, as well as to vicarious trauma. Multiple Linear Regressions showed that the variables earmarked by the study, being compassion satisfaction, social support and empathy, largely explained secondary traumatic stress and negative cognitive schemas – the two vicarious trauma measures.

In addition, qualitative data supplemented the findings from the quantitative measures or explored areas not covered by the quantitative instruments. The study results were structured around Figley's model for the progression of compassion fatigue/secondary traumatic stress in therapists, as well as other variables of interest to the study. Firstly, the quantitative data showed that empathy, compassion fatigue/secondary traumatic stress and a sense of satisfaction are equally important to claims workers and therapists.

The themes of exposure to client suffering, detachment, level of empathic engagement, personal trauma history and difficult life demands were excavated from the qualitative data, which illuminated the importance and role of each of these elements to claims workers. Having considered the various elements proposed by Figley's model in this way revealed the model to be largely suitable to the context of claims workers. However, a few areas were identified where the model requires expansion or accession, to further augment its applicability to the administrative domain.

Other areas of interest, such as utilisation of sick-leave as a coping mechanism and work-related illness were found to be salient and to contribute to levels of absenteeism. Attitudes towards professional counselling as a further avenue of support, feelings evoked by traumatised clients and the language utilised by workers in response to client traumata were gauged. Further effects on participants were identified as well as a distinct group-mood that distinguished the worker groups from one another. Examples of the permeating effects of vicarious trauma that reach beyond the person were presented.

The composition of the support network of each group revealed interesting differences. A small needs assessment identified work-based support as deficient and other sources of stress that need remedying to alleviate work-related and secondary traumatic stress was uncovered. Suggestions for improvements to the work context were also uncovered. Finally, the participant or emic voice was honoured whereby interesting themes that emerged spontaneously from the data were presented.

The main themes that emerged pointed towards additional work effects/challenges, other sources of stress, emotional effects/challenges as well as the issue of self-care. Where the quantitative and qualitative data intersected, the same results were largely pointed towards, the one supporting the other.

In all, the present research yielded a comprehensive exploration of vicarious trauma and elucidated a wide range of effects on participants. A bio-psychosocial stance created an impression of how various levels of functioning are impacted upon. For instance, intrapersonal effects along various psychological dimensions and within the physiological sphere were found to also suggest or illustrate interpersonal effects. Difficulties in the work context revealed by the qualitative data were also found to pose interpersonal problems. The social realm was explored by considering social support as well as the work and organisational contexts that yielded interesting results and offered the reader a sense of each group's work environment alongside its unique challenges.

The central aim, to contribute unique information to the existing knowledge on vicarious trauma and to expand the application of the construct into less familiar territory, was accomplished by focusing on short-term insurance claims workers, a group less well-known in vicarious trauma research terms. Results from the study also assisted in identifying yet another group vulnerable to vicarious trauma, bringing researchers one step closer to identifying the full range of workers affected by this phenomenon, as well as revealing another work setting conducive to vicarious trauma. How the discussion is structured, is looked at next.

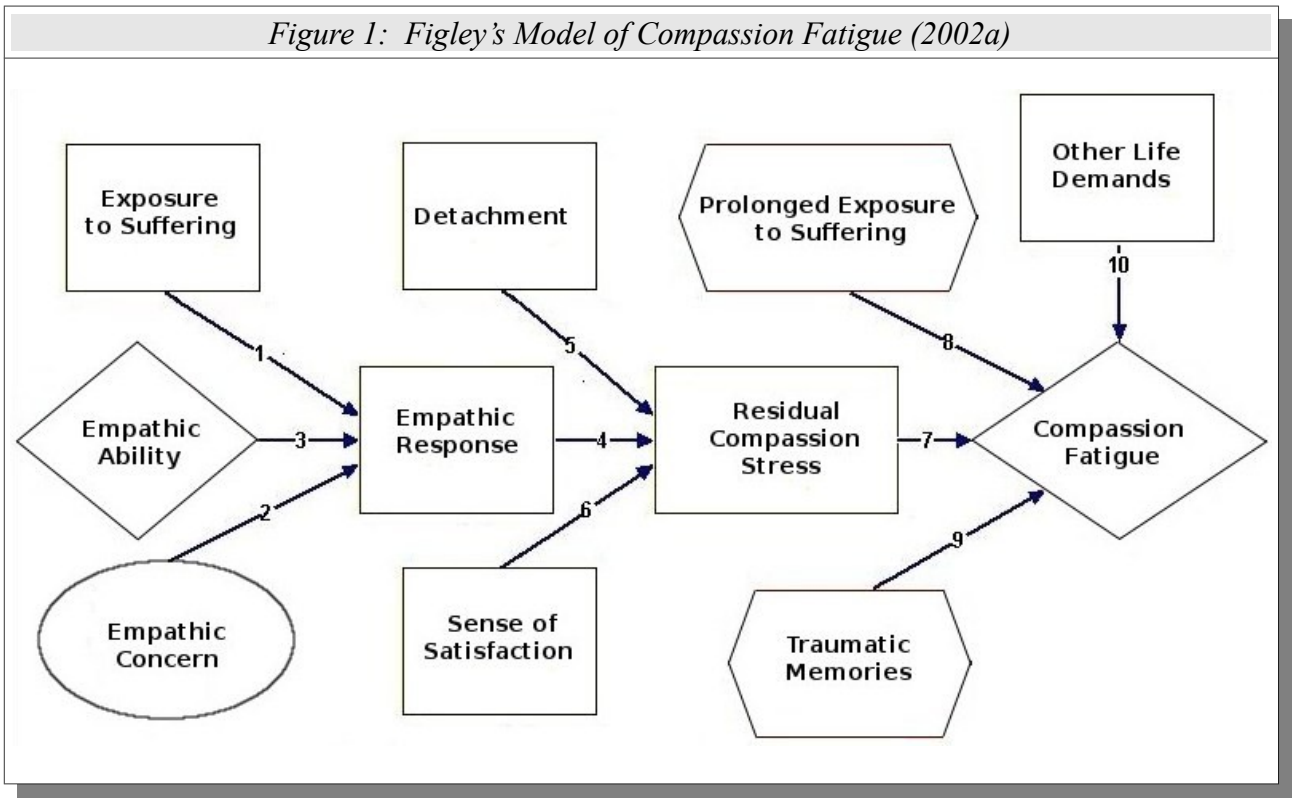
2 Discussion Overview

This chapter is structured around the theories unpacked in the study. As stated before, the bio-psychosocial precept that psychological phenomena affect various areas of functioning was adopted by the present research. This theory maintains that affected individuals do not exist in a vacuum and that effects in one area of life will commonly spill into other areas of functioning. Bio-psychosocial theory is used purely as a structuring instrument to frame the study and to organise results at the intrapersonal, interpersonal, social and organisational areas of functioning. Within this framework, Figley's model of compassion fatigue (2002a) further drives the discussion, and constructivist self-development theory examines the cognitive effects of vicarious trauma. For ease of reference, *Figure 1,* depicting Figley's model, is repeated.

3 Figley's Model of Compassion Fatigue

The introductory chapter mentioned that Figley (2003) sensitised researchers to not only focus on populations more obviously associated with vicarious trauma, but to look more widely to fully reveal the costs of caring. To this end, Figley's model was deconstructed and measuring instruments chosen to cover some of the core elements to determine its applicability to the administrative domain.

Figure 1: Figley's Model of Compassion Fatigue (2002a)



The remainder of components were covered by the self-constructed questionnaire that posed some open-ended questions. Again, *Appendix A* offers a concise visualisation of how each model element was covered. The ensuing part of this chapter is structured around this model and the importance of each component to claims workers is considered. How certain components might be expanded upon or added to the model to maximise its applicability to the administrative context is also discussed.

The theory chapter pointed out that Figley's model explains the onset of compassion fatigue/secondary traumatic stress and simultaneously indicates the course of action for treatment

and prevention (2002a). Therefore, expanding upon this model would not only assist in explaining the progression of negative symptoms in administrative groups, but could also serve as a stepwise map to those who wish to take charge of their well-being.

3.1 Vicarious trauma pathways.

The first three elements of Figley's model – the vicarious trauma pathways – are trauma exposure, empathic ability and empathic concern, and are considered in this context.

3.1.1 Exposure to suffering.

Figley's model (2002a) proposes exposure to suffering as the first pathway to vicarious trauma, which entails the worker accumulatively absorbing traumatic energy from each client. This model component is based on the theoretical precept that dealing with the trauma of others can induce vicarious traumatisation (McCann & Pearlman, 1990).

From a bio-psychosocial perspective, the general biological processes that underlie the stress response are believed to be universal, but the specific dynamics of this process is often a function of the environment that persons find themselves in (Christopher, 2004). In the short-term insurance industry, insurance policyholders seek monetary restitution in the aftermath of losses. Gough (2007) states that working with individuals who have suffered losses, be they emotional or monetary, is in itself challenging. Claims worker/client interactions are structured solely around monetary losses, and client traumata are inadvertently encountered during these negotiations.

Even though it was expected that claims workers would encounter traumatised clients frequently, the severity of some cases was unexpected. The level of trauma involved in the cases dealt with by claims workers, in some cases, matched that of trauma counsellors. For instance, the frequency with which murder and rape cases were handled by claims workers was surprising. The CSVR (2007) found that a significant number of rapes and murders initially commence as property crimes which then end in violence. During a meeting with an insurance manager, she commented that rape victims are encountered with sufficient frequency to warrant the introduction of specific protocols for handling these sensitive cases.

An array of studies also evidenced the *frequency* of exposure to traumatised clients to be linked to a significant increase in the likelihood of secondary traumatic stress (Baird & Kracen, 2006). Claims

workers handled cases involving death, suicide, violent crime, torture and serious injury from accidents unexpectedly frequent. A fifth of claims workers expressed concern over the frequency with which they encounter disturbing cases. It either instilled fear or impinged upon their coping abilities.

The qualitative analysis indicated that participants are affected by cases for quite a long period of time. The majority of participants were usually affected during and for a short while after dealing with traumatised clients, but a significant percentage were affected for a number of months or even several years. Also, the qualitative data indicated that claims workers found it somewhat more difficult to forget more disturbing cases than did trauma counsellors.

Clearly, the frequency and severity of traumas encountered in the present study are sufficient grounds for vicarious traumatisation to occur, placing claims workers at considerable risk. Exposure to suffering, proposed by Figley's model, is as significant a pathway of vicarious traumatisation in claims workers as in therapists. The next point elaborates on another aspect of exposure to trauma.

3.1.1.1 Prolonged exposure to suffering.

Figley's model (2002a) suggests that ongoing exposure to trauma dramatically increases the risks of negative outcomes. This sentiment is shared by a number of theorists (Jordan, 2001; McCann & Pearlman, 1990; Steed & Downing, 1998). Prolonged exposure poses a constant threat as the person could at any time become overwhelmed by additional pressures or a diminution in support (Jordan 2001). Claims workers, as with other groups dealing with traumatised clients, have the added risk of prolonged exposure by nature of their work. Assisting clients traumatised by losses, accidents and criminal acts are part of their everyday reality, placing them at considerable peril. The next section looks at some of the ways in which trauma is transmitted.

3.1.1.2 Emotional contagion, negativity bias and negativity ratio.

Emotional contagion, negativity bias and negativity ratio play important roles during exposure to client distress, each contributing to the process of vicarious trauma. These concepts do not form part of Figley's model, but offer additional insight into the processes underlying vicarious trauma. Discussing the mechanisms traditionally at work within therapeutic settings, such as countertransference, is less appropriate in relation to administrative workers. Instead, the concepts presented here underlie *all* human interactions.

Emotional contagion theory fits the administrative context well. Contagion theorists maintain that we share an innate tendency to mimic and mirror the emotions expressed by others (Hatfield *et al*., 1993). Therefore, it would also extend to claims worker settings, whereby workers absorb, internalise and mirror traumatic energy, causing them to experience some of the trauma expressed by clients. To reiterate, much of the contagion process is subliminal and automatic, whereby we "*feel ourselves into the emotional landscape*" of others involuntarily (Hatfield *et al.*, 1993 p. 96).

Listening to distressed clients, whether they share information on the event or not, or whether the claims worker conveys empathy or not, is sufficient to induce emotional contagion. As emotional expression occurs during any interaction, this phenomenon is not limited to face-to-face contact, but also extends to telephonic set-ups (McCalla & Ezingeard, 2005). In the voice-to-voice context, claims workers respond to language content, voice intonation and words signalling emotion. Although vicarious trauma research in call centres is sparse, Dunkley and Whelan's study evidenced vicarious trauma in telephone counsellors (2006a).

Surprisingly, examples of emotional contagion emerged strongly and spontaneously from the qualitative data. Out of the two groups dealing with client traumata, the notion was most prominently articulated by trauma counsellors, but also involved a considerable percentage of claims workers, who described "*feeling what their clients feel*". Emotional contagion was most often demonstrated by holiday booking consultants who mirrored client anger, indicating that anger is even more contagious than trauma. However, effects from anger proved to abate more quickly.

Moreover, the negativity bias proposes that negativity is more readily passed on than positive information or affect, making dissemination of trauma very likely. Seeing that claims workers deal with clients' losses, information from clients would almost always be negative, creating a steady influx of negative energy. The negativity ratio, as proposed by the broaden-and-build theory, predicts a negative outcome under these circumstances (B. L. Frederickson, as cited in Radey & Figley, 2007, p. 208).

According to this theory, the negative to positive ratio determines whether a person will experience a positive or negative outcome. For instance, one would draw a positive affect from a positive environment which is likely to generate a positive outcome – such as job and compassion satisfaction. As indicated, claims workers operate in a negative environment, largely generating negative experiences, likely to result in negative outcomes – such as secondary traumatic stress.

Almost a third of the claims workers illustrated a negative outcome, denoted by serious levels of secondary traumatic stress. They were dominated by an air of negativity, whereby two-thirds reported negative effects or emotions of varying degrees from dealing with traumatised clients. Dramatically fewer trauma counsellors and even fewer holiday booking consultants reported similar effects. Constantly being confronted with negative information with a high contagion potency, given our innate negativity bias and the lack of positive input to counterbalance this state, it is no surprise that so many claims workers have become bogged down in negativity.

The power of emotional contagion and high negativity ratio was further exemplified by the qualitative data. A number of claims workers from the severe secondary traumatic stress category indicated that they do *not* connect empathically with clients. They focus on work and ask only for necessary information. However, when looking at data from claims worker P67, a dramatic effect is nonetheless revealed:

> *"About 3 years ago an elderly gentleman reported a stolen vehicle claim where he was tied up and beaten and his wife murdered in their own home! Since then I try not to form part of what the client is telling me. I just ask what I need to and move on ... I try, if the memory comes up, to block it out with something else."*

This statement indicates that the participant was deeply affected by this case and, three years later, he still refrains from connecting empathically with clients. However, focusing on work and not consciously engaging with client traumata do not diminish negative effects, as his secondary traumatic stress score was the single highest score in the sample. This confirms the contagion precept that we cannot completely bypass emotional content and that emotional contagion happens involuntarily and subconsciously (Hatfield *et al*., 1993).

Furthermore, researchers have found emotional contagion to also be at work in groups and organisations. The moods of group members often converge into a work-group mood that is recognisable and measurable (Barsade, 2002). In the present study, the three groups indeed each presented with a different sense of group-mood. The claims workers were dominated by horror, shock and fear. They also expressed a lot of sadness and heartache, and their anxiety and unease were palpable. These strong feelings are largely reflective of those of their clients – the initial shock, horror and fear from being victimised or from being in an accident, followed by grief over the loss. Anxiety and unease would probably remain with clients long after these events. Claims

workers seem to have "*caught*" and internalised the initial panic as well as residual fear exhibited by clients, indicated by the magnitude of expressions of fear from this group.

The trauma counsellors also expressed horror and sadness; however, anger was more salient. Their group-mood is also reflective of the clients they encounter most. They mirrored the initial horror of being victimised by predators and abusers, followed by sadness over the ordeal and a sense of emotional loss expressed by clients, including anger towards perpetrators and the unfairness of these situations. These negative effects are further circulated into the worker group with the potential to cause harm, such as secondary traumatic stress symptoms. The relevance and importance of empathy to claims workers are considered next.

3.2.1 Empathy.

Empathy is another vicarious trauma pathway. The nature of empathy is first uncovered, followed by further consideration of this pathway.

3.2.1.1 The nature of empathy.

The three components of Figley's model relating to empathy refer to the person's empathic ability, the concern to respond and the empathic response itself (2002a). Figley views empathy as a paradox as it is the keystone to helping others, but also the pathway to vicarious traumatisation. At the outset, it was thought that empathy might not play an important role in claims workers as empathic engagement is not their primary objective – recording and settling claims are. However, the study revealed that empathy plays as important a role in claims workers as in the comparison group of trauma counsellors.

In the present study, empathy was measured along four different constituent elements. Multivariate analysis of variance did not detect significant differences in empathy among the three worker groups. However, a one-way analysis of variance revealed some interesting results for the empathy sub-scales, being Perspective Taking, Empathic Concern, Personal Distress and Fantasy.

Claims workers are neither required nor trained to be empathic, but they nonetheless conveyed deep empathy in their human capacity. However, regarding Perspective Taking, trauma counsellors showed a significantly larger capability and/or tendency to take on the perspective of clients compared to claims workers. This is to be expected, as their professional role revolves around

empathic engagement and quality empathic responses. They likely also receive training to expand empathic capabilities, to enable effective counselling and understand post-traumatic responses.

No significant difference in Empathic Concern was detected among the three worker groups. Participants seemed to show similar levels of concern and compassion towards clients. They also demonstrated to be equally motivated to assist. However, intuitively, one would have expected trauma counsellors to have greater concern for the well-being of others, compared to the general population. Although, one has to take into account the numbing effect of constant empathic engagement (Salston & Figley, 2003). These authors explain that therapists often habitually distance themselves from the suffering of others to protect themselves by tuning out, or by not remaining present during client interactions. The qualitative results indicated that trauma counsellors expressed more numbness in relation to other participants. In more extreme cases, involving four percent of trauma counsellors, they often felt so numb that they consciously immersed themselves in the client's emotional pain to provide more effective counselling:

> P42*: "I tend to feel numb and disconnected after dealing with many trauma cases. Then I place myself in their shoes, which sometimes help to "re-connect" with the client."*

The dimension of Personal Distress was of particular importance to the study. Claims workers demonstrated significantly higher levels of emotional upset from empathic engagement with clients than trauma counsellors. The qualitative data revealed anxiety to be more prevalent in claims workers and they scored highest on secondary traumatic stress, indicating greater levels of distress. Distress is augmented when a person's coping capabilities and resources are exceeded, threatening the person's efficiency (Craig & Sprang, 2010). This outcome is more likely where negative energy is not counteracted by positive aspects in the person's life (Radey & Figley, 2007). The study revealed that positive avenues, such as social support, self-care, compassion satisfaction and ability to detach, were lacking in claims workers. Coupled with lack of training and resources, it becomes clear why claims workers are more distressed than trauma counsellors.

Finally, trauma counsellors showed a greater tendency and capacity to emotionally identify with fictional characters than claims workers; however, the result did not reach significance. Interestingly, the only significant difference was observed between trauma counsellors and holiday booking consultants, who presented with the lowest scores. Trauma counsellors, who utilise

empathy most often, showed the greatest capacity with respect to Fantasy. These results suggest that, although empathy is innate, certain aspects of it might be influenced by practice or training.

3.2.1.2 Complexities of the empathy pathway.

Many who have attempted to research empathy have remarked on its complexity (Ashraf, 2004; D'Ambrosio, Olivier, Didon & Besche, 2009). As with defining empathy, measuring this concept is equally precarious. Subsequently, research results are diverse, contradictory and even perplexing. The present study was no exception as challenging findings were made. Figley's model illustrates the centrality of this concept to therapists by presenting it in three prongs. Empathy is both a keystone and downfall, and those with a greater empathic capacity run a greater risk for secondary traumatic stress (Figley, 2002a) Therapists absorb and relive traumatic information by letting it unfold within their own frame of reference, a process required for therapists to understand their clients' experiences and needs (Figley, 2002a).

Even though claims workers were not expected to forge a connection with clients, the qualitative data nonetheless indicated that as many as 42% do connect deeply. The level of empathic engagement was a surprise. This deep level of empathic engagement is of great consequence, as Figley (2002b, p.124) explains that the *level* of empathy is pivotal in the trauma transmission process – a deeper connection translates to more serious effects from traumatic materials.

Figley (2002a) states that, with empathy, therapists project themselves into the position of clients to gain insight into their behaviours, thoughts and feelings. In doing so, the therapist might experience feelings and emotional upheaval parallel to that of clients. Ashraf (2004) states that empathy is our innate way of gauging how someone feels by experiencing their emotions. Emotional projection will therefore not only happen in therapeutic relationships, but in all instances where individuals connect emotionally. Claims workers were no exception as the qualitative data revealed that 14% of them felt what their clients were feeling. Even though they interact with traumatised clients for administrative purposes, they are not unaffected by their trauma.

Empathy as a pathway to vicarious trauma was further confirmed by statistical analysis. Stepwise Regressions flagged empathy as the second strongest predictor in *both* secondary traumatic stress and negative cognitive schemas in the sample. This means that more empathy and deeper engagement are associated with higher levels of secondary traumatic stress and negative cognitive schemas. However, for secondary traumatic stress, the reverse could also be true. Those with

elevated levels of secondary traumatic stress might be identifying more strongly with traumatised clients, reaching out from their own position of emotional distress.

However, as with other studies, the relationships between empathy and other psychological concepts were far from simple. Empathy was the second strongest predictor of secondary traumatic stress in claims workers, but emerged as the least powerful predictor of negative cognitive schemas. Also, the significant correlation unearthed between empathy and secondary traumatic stress in claims workers and in the sample, mostly pointed towards what empathy literature suggests – that more empathy and deeper empathic engagement can set vicarious trauma in motion. However, empathy did not significantly correlate with negative cognitive schemas. This combination of results mean that empathic engagement with traumatised individuals can induce secondary traumatic stress, whereas it does not necessarily cause a dramatic negative shift in cognitive schemas.

This was interesting as secondary traumatic stress and negative cognitive schemas are both outcomes of the same process – that of vicarious trauma. One would think that they would share the same pathways – empathy being one. However, this was not entirely the case in the present study. MacRitchie (2006) reported a similar result from which she concluded that negative cognitive schemas are far more subtle measures of vicarious trauma. However, the present research concludes that this result is more a product of secondary traumatic stress and negative cognitive schemas being two separate and complex concepts, each with its own dynamics, underlying mechanisms, pathways and contributory factors.

Surprisingly, empathy results were more difficult to interpret for trauma counsellors. Intuitively, one would expect that they would be more affected, seeing that they utilise empathy with such frequency within the therapeutic process. Also, content analysis indicated that they form deep connections to a much greater extent than claims workers, involving almost two-thirds of this group. However, trauma counsellors were far less affected than claims workers.

Possible explanations are their training in psychology, their general awareness of the risks associated with their work and their realisation of the importance of self-care. They also customarily receive supervision and counselling. The qualitative data also indicated that trauma counsellors generally viewed their work in a less negative light than did claims workers, indicating that they can more often remain emotionally neutral during client interactions. They also reported

the most positive experiences, highest levels of compassion satisfaction, greater social support as well as far better abilities to detach from client distress. This demonstrates the importance of modulating negative affect with positive energy (Radey & Figley, 2007).

Gentry (2002) states that intentionality – a decision to recognise and manage the effects of trauma work – already places one on the correct path. It is assumed that most trauma counsellors, through their training, might possess this insight and intentionality. Judging from the significantly lower levels of vicarious trauma exhibited by this group, they are better able to shield themselves from negative energy compared to claims workers. Trauma counsellors did indeed show more social support and self-care practices than claims workers. Some propose that sometimes, even the simplest of strategies, such as self-soothing and collegial support, can make a significant difference (Gentry, 2002). Humour is believed to be one of the most potent and highest forms of coping with life stresses (Figley, 2002b*)*. Trauma counsellor P20 demonstrates the power of this simple strategy that lightens the mood, reduces stress and increases his sense of job satisfaction:

"Colleagues provide comic relief and make the job here worthwhile".

The significant correlation detected between compassion satisfaction and empathy emphasised the paradoxical nature of empathy in that high levels of both variables coincided. It is counter-intuitive that empathy would exert an influence on both secondary traumatic stress, a negative outcome, and compassion satisfaction, a positive experience. This confirms the theoretical notion that empathy can both heal and hurt (Figley, 2002a). Given the results on empathy discussed thus far, it is concluded that the components of Figley's model relating to empathy are of great consequence to claims workers, given their high levels of distress and negative outcomes from empathic engagement with traumatised clients. The next component in Figley's model is that of detachment.

3.2 Detachment.

Figley's model presents detachment as a protective factor that can diminish or prevent secondary traumatic stress by negating residual stress left behind by each empathic engagement (2002a). It involves disengaging from the feelings and thoughts associated with client traumata and to return to one's own life (Figley, 2002a). Interestingly, nine percent of trauma counsellors and eight percent of holiday booking consultants described rituals they routinely follow to effectively signify the transition from work to personal time. These rituals are indeed displays of mindful detachment, preventing work issues from entering into private life. However, the claims workers did not express

the same level of mindful efforts of letting go. The repercussions of ineffective disengagement were detected in the present study. For instance, claims workers generally expressed the greatest difficulty to detach from traumatic materials as demonstrated by these statements:

> P71: *"It does trouble me. Some cases go home with you."*
>
> P75: *"Depending on the severity of the case, it often stays with me for days or weeks. Often enough to worry about it when at home."*

Inability to disengage from traumatic materials could be contributing to the high levels of vicarious trauma observed in the claims workers. Next, a sense of satisfaction is considered.

3.3 Sense of satisfaction.

Sense of satisfaction is another factor extolled in Figley's model for the diminution of negative outcomes. A sense of accomplishment with the service provided to clients can instil a sense of satisfaction that can reduce secondary traumatic stress (Figley, 2002a). Positive input, such as a sense of satisfaction, is crucial to counteract negative energy from trauma exposure. Radey and Figley (2007) report that something as negative as secondary traumatic stress can culminate in something positive, such as compassion satisfaction, if the positivity ratio is sufficient. The study results largely supported this sentiment as those with higher levels of compassion satisfaction exhibited fewer negative outcomes. This result was touched upon in the previous section, clearly illustrating the affirmative effects of positive energy in vicarious trauma.

Furthermore, claims workers presented with the lowest levels of compassion satisfaction as well as the highest levels of vicarious trauma, as indicated by their significantly higher secondary traumatic stress and negative cognitive schema scores in the sample. Therefore, they do not derive satisfaction from their compassion responses and experience their empathic responses as ineffective and not making a difference to the distress of clients. This could be due to the fact that they largely possess administrative skills, and lack training in providing effective compassion responses. They might also not anticipate the challenges of working with traumatised individuals and might be disillusioned by these difficulties.

Stamm (2010) emphasises the importance of looking at scores in combination. High levels of secondary traumatic stress coupled with low levels of compassion satisfaction, as expressed by a large

percentage of claims workers, is believed to be a particularly unfavourable combination. Affected persons are likely to feel overwhelmed, ineffective at their job and might even experience fear in the work setting (Stamm, 2010). Fear was indeed more prevalent in claims workers than in the other two groups. Stamm suggests that persons presenting with this combination of scores, should perhaps remove themselves from this work setting or at least re-examine their work situation. Furthermore, from the qualitative data, 24% of the claims workers admitted to often experiencing a sense of helplessness or paralysis due to a lack of skills and training in trauma assistance. Statements ranged from uncertainty as to how to assist, not knowing how to assist in more severe cases, to feeling a need to do more for the client's emotional state. The following statement from claims worker P68 stood out the most:

"I don't have the required skills to assist the client and I will go into a panic"

By contrast, trauma counsellors presented with the highest levels of compassion satisfaction. Of the three worker groups, they are most satisfied with their service and compassion responses. Their psychology training clearly enables them to work more effectively with traumatised individuals. Knowing that they are making a difference in the person's life seems to further augment experiences of compassion satisfaction. Trauma counselling and other helping professions are also often described as a calling rather than a job. Being called to a profession means that one *wants* to deal with traumatised individuals and that one has a desire to help those in crisis. In the case of claims workers, dealing with traumatised clients is mostly an unexpected by-product of the job that they might be unprepared for. They do not possess the skills-set to effectively assist and might not necessarily even want to work with those in psychological distress.

The bolstering effect of compassion satisfaction was further expressed by the significant positive relationship between compassion satisfaction and empathy seen in the sample. This suggests that the positive energy generated by compassion satisfaction can dramatically diminish secondary traumatic stress (Radey & Figley, 2007). Finally, a significant correlation between compassion satisfaction and social support was also uncovered. Those with higher levels of satisfaction had more supports. It would seem that those who are happier at work are more connected to others. In turn, those who are more connected and feel better supported are likely to be happier at work as they possess larger emotional reserves to draw from when dealing with distressed clients, showing that compassion satisfaction and social support have replenishing effects. Next, the role of residual compassion stress is looked at.

3.4 Residual compassion stress.

Figley's model (2002a) illustrates how residual compassion stress can quickly gain momentum. Constant exposure to trauma, continued empathic engagement with traumatised clients, poor detachment from traumata and a compromised sense of satisfaction all contribute to the accumulation of this harmful negative energy. Not counteracting this negative energy with, say activities that bring joy, can place the person in harm's way (Gentry, 2002).

The study results confirmed the harmful nature of residual compassion stress. Firstly, the qualitative data indicated that the level of trauma claims workers are exposed to, frequently paralleled that of trauma counsellors. Contrary to expectation, the majority of claims workers formed a deep empathic connection with clients. The claims workers also expressed the greatest difficulty to effectively detach from client traumata. Finally, they exhibited the lowest levels of compassion satisfaction out of the three worker groups. As a result, claims workers accumulate significantly more residual compassion stress, as denoted by their secondary traumatic stress and negative cognitive schema scores being the highest in the sample.

In addition they exhibited a ubiquitous sense of fear, anxiety and unease. According to McCann and Pearlman (1990), such negative outcomes are indicative of workers not being able to successfully work through and synthesise the painful traumata from clients. Their incapability to accommodate and make sense of the traumatic events encountered was further illustrated by a strong sense of disappointment in mankind, expressed by a fifth of this group. This way of thinking is seen as "*overaccommodation"* of traumatic information (Falsetti *et al*., 2003, p. 391). Instead of being disappointed in those who perpetrate evil, all of mankind is viewed as a disappointment.

If residual compassion stress is not addressed, compassion fatigue/secondary traumatic stress is the likely outcome (Figley, 2002a). As explained earlier, symptoms characteristic of secondary traumatic stress are also the hallmarks of post-traumatic stress disorder (McNally, 2003). Therefore, those with high levels of secondary traumatic stress in the present study, exhibit most of the characteristic post-traumatic stress symptoms, which is a serious outcome. The next element of Figley's model is that of traumatic memories.

3.5 Traumatic memories.

It has long been surmised that those with a personal trauma history experience more negative effects from dealing with traumatised individuals than those without a trauma history (*e.g*. Baird &

Kracen, 2006; Ortlepp & Friedman, 2002; Schauben & Frazier, 1995; Steed & Downing, 1998). However, results on the role of trauma history are divided. Some studies indicate personal trauma history as important in vicarious trauma, seeing it as a noteworthy correlate (*e.g*. Adams *et al*., 2004; McCann & Pearlman, 1990; Salston & Figley, 2003). These authors maintain that trauma does not heal trauma, but only adds to it, implicating it as contributory to poor psychological health. Yet, others have found no noteworthy correlation between vicarious trauma outcomes and personal trauma history (Ortlepp & Friedman, 2002; Schauben & Frazier, 1995).

In the present study, some data were collected on personal trauma history by the self-constructed questionnaire in order to form a sense of its role. More than a quarter of the sample indicated having experienced personal trauma recently. Four percent of the sample suffered more than one traumatic event. These data primarily served to screen for participants with levels of trauma that rendered them unfit for participation. Surprisingly, the theme of personal trauma history emerged spontaneously elsewhere in the data. For instance, eight percent of the claims workers observed that personal trauma impinged upon their ability to effectively assist. These participants articulated the awareness that their own traumatic experiences were triggered and reignited by similar client traumas. They found these to cause more stress and pose more difficult to deal with than other unrelated types of trauma.

Again, this percentage is modest, but the finding is nonetheless significant as none of the questions specifically referred to the impairment of abilities from personal trauma. Possibly due to their training and greater insight into trauma work, trauma counsellors presented with a significantly greater awareness around this issue, whereby 24% observed that their own trauma played a compounding role in their work. From these results, it is concluded that personal trauma history does pose an additional risk. The distress of one's own traumas resurfacing adds to residual compassion stress, which in turn increases the likelihood of the negative outcomes associated with vicarious trauma. Next, other life demands, an equally capricious hurdle, are discussed.

3.6 Other life demands.

This model element refers to those situations that demand attention in other areas of life that possess the ability to temporarily disrupt life and one's level of functioning (Figley, 2002a). Even unexpected changes in routine or schedule and managing other demanding responsibilities could add strain (Figley, 2002a). These include financial difficulties, changes in social status, illness and added professional or personal responsibilities. We usually take these events in our stride, often

with exasperation, but they are mostly ephemeral challenges that we eventually overcome or adapt to. However, combined with the other factors of Figley's model, these life events could add sufficient stress to induce secondary traumatic stress (Figley, 2002a). As stated previously, even though claims workers might be coping well at a given moment, they could become overwhelmed by these additional, unexpected life pressures (Jordan 2001).

Difficult life demands were in fact very pervasive in the sample. More than two-thirds of the claims workers described how recent life disruptions had affected them negatively. The following statements from claims workers exemplify the diversity of challenges they had to contend with, as well as the added level of strain:

> P80: *"Bad break-up and financial mishaps. I am constantly worried and uncertain. [It affected me] a lot, quite a lot!"*
>
> P81: *"My 1 year old daughter getting sick. [I felt] quite bad, realising that I don't have much to support her financially. [It affected me] quite a lot."*
>
> P93: *"Miscarriage. It made me very emotional and very depressed. I felt very upset and emotional and a failure as a woman."*
>
> P95: *"My husband left and now I am suddenly the head of the house. It is very difficult for me. Especially financially. [It affected me] a lot."*

Very few of these claims workers, only two percent, experienced a positive outcome from difficult life demands:

> P62: *"Finances. Transport. It made me stronger. [It affected me] a lot, but it had a positive side."*

In comparison, just over half of the trauma counsellors, significantly fewer than claims workers, found difficult life challenges to add strain:

> P22: *"Job that I do not enjoy. Pressurised job. Balancing roles - ie work plus 2 children plus husband. Stress of living in a busy city. Sometimes feel depressed and can at times*

feel overwhelmed. Very little time for self. Feel there is no time to partake in activities that I enjoy. [It affected me] a lot."

P27: *"One very close friend passed away 3 weeks ago. Stressful personal events (studies, finances etc) made me stressed, emotional and worried. [It affected me] quite a lot as the life demands were quite severe."*

P33: *"To be in a demanding work environment and at home my husband is sick. My blood pressure has risen. Yes [it affected me], especially my health."*

P41: *"Relationship problems with my boyfriend. It made me tired and unhappy and I cried a lot for a while but we have sorted out the problem. For a while it was very difficult."*

A much larger percentage of the trauma counsellors – 18% – found life challenges to have a positive outcome:

P05: "*Going through a divorce. Made me listen more and like myself all over again. [It affected me] a lot."*

P30: *"... I have experienced suffering in life and accept that it is how life is. It happens to us all in one way or another. I think it has made me a richer person – more empathic. A lot of it affected all aspects of my life - it changed my way of thinking about life. It matured me, but it also made me seek joy in life."*

The control group of holiday booking consultants described the least disruption from life events, affecting roughly one-third of this group. The control group also reported as many positive outcomes as the trauma counsellors. These results do not suggest that one group experienced more difficulties than the others. They are believed to be reflective of patterns of thinking and appraisals of life events, rather than representing the frequency of such events in the real world. Therefore, claims workers did not encounter more difficult life demands, they were simply less able to cope. To the over-extended person, an unexpected event can seem catastrophic and insurmountable, whereas it would hardly cause a stir in someone who is happy and faring well.

The very few positive outcomes described by claims workers compared to the other two groups also suggest that one's ability to recognise and experience positivity is impaired by stress. Many authors have found secondary traumatic stress to instil greater pessimism (Dheer *et al*., 2003; Ludick, 2006; McCann & Pearlman, 1990). Others have found stress and anxiety to cause persons to selectively pay attention to negative stimuli, disregarding the positive (Mitte, 2008). Indeed, claims workers perceived their life demands to be distinctively more negative when faced with similar challenges as the other participants. If one does not possess optimistic and healthy cognitive schemata, one can not perceive something to be positive and transform stress and anxiety into learning, adaptive behaviour and meaning (Christopher, 2004). Next, the negative outcomes of the process of vicarious trauma are considered.

3.7 Negative outcomes.

This section concludes the discussion of Figley's model. The last component is the end destination of the vicarious trauma process – being compassion fatigue/secondary traumatic stress. This negative outcome is reached when residual stress from trauma exposure and empathic engagement goes unchecked. It is also more likely when the positive avenues proposed by the model to counterbalance the negative are neglected. However, compassion fatigue/secondary traumatic is not the only negative outcome often reported. To increase the comprehensiveness of the study, post-traumatic stress disorder is also considered as well as negative cognitive schemas.

3.7.1 Compassion fatigue/secondary traumatic stress and post-traumatic stress disorder.

Firstly, to reiterate, amidst controversy over the correct nomenclature, compassion fatigue and secondary traumatic stress are believed to be interchangeable terms (Figley, 2003). As also stated before, many authors suggest that secondary traumatic stress is closely related to post-traumatic stress disorder (Linley & Joseph, 2004; McNally, 2003). These authors propose that the two phenomena are parallel and that they share the same symptoms and hallmarks. As also pointed out, secondary traumatic stress is often measured utilising established post-traumatic stress disorder measures or measures that have been formulated around the core symptoms of post-traumatic stress disorder (Bride *et al*., 2003). Therefore, those who score high on secondary traumatic stress also exhibit the hallmarks of post-traumatic stress disorder.

As highlighted previously, the average secondary traumatic stress score for the claims worker group fell within the moderate category. Eight of the 50 claims workers exhibited high and 14 severe levels of secondary traumatic stress. This group also yielded the single highest score for the

sample. Claims workers were more often affected by client traumata than not, as 44 out of 50 presented with some level of secondary traumatic stress. By nature of the measure utilised, it can be inferred that the 22 claims workers with scores on the high end of the scale, would also exhibit varying degrees of post-traumatic stress symptoms. By comparison, the average score for trauma counsellors fell within the mild category, whereas the holiday booking consultants exhibited little or no secondary traumatic stress.

Intergroup analysis of variance revealed significantly higher levels of secondary traumatic stress in claims workers in comparison to the other two groups. The magnitude of some of the individual scores were especially disconcerting, suggesting that those claims workers are in need of psychological assistance. Furthermore, claims workers scored significantly higher on the Intrusion, Avoidance and Arousal sub-scales, which pin-point post-traumatic stress disorder hallmarks. This means that they experience significantly higher levels of intrusive thoughts about clients, disturbing dreams and a sense of reliving client traumas (Bride *et al*., 2009).

They also experience significantly more psychological distress and physiological reactions associated with intrusive traumata. In terms of avoidance symptoms, claims workers exhibited the most behaviours aimed at avoiding clients, recollections of client traumas and places associated with these traumas. The significantly higher prevalence in arousal symptoms means that they are experiencing more sleep disturbances, irritability and difficulty concentrating (Bride *et al*., 2009). The qualitative data confirmed these results as claims workers complained about insomnia and trouble sleeping, being haunted by client experiences or constantly feeling agitated and moody.

Those affected are also likely to be hyper-vigilant and startle more easily (Bride *et al*., 2009). The qualitative data indeed indicated that claims workers are considerably more cautious, feeling a greater sense of vulnerability. On top of this, claims workers experienced a group-mood characterised by fear, unease, anxiety and worry. Finally, those affected more seriously would also experience lapses in memory and an overall diminished activity level (Bride *et al*., 2009). The deficient levels of support as well as the interpersonal problems flagged for this group also showed a greater detachment from others. Many described how conflict over their constant moodiness and not wanting to be around family and friends impacted upon relationships. The next section discusses negative cognitive schemas.

4 Other Important Variables

4.1 Negative cognitive schemas.

Another effect from vicarious trauma at the intrapersonal level is that of negative cognitive schemas. It has long been suggested that the process of vicarious traumatisation also holds undesirable cognitive outcomes (McCann & Pearlman, 1990). Constructivist self-development theory (CSDT) provides a framework for understanding these outcomes. To briefly reiterate, CSDT proposes that we construct our realities from complex cognitive structures that we develop throughout our lives. Concomitantly, we also interpret all experiences within this reality from these cognitive structures (McCann & Pearlman, 1990). Cognitive structures refer to schemas or mental frameworks that encompass our beliefs, assumptions and expectations about the world, ourselves and others, including assumptions about causality and trustiness of sensory information (McCann & Pearlman, 1990). The CSDT precept is that traumatic materials from clients can potentially negatively transform these schemas.

Firstly, claims workers presented with significantly higher levels of negative cognitive schemas compared to the other two groups. Even though the group item means for this variable are not particularly high, claims workers nonetheless showed a significantly higher prevalence in negative beliefs. Also, high levels of negative cognitive schemas and secondary traumatic stress, the two vicarious trauma measures, coincided.

Logically speaking, the more secondary traumatic stress the person experiences, the more the world is viewed through a lens coloured by psychological distress. The more stress that is generated by the realisation that the world is dangerous and malevolent, the more negative beliefs become. If the person's experiences of the world are largely stressful, these negative beliefs are reaffirmed and permanently consolidated into the person's mental framework. In conjunction to secondary traumatic stress, constructivist self-development theory also highlights two main psychological manifestations that are believed to further coincide – the negative cognitive schemas mentioned earlier as well as intrusive trauma, the latter being comparable to post-traumatic stress disorder. These post-traumatic stress symptoms would likely add additional stress and would further perpetuate negative beliefs.

Next, no correlation was detected between negative cognitive schemas and empathy. This finding was discussed at length earlier, and is therefore not considered again. A relationship was established between compassion satisfaction and negative cognitive schemas, which was also

touched upon previously. However, within this context, those workers more satisfied with their compassion response showed significantly fewer negative cognitive schemas, which yet again demonstrate the protective potency of positive energy in eradicating negative outcomes (Radey & Figley, 2007). The reverse might also be true, in that those with fewer negative cognitive schemas generally derived significantly more satisfaction from assisting traumatised individuals.

In addition, Stepwise Regression analysis shed further light on cognitive schemata. Firstly, social support was the most powerful explanatory variable for negative cognitive schemas. Therefore, the more isolated the person is from contact with supportive, helpful and caring people, the more negative their beliefs about the world, themselves and others become. This makes sense as, if one does not engage with supportive and caring people on a regular basis, one is mainly left with the many testimonies from traumatised clients about the callousness and cruelty of humankind. Not having nurturing relationships to prove the contrary, the person might soon forget how enjoyable, restorative and uplifting social relationships can be. The negative soon outweighs the positive, leaving the person with fewer optimistic experiences to base beliefs upon or to challenge the influx of negative information about humankind.

The person becomes more isolated and less motivated to seek the company of others, and a vicious cycle of negativity is set in motion. Also, if a person is constantly cautious and mistrustful towards others, the person might soon be avoided because of the negativity they exude – very few people would choose to be around a suspicious, pessimistic individual. Fear of suffering the same fate as clients who have fallen victim to many unpredictable life events could also deter the person further from stepping into the social arena.

Next, empathy emerged as the second most powerful predictor for negative cognitive schemas. Even though there was no significant correlation between negative cognitive schemas and empathy, this result nonetheless indicates that empathy, especially when coupled with insufficient social support and low levels of compassion satisfaction, nonetheless contributes to negativity in cognitive schemas. Finally, compassion satisfaction was the least powerful explanatory variable for negative cognitive schemas. Being able to more effectively convey compassion to traumatised clients seems to help, to some extent, to preserve positive beliefs about the self, others and the world. Feeling positive about the help one's empathy provides and believing that one is making a difference in the lives of traumatised clients, seems to help bolster positive beliefs about the self. As long as one

possesses optimistic and healthy cognitive schemata, one can perceive things to be positive and transform stress and anxiety into learning, adaptive behaviour and meaning (Christopher, 2004).

Stepwise Regression analysis for each worker group accentuated the dramatic differences in work contexts. Workers are affected in very different ways believed to be reflective of their very different work environments. For instance, compassion satisfaction emerged as the most powerful predictor of negative cognitive schemas in claims workers, followed by social support and empathy. Out of the three groups, claims workers presented with the least compassion satisfaction and social support. This result indicates that, if these precious resources should dwindle even further, it would contribute most greatly to negative cognitive schemas. For the trauma counsellors, for instance, social support emerged as the most powerful predictor for negative cognitive schemas. Due to the nature of their work constantly exposing them to the travesties of life, contact with happy, nurturing individuals was shown to be pivotal in preserving positive schemas. This also suggests that they should receive even more social support than they currently are.

The above findings were probed more deeply by also looking at the level of variance in each of the different needs areas covered by the TSI Belief sub-scales. McCann and Pearlman (1990) identify beliefs in five needs areas to be particularly susceptible to negative transformation from traumatic engagements, being trust, safety, control, esteem and intimacy. The present study utilised the measuring instrument developed from cognitive self-development theory that assesses these areas in relation to the self as well as to others. These are Self-Safety, Other-Safety, Self-Esteem, Other-Esteem, Self-Control, Other-Control, Self-Intimacy, Other-Intimacy, Self-Trust and Other-Trust. Again, group means were not particularly high, but claims workers consistently showed a significantly higher prevalence in negative cognitive schemas on nine of the ten sub-scales, which are considered next.

4.1.1 Safety beliefs.

Cognitive schemas about safety are very vulnerable to vicarious trauma (McCann & Pearlman, 1990). Claims workers, who presented with the highest levels of vicarious trauma, indeed showed significantly higher levels of negativity in the areas of Self- and Other-Safety. The first mainly involves the perception of safety from external dangers, but also one's own destructive thoughts and impulses. Other-Safety captures the degree of concern the person has about the safety of loved ones. As expected, due to the relative absence of traumatised clients, holiday booking consultants

exhibited the fewest negative schemas in these areas. Claims workers clearly felt the most unsafe, and even more so when it came to the safety of loved ones.

Considering the high ratio of serious injuries, accidents, death and violent crimes claims workers come into contact with, it is understandable that these frightening events would challenge their safety beliefs. Especially in the case of violent crimes and accidents, there are serious contraventions of personal safety. Regular contact with clients who have experienced such contraventions have led to claims workers revisiting their own evaluations of safety, in part basing these beliefs on client experiences of the world as being hazardous and precarious. Trauma counsellors showed significantly more resilience in these areas. Their daily reality also involves many contraventions of personal safety described by clients. However, it is believed that they draw upon their training and insight into trauma responses and the risks associated with trauma work. Trauma counsellors also presented with significantly greater positive energy in their lives – including high levels of compassion satisfaction, social support and superior abilities to distance themselves from client traumata, which all seem to aid in preserving positive safety schemata.

Behavioural implications of negative safety beliefs could typically entail hyper-vigilance, an ever-present expectation to be victimised, or the loss of trust in one's own instincts (Hesse, 2003). Persons might even start feeling powerless, at complete mercy of life's capriciousness and as having very little efficacy in their lives and the world (McCann & Pearlman, 1990). Greater fearfulness and a sense of vulnerability were indeed expressed by claims workers:

> P57: "*I started realising that we are not safe*."
>
> P55: "*My job makes me cautious."*
>
> P66: "*Generally a hijacking incident [scares me], as it can happen to anyone at any time. It makes one think about when it will happen to me, and as we stay in Johannesburg it has happened to a lot of people I know, which is a scary thought."*

From this position of fear and vulnerability, it can be surmised that claims workers might be restricting their personal freedom of movement as well as that of loved ones. Loss of personal autonomy is often an effect associated with uprooted safety beliefs (McCann & Pearlman, 1990). Furthermore, as suggested by their significantly fewer social ties, claims workers have likely also

decreased their levels of social activity. McCann and Pearlman (1990) point out that challenged beliefs commonly entail a loss of esteem for others or humankind in general, a notion that emerged very strongly in the present study, clearly demonstrating that constant dealings with clients around heinous acts do come at a cost.

4.1.2 Esteem beliefs.

In continuation of the subject of esteem, vicarious trauma can impact upon the psychological need to view ourselves and others as benevolent and worthy of respect (McCann & Pearlman, 1990). Group means in the areas of Self- and Other-Esteem were relatively low, signifying less negativity in these areas. However, claims workers demonstrated significantly greater negativity, indicating that their esteem for themselves and others has nevertheless been impinged upon.

Affected persons increasingly view themselves as undeserving of good fortune, not being particularly likeable and, in extreme cases, to be evil. Those affected also often question their own self-worth, wondering what use they are if they cannot help others? (Hesse, 2003). Claims workers did in fact express strong feelings of inadequacy. Through the qualitative data, a number of them expressed a need for a more sophisticated skills-set to better assist traumatised clients, wanting to alleviate their emotional pain. Some described paralysis and even panic when faced with traumatised clients. Discontent with their inability to assist more effectively seems to be affecting their feelings of self-worth.

A decline in self-esteem is also often flanked by the person devaluing, criticising and taking a cynical stance towards the capabilities and worth of others (Hesse, 2003). Moreover, the discrepancy between positive beliefs about people, and the reality of what humans are capable of, can further augment loss of esteem for the human race (McCann & Pearlman, 1990). Also, Other-Esteem scores for the sample showed that beliefs in this area were more adversely affected than for Self-Esteem. This is to be expected considering the many heinous acts, perpetrated by others, that claims workers and trauma counsellors constantly deal with.

Furthermore, anger is commonly an outward expression over the perceived malevolence of the world and the painful shattering of cherished idealisms (McCann & Pearlman, 1990). Anger at humankind was especially an issue for trauma counsellors. Almost a third of them presented with anger towards perpetrators over the suffering they have caused. Of course, anger was also a salient issue for holiday booking consultants, but was mostly in response to client anger and abuse. In

addition, trauma counsellors and claims workers used words expressing horror with similar frequency, pointing towards shared feelings of repugnance towards mankind.

Considering that claims workers deal with so many violent crimes, torture and even instances of rape, their expressions of anger were surprisingly few. They reacted more with shock and fear. This tendency makes sense when considering that the traumatised clients most often encountered by them are crime and accident survivors. Carlson and Dutton (2003) found the most common psychological difficulty in crime victims to be post-traumatic stress symptoms, fear and various phobias (Carlson & Dutton, 2003). Nearly one-third of vehicle accident victims investigated by Bryant and Harvey (1996) presented with post-traumatic stress disorder and anxiety.

Hickling and Blanchard (1992) also reported a very high prevalence in post-traumatic stress symptoms, anxiety and phobias in their study of vehicle accident survivors. The set of reactions to a traumatic event presented by the DSM-IV, entail feelings of horror, intense fear, helplessness, shock and disbelief (Barlow & Durand, 2001). In the wake of such events, insurance clients are likely to exhibit these responses. From a contagion point of view, the more shock and fear clients present with, the more likely it is that these emotions will be "caught" and expressed by claims workers. The next area under investigation is that of control.

4.1.3 Control beliefs.

Those affected by vicarious trauma often lose their sense of personal control (McCann & Pearlman, 1990). The Self-Control sub-scale gauges the level of comfort with being oneself, being in control of one's faculties and emotions as well as the level of acceptance of help from others. Other-Control refers to the person's ability to relinquish control and take instruction. It also gauges whether the person is controlling or perceives to be controlled. Along both dimensions, significant differences were observed between the claims workers and the other two groups. Alongside the vulnerability expressed by the claims workers, they also expressed a sense of helplessness or feeling that they have very little power and control in the world.

Affected persons often inappropriately incite traumatised individuals to take action instead of empathising with them (McCann & Pearlman, 1990). The affected person is also sometimes domineering in work situations and ill-at-ease when someone else takes the lead, finding it difficult to relinquish what little control they do have. They might also become controlling in personal relationships (Hesse, 2003). The claims workers did in fact describe the most relationship problems

out of the three groups, involving 20% of this group. Relationship difficulties stemming from unhelpful cognitive schemata could be further contributing to the significantly smaller support networks presented by claims workers. Also, as illustrated by the qualitative data, powerlessness when interacting with traumatised individuals was articulated with equal frequency by claims workers and trauma counsellors, compared to holiday booking consultants who very rarely articulated a sense of helplessness.

The many claims workers who expressed a need to do more for trauma clients further suggest a position of compromised control. Discomfort evoked by their own sense of helplessness might instil strong impulses to take control of the client's emotional state, in an effort to restore their personal sense of control. An interesting, extreme position was illustrated by one claims worker in particular. He was preoccupied with the desire to avenge a loss he had recently suffered. McCann and Pearlman (1990) point out that such ideation is not uncommon where one's power and efficacy come into question. They explain that the affected person often feels that taking revenge would somehow reaffirm their personal power. The next needs area is that of intimacy.

4.1.4 Intimacy beliefs.

Vicarious trauma is believed to also impact upon our psychological need to be connected to others and ourselves (Pearlman & Mac Ian, 1995). The Self-Intimacy sub-scale measures the degree of closeness or disconnectedness from oneself, the ability to self-soothe, how available persons are to themselves and the level of comfort when alone. Other-Intimacy gauges the degree of closeness or disconnectedness from others and the extent of feeling loved. Claims workers again presented with significantly higher negativity in these areas. Typically, affected persons are constantly at odds with a world they feel separated from (McCann & Pearlman, 1990).

Those affected are in daily confrontation with themselves, feel disconnected from themselves and others, experience a precarious sense of self-cohesion, and experience constant fear and dissociation (Pearlman, 1998). Some of the claims workers did in fact describe similar effects in the qualitative data, especially feelings of disconnect, fear and dissociation. Their loss of faith in mankind could further fuel feelings of alienation. The person eventually becomes emotionally unavailable to both loved ones and to themselves (Hesse, 2003).

Hesse further states that negative changes in self-capacities – to maintain a positive sense of self and a sense of connectedness to others – often have undesirable results. Emotional numbing as well

as numbing behaviours such as overeating, excessive alcohol intake, overworking or overspending are common (Hesse, 2003). A sense of numbness was described by nine percent of trauma counsellors and two percent of claims workers. Typical numbing behaviours were described by a further four percent of claims workers. The next dimension to be considered is that of trust.

4.1.5 Trust beliefs.

Beliefs about trust are often shattered by vicarious trauma (Pearlman & McCann, 1990). Self-Trust refers to the level of dependability on the self, whereas Other-Trust refers to the level of trust placed in others. No significant difference was detected for Self-Trust, which means that the prevalence/absence of negative cognitive schemas in this area was very similar across the worker groups. The group item means were not particularly high, which indicates that beliefs in the area of Self-Trust were reasonably unaffected. Participants therefore mostly trust in their own judgement, instincts, ability to make decisions and generally do not experience high levels of self-doubt. Therefore, constant exposure to traumatised clients on the one hand, and client anger and rudeness on the other, has not had a dramatic effect on the level of trust participants place in themselves and their capabilities.

However, claims workers demonstrated significantly greater negative cognitive schemas in the area of Other-Trust. Hearing about the many acts of deception, cruelty, betrayal and violation of trust perpetrated against insurance clients have clearly impacted upon the level of trust they confide in others. Trauma counsellors, who deal with even more of these atrocities, showed significantly greater resilience in this area. Training, supervision, self-care, greater levels of social support and more compassion satisfaction seem to largely shield them from negativity in this area. Those with trust issues usually demonstrate distrust, cynicism and suspicion towards the motives of others (McCann & Pearlman, 1990). This can become especially problematic when intimate partners, friends, and family are viewed with the same mistrustful eye, causing considerable tension (Hesse, 2003). As highlighted before, 20% of claims workers described relationship problems and conflict, as well as 17% of holiday booking consultants and 15% of trauma counsellors. Of course, mistrust and conflict with others could again in part explain why claims workers have considerably smaller support networks and the least sufficient social support.

In conclusion, different patterns of effects were elicited by the very different clientele and work contexts of each worker group; however, claims workers consistently presented with the highest

levels of negativity in their cognitive schemas in all needs areas except Self-Trust. The next section looks at effects at the physical level.

5 Negative Physical Outcomes

Physical health is another intrapersonal level believed to be adversely affected by vicarious traumatisation. There is mounting evidence that psychological trauma bears strong associations with poor health, and that continuous exposure to traumatic stress is linked to increased risks and incidences of serious, acute and chronic physical illnesses (Norman *et al*., 2006).

Participants in the present study described many ailments they believe were caused by work-stress. Claims workers and trauma counsellors have the added burden of secondary traumatic stress that can could further influence their health. The claims workers indeed expressed a strong belief that work-stress and the unrelenting pressure of dealing with clients in crisis are contributing to their illnesses. A large percentage also described a decline in their general health and well-being in unrelated parts of the questionnaire, which they partly attributed to work-pressure. They described chronic fatigue, prevailing lack of energy, restlessness, feeling run-down and even experiencing excessive weight-gain. Four percent of claims workers reported trouble sleeping. Claims worker P67 described how encounters with distressed clients tend to surface when sleep is slow to come:

> *"[I] try my best to block it out. It is hard not to think about it. Especially when I have trouble sleeping.*"

Claims worker P90 felt that her immunity is compromised due to chronic stress:

> "*I am very susceptible to infections and feel run down.*"

Furthermore, claims worker P60 described being ill so often over the past six months that her annual sick-leave quota was insufficient:

> "*Every month I took sick leave and even took annual leave because I was sick.*"

Booysen (2005) described similar chronic health complaints in her sample of caregivers, which also included chronic tiredness, persisting lethargy and susceptibility to infection. Annscheutz (1999) found that if the initial warning signals of cumulative stress are ignored, illness often sets in. She

states that neglect persisting for as little as six to 18 months could cause mild physical symptoms such as sleep disturbances, frequent headaches, infections, muscle aches as well as constant fatigue. If ignored, these milder symptoms can take on a more serious, chronic form, what she refers to as "*entrenched cumulative stress*", often requiring medical attention (Annschuetz, 1999, p. 18). Annsheutz explains that it is usually in the entrenched phase that chronic symptoms such as fatigue, depression, anxiety and even alcohol or drug abuse emerge, most of which were reported by participants in the present study. Claims worker P93 described the toll that work-stress took on her body:

> "*The stress at work might have contributed a little to my miscarriage.*"

Many of the trauma counsellors also felt confident that work-stress played a part in their illnesses. This was significantly less so than for claims workers, who expressed more than double the number of health complaints. However, some of the trauma counsellors, including P25, felt run-down or burnt out, compromising their vitality and immune systems:

> "*[Work-stress]* r*esulting in getting "flu" symptoms easily as body was tired. Sometimes feel a lack of energy causing me to be tired.*"

Trauma counsellor P44 described a more serious health-scare, unequivocally from work-stress:

> "*My health scare was stress related, which shows that I am over-extending myself. I am now forced to take better care of myself, for the sake of my health and am forced to manage my stress (which I work hard at, but find very, very difficult).* "

As in the case of claims workers, trauma counsellors also described health-related difficulties that cropped up in unrelated parts of the data. Some described problems similar to claims workers, whereas others described specific problems such as stress-related back-pain and elevated blood-pressure. Murphy (1996) reported that blood-pressure and problems stemming from chronic muscle tension are common psycho-physiological complaints from stress. Finally, a number of trauma counsellors also reported difficulties falling or staying asleep:

> P25: "*[I] Sometimes wake up at night or wake up early.*"

By contrast, only six percent of holiday booking consultants – the lowest percentage out of the three groups – felt that stresses at work contributed to recent illnesses. The three worker groups all function in high-pressure call-centre environments with similar monitoring, time-management and work-productivity mechanisms. They also share similar challenges from management and the work environment that negatively influence organisational climate. However, holiday booking consultants reported less than a fifth of the health complaints reported by claims workers, and less than a third of the complaints presented by trauma counsellors. Holiday booking consultants not being affected in nearly the same way suggests that there is another stressor at play – that of dealing with traumatised individuals. These results clearly indicate that vicarious trauma is taking a toll on the health of exposed workers. The discussion next looks at additional ways in which positive energy can be introduced into workers' lives.

6 Other Important Sources of Positivity

Compassion satisfaction and effectively disengaging from client trauma were discussed as avenues to positive energy. However, administrative workers seemingly do not benefit nearly enough from these positive avenues proposed by Figley's model, expressing a need for additional avenues. They have to utilise whatever resources they have at their disposal, and the study found that self-care and social support are vital. These two concepts were also earmarked due to their strong theoretical associations with post-traumatic growth and positive adjustment (*e.g*. Cook & Bickman, 1990; Figley, 2002b; Salston & Figley. 2003). Self-care and social support are often extolled by Figley as having preventative and ameliorative powers (2002a; 2002b).

6.1 Self-care.

The importance of self-care was emphasised at various junctures and has been clearly linked to the treatment and prevention of vicarious trauma outcomes (Figley, 2002a; 2002b). Furthermore, self-care strategies need not be complicated or enigmatic and often-times, even the simplest of strategies are effective (Gentry, 2002). Many authors share the optimism that secondary traumatic stress is preventable, responsive to treatment and rapidly abating (Clemans, 2006; Salston & Figley, 2003; Gentry, 2002).

For instance, self-soothing, forging a connection with others, vigilance about negative symptoms and anxiety management are simple yet effective self-care strategies (Gentry, 2002). Figley (2002b) agrees that investing in relationships and self-care activities significantly reduces negative effects associated with vicarious trauma. However, warding off negative outcomes can be rather complex.

Such is human nature that we tend to ignore distress until it reaches a threshold of discomfort (Gentry, 2002). Those affected are often unable to perform their jobs well as symptoms begin to set in and intensify. Others are set on a path to systematic decline and even debilitating somatic symptoms. Often shame and guilt are experienced, with the person anguishing over secretive comfort-seeking and self-destructive behaviours (Gentry, 2002). Claims worker P87 expressed guilt over experiencing joy in the wake of serious client trauma:

> *"I felt guilty every time I had fun for a few days*"

Gentry (2002) further found that many affected individuals become over-involved and enmeshed in their careers. Indeed, a number of claims workers did describe feeling so deeply concerned for their clients that they reached out to them in their personal capacity. As heart-warming as these gestures might seem, these workers are too embroiled in their client's well-being and are over-extending themselves. Gentry (2002) also states that affected individuals often blindly chase after the approval and validation from others, such as clients, colleagues and managers, to bolster their self-worth and the belief that they are making a worthy contribution.

For those who operate from this other-validated position, it is debilitating when approval is not continuously forthcoming. These misguided perceptions are further advanced by secondary traumatic stress. The outcome is often high levels of anxiety, an overwhelming sense of powerlessness and even feelings of victimisation (Gentry, 2002). As stated before, the claims worker group was dominated by anxiety and often described a state of helplessness and paralysis when faced with traumatised clients. Only once the person matures into a self-validated position, settling into a calm grounding in the present, will these symptoms dissipate (Gentry, 2002).

Gentry also emphasises the risks of basing one's self-worth on professional achievement alone. He strongly advises that one should seek spiritual sustenance outside of one's vocation. Radey and Figley (2007) share these sentiments, whereby people often feel that they cannot take time off, exercise, or indulge in activities that they find relaxing and enjoyable. They mostly find, only once the person recognises that their self-neglect is hurting clients, that workers become more self-nurturing.

Radey and Figley (2007) emphasise the importance of strategies to combat the many negative outcomes associated with vicarious trauma. The themes of self-neglect and self-care emerged from

the qualitative data prominently and spontaneously. Combined, these two topics involved as much as 28% of the sample. In most cases, claims workers and trauma counsellors knowingly disregarded themselves, pushing themselves beyond their limits. The first two statements are from trauma counsellors, followed by two statements from claims workers to exemplify instances of self-neglect:

P22: *"[I have] very little time for myself. [I] feel there is no time to partake in activities that I enjoy."*

P42: *"I often neglect myself, friends and family for work."*

P86: *"It [work] takes up most of my day and some evenings and the odd Saturday. This time I could spend with my family or do things that I enjoy doing."*

P68: *"[I have] to be at work on Saturdays when I need to rest."*

Regarding self-care alone, 12% of the sample expressed a need for improvement. Expressing an awareness of being over-extended as well as recognising that one could benefit from self-care is already a step in the right direction. Even though self-care is an important practice in any person's life to combat the unique stresses of modern and urban life, it becomes especially important in those with added perils from the work environment, such as vicarious trauma. Even though the need for self-care was verbalised most strongly by holiday booking consultants, claims workers presented with far greater incidences of negative outcomes, making self-care most crucial to them.

Furthermore, as many as 20% of claims workers described how they have to "stay strong" for their clients, continuously having to put aside their own feelings and needs for the sake of clients. Some of these workers also felt that they constantly had to place the client's needs ahead of their own to the point where it left them feeling devalued. A few others, when asked what their management could possibly do to improve their situation, refrained from making any suggestions as they felt it to be futile. Their despondency was palpable and it is clear that they are in need of inspiration and upliftment.

Radey and Figley (2007) ask how persons can flourish while continuously letting their hearts go out and burdening themselves with the pain of others? They pose the conundrum that compassion, empathy and altruism are critical to survival and flourishing, but can also systematically deplete vital energy, leaving one in harm's way. They offer two solutions – to avoid negativity, which is near impossible when dealing with traumatised populations – or to transform it. They suggest a three-pronged approach. Firstly, one has to increase positive affect and maintain a positive attitude. This can be done by not only focusing on difficulties, but equally on successes (Radey & Figley, 2007). All three worker groups described a tendency from managers to focus only on the negative without offering any accolades for achievement. Six percent of both claims workers and trauma counsellors respectively aired the issue. Another six percent of the claims workers suggested incentives for merit to keep staff morale high. Ten percent of the sample spoke of a cold and impersonal approach from managers or feeling unappreciated or undervalued, of which only one percent extended to holiday booking consultants.

The second strategy involves increasing resources to manage stress – also secondary traumatic stress – such as finding inspiration and joy. As stated earlier, Figley (2002b) has found humour to have a dramatic effect on stress levels. Indeed laughter could prove to be the best medicine. Mora-Ripoll (2010) performed a review of literature on laughter to capture major health benefits. This literature extolled laughter as harbouring psychological, physiological, spiritual, quality-of-life as well as social benefits. This joyful bodily response, involving more than 300 muscles, has been found to produce remarkable emotional and psychological shifts (Mora-Ripoll, 2010). It induces cardiovascular and respiratory changes and fires certain neuro-endocrine and immune circuits.

Laughter was found to have quantifiable positive health benefits and is labelled a broad-spectrum healing agent (Mora-Ripoll, 2010). Gentry (2002) found that professionals who responsibly pursue a sense of aliveness derive a richness and joy that inspire others, also clients. Increased self-care is the third pivotal point. Radey and Figley (2007) urge that any profession involving hardship and trauma requires a continued quest for inspiration and positive revitalising energy. In this way one can create a crucible for transforming pain and negativity into compassion satisfaction (Gentry, 2002). To reiterate, claims workers presented with the most negative outcomes associated with vicarious trauma, and they largely lack the training, resources and insight that trauma counsellors are believed to have, and they exhibited inadequate work-based and social support. The qualitative data showed that claims workers grossly underutilise their wellness plans, a precious resource going by the wayside. Given their limited resources, and probably those of other administrative groups

dealing with traumatised clients, self-care offers definite promise. Approaches as remarkably simple, viable, effective and inexpensive as these simply cannot be left unexploited. Another positive avenue, that of social support, is looked at next.

6.2 Social Support.

Social support is another concept that fosters the potential of diminishing residual stress from client traumata. Whereas detachment and a sense of satisfaction are intrapersonal concepts, social support falls in the interpersonal realm of functioning. However, it could hold intrapersonal, interpersonal and organisational benefits, and has strong theoretical ties to post-traumatic growth and positive adjustment (Figley, 2002b). As stated before, even though social support does not form part of Figley's model, its importance in psychological well-being is often acknowledged (*e.g*. Radey & Figley, 2007; Salston & Figley. 2003). The analysis performed in the present study also flagged social support to be of notable importance to claims workers in particular.

Furthermore, in line with Alan and Ortlepp's (2000) findings, perceived social support in the present study largely stemmed from two contexts. The first one, that of work-based support, refers to support from the work context, whereas non-work-based support refers to family, friends and a diversity of other personal supports. The discussion of the social support results is looked at within these two contexts.

6.2.1 Work-based support.

Social support has been identified as a crucial factor in diminishing occupational stress and enhancing health (Alan & Ortlepp, 2000; Lutrin, 2005). It has also been identified as an important correlate in decreasing and preventing vicarious trauma outcomes (*e.g*. Baird & Kracen, 2006; Dunkley & Whelan, 2006b; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). Some studies have indicated that work-based support from colleagues, managers and supervisors is more important in diminishing work-related stress than non-work-based support (Alan & Ortlepp, 2000).

Firstly, Stepwise Regression analysis identified social support, in relation to compassion satisfaction and empathy, to be the least powerful predictor for secondary traumatic stress. This perhaps in part explains why social support is not featured by Figley's model of compassion fatigue (2002a). However, social support emerged as the strongest predictor of negative cognitive schemas, suggesting that it is especially important in protecting cognitive schemas about the self, others and the

world. As stated before, surrounding oneself with caring individuals provides affirmation that there are still good, kind and loving people, despite constant exposure to the dark side of humanity.

On the work front, the qualitative data indicated very little collegial support. Less than one percent of the sample's social network consisted of colleagues, such as co-workers, supervisors, managers and employers. As highlighted before, statements regarding ineffectual and unsupportive management involved as many as 21% of the sample. The claims workers seemed to be affected most negatively whereby as many as 28% did not feel supported or valued by their managers. They felt that the management style creates stress and lacks support and guidance. Lutrin (2005) reported that feelings of being undervalued have often been identified as a major risk factor for increased stress and diminished psychological and physical well-being among workers.

Furthermore, only 16% of claims workers had a high regard and high level of satisfaction for the support from their work context. As much as 32% of claims workers felt that they were not receiving support from their work context at all. Social support was also an issue for the other two worker groups, though to a lesser extent as, by comparison, 11% of trauma counsellors and 25% of the booking consultants felt that they were not supported by their work contexts. There seems to be room for improvement in all three worker groups; however, the claims workers and trauma counsellors have the added risk of vicarious trauma. This makes a resource such as a support system especially important.

Furthermore, there is evidence that supervisory support is the most significant form of work-based support (Alan & Ortlepp, 2000). Participants did in fact express a need for more support of this nature. Of the claims worker group, 14% requested that debriefing or counselling be more readily available. The qualitative data showed that claims workers and trauma counsellors are seriously underutilising the wellness programmes at their disposal. It is quite saddening that this significant resource is not being utilised fully. As many as 20% of claims workers and 21% of trauma counsellors did not realise that they had a counselling service available to them, which came as a surprise.

Furthermore, claims workers also felt that more support in general, such as help and consideration from management regarding the difficulties of dealing with clients in crisis, would make a considerable difference. Some claims workers suggested group debriefings to have an open dialogue with colleagues and to learn from each other. They felt that they could share coping

strategies and ways to deal more effectively with typical challenges encountered in their unique contexts. In this light, Gentry (2002) confirms that sharing with colleagues is a sound starting point to a self-care practice and in resolving negative energy. Trauma counsellors also expressed a need for more supervision, debriefing and counselling. By contrast, only four percent of the booking consultants asked for more work-based support.

However, as in the case of empathy, social support is also complicated and somewhat paradoxical in nature. For one, not all collegial or support relationships are created equal. Some studies have even found a counter-intuitive positive correlation between social support and psychological distress (Basedau, 2004; Esprey, 1996). One has to be cognisant that social support, as helpful as they might be, can also be a major source of stress (Lutrin, 2005). As stated in the preceding paragraphs, 28% of claims workers, 11% of trauma counsellors and 25% of holiday booking consultants found worker-management relationships to generate stress.

This issue was aired again, but his time in relation to colleagues. Ten percent of the sample found collegial relationships to generate stress. However, these complaints were mostly articulated by trauma counsellors and holiday booking consultants. They found some colleagues to be a hindrance and a source of stress rather than being supportive. A sense of disconnectedness, colleagues' attitudes and lack of responsibility were mostly stressed. Problems stemming from having to depend on unreliable colleagues further impinged upon group solidarity and teamwork.

The data in the present study clearly illustrated that social support not only boils down to quantity, but also quality. Figley (2002a) agrees that relationships can be toxic and suggests that relationships be re-evaluated regularly to eliminate those that are unhelpful. Social support also entails balance. Basedau (2004) points out that social support, in moderation, seems to be most advantageous. Lending too much support, to a point of over-involvement, is as counter-productive. The difficulty of striking this balance became quite apparent from the opposing qualitative data from trauma counsellors. For instance, at the one end, they described how over-zealous managers stifled and smothered them and left them with little autonomy. At the other end, they expressed feelings of complete isolation and desertion. Leaning towards either end of the support continuum clearly has equally undesirable outcomes.

Finally, the need for a greater sense of community among staff also emerged. Of the claims workers, four percent stated that team-building activities and opportunities to get to know one another

would improve feelings of community. This need was expressed most strongly by those trauma counsellors who felt isolated at work, whereby 15% of them welcomed team-building opportunities and increased social contact at and away from work. Four percent of the holiday booking consultants expressed a need for greater community and team building activities to improve group cohesion. These statements bear relevance to social support, as a greater sense of group cohesion would improve worker relations, and ultimately help consolidate collegial support. Such work-based support is important as Michie and Williams (2003) found its absence to be key in poor psychological health and illness-related absenteeism in a diversity of workers.

Despite the study revealing a strong sense of satisfaction with the perceived social support among participants, secondary traumatic stress scores were nonetheless elevated in claims workers. Therefore, satisfactory levels of familial support, on their own, are insufficient to diminish secondary traumatic stress. Figley states that it is not only vital to increase the number of supports, but also the variety of relationships (2002a). The qualitative data identified a clear lacuna in work-based support that needs improvement. It is believed that quality, but moderate levels of collegial, managerial and supervisory support, in addition to familial support, would make a marked difference in reducing vicarious trauma outcomes. Next, non-work-based social support is discussed.

6.2.2 Non-work-based support.

Basedau (2004) identified social support as the variable that receives the most attention in relation to better psychological outcomes. Despite the misgivings about social support expressed towards the end of the previous section, most authors concur on the helpful nature of social ties (Chronister *et al*., 2006; Mirzamani, 2006; Wilson & Boden, 2008). Basedau (2004) extols the importance of familial relationships, as families with greater cohesion mostly experience fewer negative outcomes, including post-traumatic stress symptoms, in the aftermath of trauma.

The qualitative data from the sample showed that participants across the worker groups mostly lean on nuclear and extended family, followed by friends. Furthermore, as many as 90% of participants indicated being very satisfied with their non-work-based support. The largely beneficial nature of social support was further echoed by the quantitative data, in that a significant inverse relationship between social support and the vicarious trauma measures was established by the Pearson *r* correlation tests.

This implies that those with higher levels of support exhibit significantly lower levels of secondary traumatic stress and negative cognitive schemas, and vice versa. These results illustrate the bolstering nature of social support that can counteract negative outcomes. Also, a significant relationship between social support and compassion satisfaction indicated that perceived social support replenishes one emotionally. Those participants who were well supported, more readily reached out to clients and viewed their compassion responses to be constructive and helpful. Those who did not experience high levels of compassion satisfaction were generally more distressed and socially withdrawn.

This clearly illustrates the notion that secondary traumatic stress, as with post-traumatic stress disorder, causes the person to withdraw from others, including family and friends. According to Basedau (2004) those affected by post-traumatic stress often show a marked decrease in social interaction, confirming the corrosive nature of vicarious trauma which not only erodes one's emotional reserves but also one's support network. Coupled with a fear of being victimised in the same ways as described by clients, it is comprehensible how social activities and support can quickly wane.

Next, Pearson *r* correlation tests results for each of the worker groups were varied. For instance, social support did not show a noteworthy relationship with secondary traumatic stress, limited to trauma counsellors. Or so it seemed. Trauma counsellors exhibited significantly higher levels of social support compared to claims workers, having presented with the largest and most varied support network out of the three groups. This suggests that they are well supported as a rule and therefore presented with less variability in social support scores, which obscured the role of social support. Therefore, this result does not mean that social support had no bearing on secondary traumatic stress. There were merely too few cases to illustrate what effects the absence of social support would have on secondary traumatic stress in this group. This is not surprising, as trauma counsellors are, by virtue, caregivers and helpers who constantly reach out to others and form nurturing connections, which also extends to the social realm.

As indicated earlier, social support is especially vital in the preservation of healthy cognitive schemata. Those with less social support harboured considerably more negative beliefs, and this suggests that the integrity of healthy cognitive schemata is under threat in the absence of social support, even in professionals, such as trauma counsellors. The importance of nurturing, restorative social relationships to continuously remind the person that people are inherently good and the world

is benevolent, was highlighted before. Uplifting social contact is crucial to prevent the person from anchoring their beliefs in the distress of clients, or negatively distorting their cognitive schemas and their frames of reference. This suggests that positive energy from social support can in fact repair the damage caused by repeated trauma exposures. The protective power of social support became even more apparent as claims workers, with the least social support, also showed the most negative outcomes in terms of secondary traumatic stress, negative cognitive schemas, personal distress from empathic engagements as well as the lowest levels of compassion satisfaction.

It can be concluded from these combined results that social support is a psychosocial resource of great importance, especially to claims workers and possibly also other administrative populations working with traumatised clients. As stated before, these populations lack training as well as the resources clinicians are traditionally believed to have access to, leaving them with fewer sources of positive energy to sustain them. Therefore, they have to embrace whatever resources are available to them, even one as rudimentary as social support. Even holiday booking consultants, who do not have the added pressure of traumatised clients, seem to benefit significantly from social support in dealing with challenging clients. Next, effects that reach beyond the affected individual are considered.

7 Other Effects Beyond the Person

At various junctures, it was described how vicarious trauma relates to bio-psychosocial theory, in that effects such as secondary traumatic stress, negative cognitive schemas and poor health, permeate all aspects of life. Naturally, the affected person does not exist within a vacuum. The many intrapersonal effects discussed thus far can cause interpersonal and social difficulties. Interpersonal problems were discussed earlier, where participations described conflict with loved ones and other relationship problems.

Work-based as well as non-work-based support systems were looked at as well as how fear, suspicion and social withdrawal associated with secondary traumatic stress can create problems within this domain. It was also considered how negative beliefs within the various needs areas can impact on relationships, social interaction and support. It was also suggested that others might avoid those affected by vicarious trauma due to the negativity they exude. Many health complaints were discussed, where resultant absenteeism would hold serious interpersonal implications, affecting colleagues as well as organisations. Further effects in the work domain are considered next.

7.1 Vicarious trauma in the workplace.

Stress, in whatever form, is undeniably one of the biggest health challenges of our time (Coetzer & Rothmann, 2002; Lu *et al*., 1999). It is destructive and cumulative, and if charged with the additional stress of dealing with the trauma of others, persons can easily become overwhelmed, pushing them beyond their coping capabilities. Dealing with client traumata is a reality for many workers, as is the case with short-term insurance claims workers. When considering some of the effects discussed thus far, a sense emerges of how vicarious trauma can impact on the workplace, especially in an administrative setting.

Firstly, it was explained how trauma exposure and empathy are the pathways which set vicarious trauma into motion. Contagion theory was utilised to demonstrate how negative emotions, including trauma, can be passed from client to worker, after which it is disseminated into the organisation, even converging into a recognisable group-mood. It was considered how entire organisations can become trapped in an emotional circuit matching that of the client-group.

Annscheutz (1999) admonishes that organisations can increase the likelihood of vicarious trauma when they do not provide sufficient respite for their staff. Inadequate leave or time off, unrealistically high workloads and insufficient supervision can increase the risks of vicarious trauma. Not acknowledging the effects, pervasiveness and seriousness of client traumata, failing to support staff in identifying or addressing the signs of vicarious trauma and not providing continued education can have further ramifications (Saakvitne & Pearlman, 1996). Interestingly, all of the aforementioned issues where raised by participants in the present study in one way or another, substantiating their significance.

Furthermore, avenues for positive energy were largely found to be deficient in claims workers in particular. For instance, they presented with the lowest levels of compassion satisfaction and social support. It was stated before that lack of social support can promote sickness-related absenteeism in workers (Michie & Williams, 2003). Claims workers indeed presented with the highest levels of negative effects and health-related complaints. In addition, claims workers admitted most often to utilising sick-leave as a coping mechanism out of the three worker groups, involving as much as 46% of this group. One claims worker admitted to utilising as much as 90% of available sick leave to escape work-pressure. Others disclosed doing so more often than they felt comfortable admitting. Claims worker P78 made this comment:

"[There is] nothing that I can't handle in life"

However, this same person later admitted to anaesthetising himself with alcohol to a point where it contributed to absences from work. This person stated that financial instability and the stresses from assisting clients in crisis were the most significant sources of stress in his life.

A South African study, conducted by Booysen (2005, p. 47) also found caregivers in her sample to use sick leave as "*a means to cope*". Mc Clenney (1992) found absenteeism to be one of the most costly universal problems faced by employers, amounting to hundreds of billions per annum. The loss of approximately 400 million workdays a year in the United Sates of America alone is attributed to unscheduled absenteeism (Mc Clenney, 1992). She describes how it causes friction and erodes the morale of co-workers who have to continuously stand in for absent colleagues.

To managers, absences may be a category of undesirable behaviour, whereas to the worker, it may be reflective of deep-seated feelings of unhappiness, especially over inequitable treatment at work (Mc Clenney, 1992). In the present study, unhappiness was in fact conveyed over several obstacles in the work-place. The claims workers articulated gripes with managers most often, involving 28% them. Most described the management style to be stressful and cold as well as unresponsive to their needs, while always giving precedence to client needs. Favouritism and lack of leadership were also clear impediments.

Similar gripes were verbalised by the other two worker groups, but, to a much lesser extent. Management style emerged as the third highest source of stress across worker groups, raised by 21% of the sample, affecting claims workers the most. For the organisation, such a management style could hold serious ramifications. Apart from loss in revenue and the strain caused by high levels of unauthorised absenteeism, staff attrition is another complication. Suri and Soni (2007) caution that a detached management style, leaning more towards productivity while neglecting staff needs, makes staff retention even more challenging.

In addition, claims workers expressed the lowest levels of compassion satisfaction, concomitant to the greatest need for more developed skills-sets. Mc Clenney (1992) and Josias (2005) cited several studies where a clear link was found between a lack of satisfaction in the work-place and elevated absenteeism rates. If claims workers are not satisfied with their compassion response and emotional assistance to clients, chances are that their overall job satisfaction could also be compromised.

High levels of non-illness-related absences echoed their palpable sense of dissatisfaction. As budgetary pressures and competitiveness of companies increase, also in South Africa, absenteeism is viewed in a progressively serious light. Organisations globally are increasing attention to reducing costs as well as the detrimental effects on productivity associated with unauthorised absences from work (Josias, 2005). Some African organisations have introduced certain incentives for workers with no absences and have shifted to using absence rates as a key worker performance indicator (Josias, 2005).

Another serious problem that has come to researchers' attention, is that of workplace violence due to stress. Conflict is most often produced in workplaces with high-demand/low-control, or high-effort/low-reward environments (Annschuetz, 1999). Claims workers in particular felt that they were not salaried according to their worth and most often expressed gripes about management focusing more on mistakes and disregarding achievements. Within this setting, many workers might feel that their efforts far exceeded their reward which could augment conflict in the workplace and, in extreme cases, even culminate in workplace violence. Annschuetz further explains that a burdensome workload coupled with a sense of powerlessness or injustice can quickly cause workers to reach the limits of their abilities to cope.

Furthermore, the array of negative cognitive effects excavated earlier offers further insight into what worker relations might be like. Firstly, claims workers scored significantly higher on nine of the cognitive schema sub-scales, with the exception of Self-Trust. Group item means for Self-Trust were in the lower range of the sub-scale across worker groups, however, this does not rule out individuals with high levels of negativity in this area. In the work context, those with high Self-Trust scores would exhibit a host of problems, such as second-guessing themselves, being unable to make decisions, having little trust in their own judgement or instincts and expressing high levels of self-doubt. One need only think of the consequences these behaviours might have in environments where workers need to be confident and make speedy decisions under pressure.

In the work environment, those with high Other-Trust scores would be distrustful of colleagues, management and their motives. Distrust is never conducive to teamwork and healthy worker-relations. It is also easy to see how distrust might interfere where workers need to depend on one another. Lack of dependability among workers did emerge from the qualitative data, especially for trauma counsellors. It might be difficult to delegate and leave important tasks to those who are not trusted, and equally difficult to accept instruction from those whose motives are viewed with a

mistrustful eye. Similarly, distrust in the work domain would also seriously impair the relations between workers and their clientele.

Other-Safety might not have a particular bearing on the workplace. However, those expressing high levels of concerns about the safety of others might become stifling and controlling of the movement and freedom of others. They might constantly admonish those around them about lurking dangers and might be anxious, tense and unable to relax. Their apprehensiveness might instil anxiety in others. From an emotional contagion standpoint, the high levels of fear, anxiety and nervousness that was observed in the claims workers might be further propagated into the worker group, affecting their overall group-mood and job satisfaction.

Self-Esteem beliefs were also not impacted upon dramatically by client traumata. Although Self-Esteem was found to be rather impervious to disruption, claims workers nonetheless demonstrated significantly higher levels of negativity in this area compared to the other two groups. In the work environment, self-esteem issues can affect worker efficiency, decision-making abilities and worker confidence. Those affected might second-guess their efficiency, abilities to handle challenging situations as well as managing tasks. Mehrabian (1998) describes the most common negative effects in the area of self-esteem to be depression, anxiety, worry, lack of confidence and being uncertain of oneself.

Intuitively, someone exhibiting these traits might not perform well under pressure and might not take constructive criticism well. Healthy self-esteem is associated with optimism, effective stress facilitation and better emotion regulation (Mehrabian, 1998). Therefore, those affected might be more emotionally volatile, less able to deal with stress and less positive. Healthy self-esteem is also associated with better goal management (Mehrabian, 1998). Therefore, affected workers would likely be less driven and less able to set and attain goals satisfactorily, which could diminish their overall productivity. In a high-pressure, crisis-driven environment, as is the case for claims workers, an unproductive, unsure colleague might generate stress and unpopularity.

Next, those with negative beliefs in the area of Other-Esteem are likely to devalue, criticise, and become cynical about the capabilities and worth of others, behaviours that could generate friction among colleagues. Claims workers did in fact express dissatisfaction with managers and some colleagues quite strongly. Negative Other-Esteem might also cause the person not to take constructive criticism and direction well. They might hesitate to recognise and accept authority in

the work-place. Not valuing others might cause the person not to care about retaining clients. They might feel indifferent towards whether they are helping clients effectively or not or whether they are delivering quality service or not.

Workers with high Self-Control scores are likely to be explosive and highly strung, perhaps even prone to outbursts. Constantly having to contend with emotional volatility in the work-place would most certainly generate stress and unpopularity. Other-Control scores were also consistently higher for claims workers, meaning that overbearingness and unwillingness to relinquishing control to others would be more prevalent. Affected individuals would possibly find it difficult to accept authority, ask for help or to effectively follow instruction without feeling that their control is being usurped. They might find it difficult to delegate as they may want to remain in control of all aspects of their work, encumbering teamwork.

High levels of negativity in Self-Intimacy beliefs would cause affected workers to feel unable to comfort themselves in difficult situations and to effectively work unsupervised. As these individuals experience discomfort when left on their own, they would constantly need input and reassurance from others to function satisfactorily. Standing alienated from yourself also means that you probably do not realise your own potential and recognise your strengths. Such individuals may become emotionally unavailable to themselves and might become over-invested in the lives of clients (Hesse, 2002). Claims workers did in fact demonstrate a tendency to become over-involved in clients' lives in ways that went way beyond their duties. Although these acts might be moving, they show that these workers are unable to remain objective and to maintain a healthy distance from client traumata.

In cases where Other-Intimacy is affected, individuals feel alienated from others and within the work setting this might translate to feeling distant and even at odds with the group. Feeling like an outsider would frustrate teamwork, team spirit and group cohesiveness. Those affected might feel a lack of responsibility and perhaps even a diminished sense of loyalty to the group and its goals. Such a lack of commitment might also result in increased absenteeism from work and group activities, a trend most evident in claims workers. Those lacking Other-Intimacy might also show weak commitment to management and their organisation in general. As stated before, Ladebo (2009) found that those with weak commitment typically engage in withdrawal behaviours and perform poorly. Along with this distancing comes an erosion of one's sense of effectiveness. Affected persons are also mostly unwilling to participate in discretionary organisation-directed

citizenship behaviours, which refer to one's sense of personal responsibility to continuously assist the organisation and co-workers (Ladebo, 2009).

Finally, from the biographical data, claims workers showed the least career longevity. The bulk of workers attained up to four years of service, with a dramatic decline upwards of four years. Surprisingly, trauma counsellors showed the second least career longevity, with fewest participants in the nine to 12 years of service category. However, the trauma counsellors were the only worker group to achieve more than 17 years of service. It would seem that many trauma counsellors leave the profession after approximately nine years, whereas claims workers showed considerable attrition after only four years of service.

Attrition became especially apparent considering that holiday booking consultants attained upwards of five years of service nearly six times more often than did claims workers. Claims workers also showed a dramatic decline in workers over the age of 30. Only 13 of the 50 claims workers were older than 30 compared to 22 trauma counsellors and holiday booking consultants respectively. The claims worker group yielded only one person in the 41+ age category compared to 13 trauma counsellors and five holiday booking consultants, flagging high levels of career transience in claims workers.

High staff turn-over can be very costly in terms of the loss of talent, experience as well as the added costs of recruitment and training of new staff (Loi *et al*., 2006). In recent years, the objective of retaining human talent has become a greater challenge than ever before, owing to a shift that started in the 1990s (Suri & Soni, 2007). Workers have started to move away from a "*lifetime employment*" mindset towards "*owning their own career*" (Suri & Soni, 2007, p. 222). The latter involves workers no longer thinking in terms of staying in a profession, but being more geared towards collecting experience and knowledge from different organisations to enhance skills-set growth (Suri & Soni, 2007). When considering how companies have restructured, downsized and become more occupied with streamlining operations over the years, including in South Africa, the loss of worker confidence and loyalty is a logical end-result.

Other than high rates of natural attrition, poaching of talent and incidences of burnout are further contributing to resignations (Suri & Soni, 2007). These authors further add that attrition is especially apparent in high-stress environments. Managing attrition has become an immediate concern that has shifted more to the forefront in recent years. Given the aforementioned mind-shift

away from career longevity, the international recession, coupled with management issues and other areas of contention, effectively retaining staff has become especially challenging.

Furthermore, Sexton (1999) admonishes that, when experienced staff are lost, neophyte members are even more vulnerable to vicarious trauma. Moreover, workers exhibiting high levels of secondary traumatic stress, would exhibit high levels of the hallmark symptoms of post-traumatic stress disorder. From the quantitative data, claims workers indeed exhibited the highest arousal, avoidance and intrusion symptoms out of the three groups. In the work context, intrusion symptoms would result in difficulty in concentrating and remaining focused, as well as an increase in stress and anxiety. Under these circumstances, productivity would falter. Six percent of trauma counsellors did in fact mention intrusive thoughts or flashbacks in the qualitative data, whereas four percent of claims workers described reliving or being "*haunted*" by client experiences.

Those with high levels of avoidance symptoms might avoid dealing with traumatised individuals or particular clients. They might be filled with trepidation when confronted with traumatised clients. In extreme cases, the person might have recourse to avoid the workplace altogether. Claims workers did in fact often resort to avoiding the work-place, as indicated by 46% taking non-illness-related leaves of absence to cope. As stated earlier, costs incurred from high rates of absenteeism are astronomical (Josias, 2005).

Lastly, high levels of arousal could cause the person to be reactive, stressed and unable to remain composed. A tense, anxious work-mood is likely to further hamper team spirit, group cohesion and job satisfaction. Of course, more stress fuels an inability to cope and more illnesses, again resulting in escalated absences from work, a trend most pronounced in claims workers. Of course, high incidences of illness resulting in absenteeism, have serious interpersonal as well as organisational implications. Empirical evidence indicates that emotionally exhausted employees are often weakly committed to management and the organisations they work for (Ladebo, 2009). They often exercise a withdrawal cognitive style, by which persons cognitively and mentally distance themselves from their work as a way to cope with work demands.

It is believed that the discussion has illuminated how vicarious trauma affects the person, impacts upon family, friends and colleagues and "*infects*" worker groups and organisations. The snapshots of worker experiences offered by the present study collectively illustrate the great costs of dealing with client traumata and several reasons why this phenomenon cannot be dismissed. Vicarious

trauma has a reach of great depth and breadth, but is highly responsive to even the most modest of changes. Making these simple changes has the capability of not only reversing many of the effects, but to increase the person's general happiness and well-being.

The next chapter concludes the thesis by looking at recommendations, limitations and future directions for research.

CHAPTER NINE: CONCLUSION

Recommendations, Limitations and Future Research

1 Recommendations

1.1 Revision of Figley's model for administrative workers.

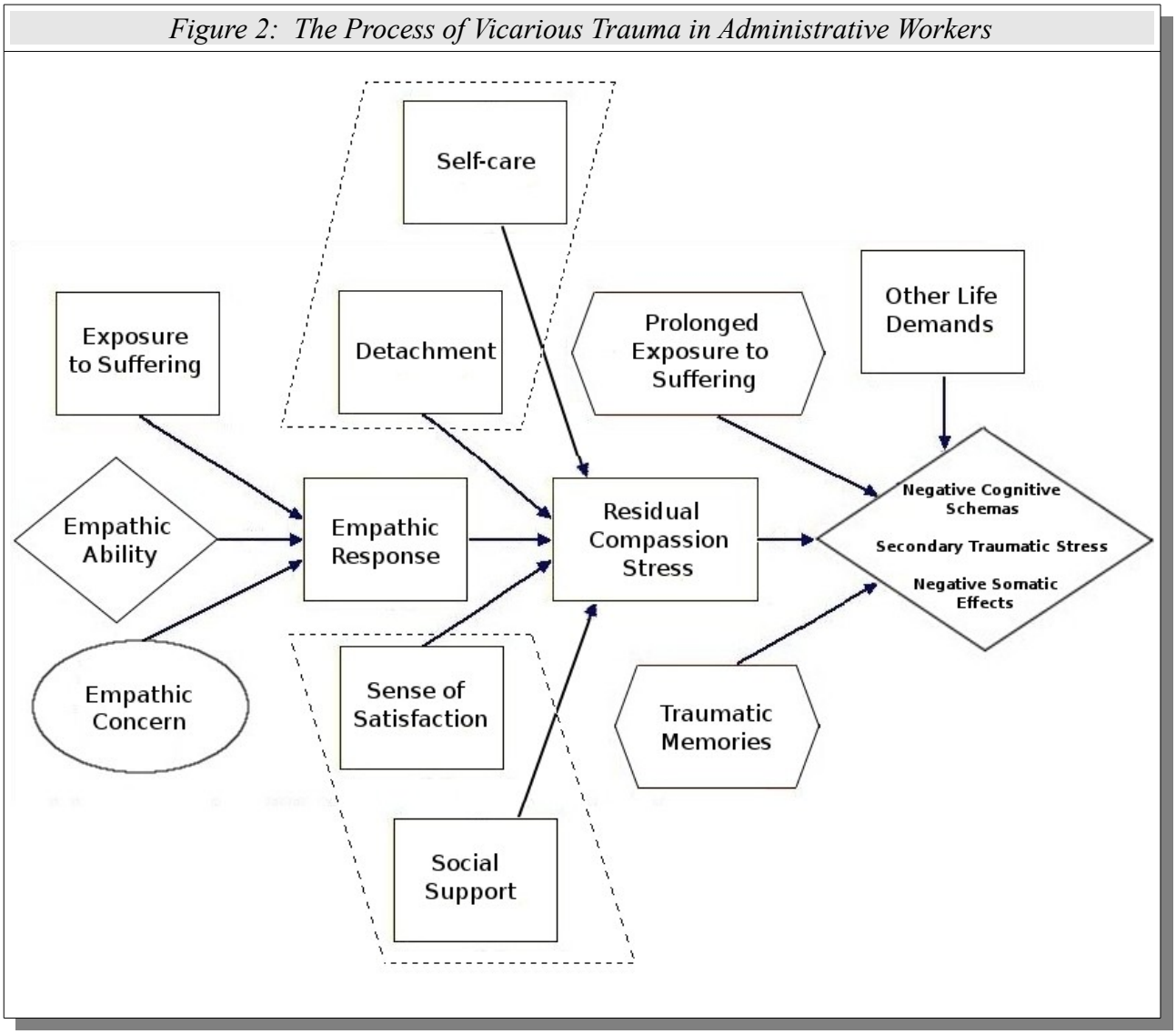
At the outset of the study, the goal was set to determine the suitability of applying Figley's (2002a) model of compassion fatigue to groups other than therapists. The suitability, especially in terms of the administrative context, was looked into by focusing on short-term insurance claims workers. As explained previously, the first step involved collecting either qualitative or quantitative data, or in some cases both, on each of the concepts covered by the model. In doing so, the role and importance of each concept could be examined.

Every aspect of the model proved to be as important to claims workers as the therapists it was developed for. The psychometric data showed that each variable investigated was significant. The qualitative results were taken as indicative of the relevance of each area covered, as each proved to be of concern or importance to claims workers. Even empathy, which was initially thought of as much less important to the administrative context, proved to be significant. Claims workers were found to engage as deeply with clients as trauma counsellors. Also, the empathy pathway was found to be most harmful to claims workers, given their high levels of vicarious trauma and personal distress from empathic engagement. Also, no significant difference in empathic concern among the three worker groups was found, indicating the innate tendency and universal importance of this construct in human interactions. In addition, the study also revealed sound ways in which the model can be expanded upon to better fit the administrative context, displayed in *Figure 2.*

For one, claims workers were found not to possess sufficient positive avenues or resources to draw psychological sustenance from. To ensure that the positivity-negativity ratio is increased to more optimal levels, self-care and social support are included as additional ways to sublimate the crucial positive energy required to counteract the process of vicarious trauma. Although social support did not have a dramatic effect on secondary traumatic stress, it proved to be crucial in the preservation of healthy, positive cognitive schemas. The areas of *Figure 2* in dotted lines denote avenues of positive input that workers need to continuously cultivate and maintain. Also, it was found that compassion fatigue/secondary traumatic stress is not the only deleterious outcome of vicarious trauma. In affected claims workers, alongside high levels of secondary traumatic stress, negative cognitive schemas and a myriad of stress-related health complaints were pervasive. Therefore, for

administrative workers, it might be judicious to also be cognisant of these additional perils associated with trauma exposure.

Figure 2: The Process of Vicarious Trauma in Administrative Workers



It has to be mentioned that correctly labelling the outcome element of the expanded model was challenging. In keeping with the notion of de-stigmatising and demystifying vicarious trauma, over or understating the risks involved are undesirable. In pursuit of these goals, Figley (2003) formulated the friendlier term of compassion fatigue as opposed to secondary traumatic stress to denote the outcome of the process depicted by his model. Ways in which a softer approach could also be achieved in the present study were considered. However, after some deliberation the conclusion was reached that utilising more affable terms or labelling outcomes something other

than what they are, would negate the goal-oriented objective of the revised model. Not labelling the final element accurately would detract from the educational property of the model and prevent workers from recognising warning signs. Therefore, after careful consideration, it was decided to present the three outcomes side-by-side as "*Negative Cognitive Schemas; Secondary Traumatic Stress and Negative Somatic Effects*". Using these three daunting terms would probably evoke strong criticism, as they might overstate the seriousness of vicarious trauma and perpetuate concern in workers. However, it is believed that ineffectual labelling would obscure the model's efficacy and misguide employers and employees by not providing them with an accurate, clear map of the progression and prevention of vicarious trauma. Its treatment and prevention are considered next.

1.2 Amelioration of vicarious trauma in administrative populations.

As stated above, Figley's model not only serves to predict the onset and progression of compassion fatigue/secondary traumatic stress, but is also a sound starting-block for mitigating and preventing negative outcomes (Figley, 2002a). It is believed that the same can be said of the above expanded version of the model. Each of the elements can be treated as a step in educating exposed workers and improving care and well-being. To this end, Figley firstly feels that providing an overview of vicarious trauma for instructional purposes is vital. At the one end, the model informs workers of the hazards of continued trauma exposure and empathic engagement. At the other end, workers are made aware that traumatic memories, other life demands and prolonged exposure have the potential to further advance the process of vicarious trauma.

The middle elements of the model could serve as a care map to both employers and employees, to continuously keep workers on track with ameliorative goals. Following these steps would not only improve vicarious trauma, but overall well-being, as these are all-round health practices that anyone could benefit from. Increasing job satisfaction, self-care practices, effectively disengaging from work stresses and surrounding oneself with caring supports are always good strategies, no matter what one's profession. Moreover, workers and employers alike stand to benefit from these healthy practices.

For instance, if workers are supported in making simple, positive changes in their work-lives, positive outcomes will also permeate other areas of their lives. Conversely, encouraging workers to attain a state of greater health and happiness in their personal lives would again impart benefits in the work-domain, as someone who is healthier and happier at home will be happier in the work setting and perhaps even more productive, setting into motion a positive win-win cycle. Reducing

stress, in whatever form, including secondary traumatic stress, will simultaneously improve other forms of stress the person might be under.

Next, for existing workers and new appointees alike, the model could serve as an excellent plan of continued care and province. In this respect, workers need to recognise that residual stress is perilous and should be neutralised continuously. By means of the model, they are furnished with sensible ways in which to do so. Workers and employers should constantly attempt to maintain a healthy positivity-negativity ratio in their work-lives. In life in general, optimism is associated with more positive outcomes as negative effects are mitigated by perseverance of this construct (Moultrie, 2004).

According to the broaden-and-build model of positive emotions, one should aim to increase the ratio of positive affect, including feeling grateful, upbeat and expressing liking and appreciation, in relation to negative affect (B. L. Frederickson, as cited in Radey & Figley, 2007, p. 208). These authors refer to several astute studies that have indicated a ratio of at least three to one to be facilitative of flourishing and well-being. The efficacy of increased positivity has not only been proven in work settings, but also in other areas of life, especially on the marital front (Radey & Figley, 2007).

There is, in fact, much room for improvement in this respect, as a study involving a similar sample of claims workers, which preceded this study, was found not to be particularly positive or optimistic (Ludick, 2006). Including the two further positive avenues – that of social support and self-care – in the expanded model, would hopefully assist in facilitating more desirable positivity ratios in claims workers and other administrative populations alike. As stated before, self-care practices need not be costly, enigmatic or complex. Simple strategies such as bringing more joy, humour and support into one's life could improve overall quality of life and diminish negative outcomes.

Also, social support is one of the most widely accepted factors in diminishing occupational stress, enhancing health as well as decreasing and preventing vicarious trauma outcomes (*e.g.* Baird & Kracen, 2006; Dunkley & Whelan, 2006b; McCann & Pearlman, 1990; Salston & Figley, 2003). Better work-based support, more understanding managers and a more positive work atmosphere could further nurture workers into countering work and secondary traumatic stress. Being as focused on worker needs as on those of clients would augment productivity and worker relations, provide a healthy balance and increase worker commitment. Next to clients, human resources are

probably the most precious commodity the administrative sector has.

Addressing work-stress, including secondary traumatic stress, would also automatically increase compassion satisfaction and an overall sense of satisfaction in the work-place, points that are crucial in protecting workers against vicarious trauma, increasing productivity and promoting staff retention. Bell *et al*. (2003) go one step further by suggesting that organisations adopt further preventative strategies, such as changes in organisational culture as well as monitoring and balancing workload. Collegial and managerial support, encouragement of self-care practices, adequate benefits, as well as staff development opportunities were all found to be beneficial (Hesse, 2002).

Next, workers should be placed in the best possible position to recognise the onset of undesirable outcomes. They should respond to the first signs, and if they cannot address the challenges by means of self-care, they should be able to have an open dialogue with their employers. Those insurers with employee assistance and wellness programmes are congratulated on their efforts and commitment to their worker corps. However, these valuable programmes were found to be under-utilised, letting this costly and precious resource fall by the wayside. Employers making these programmes available, should perhaps focus on making this resource optimally accessible going forward. Salston and Figley (2003) have very specific and useful ideas on responsible crisis intervention:

For instance, if there is a critical incident that evokes secondary traumatic stress or if the person is in need of assistance, the person should be allowed to access the programme voluntarily and as often as needed to resolve the matter. Salston and Figley (2003) strongly feel that any intervention should be voluntary, tailored to worker needs and should be offered continuously if one is to maintain health and well-being. They feel that even though crisis intervention is imperative, it should never be forced on workers. These authors conclude that, no matter the method of intervention, workers always need to be in charge of addressing their experiences, as to acquire the necessary instruction and skills that they can then take with them in life. Such life-skills can, of course, be applied in other aspects of life, maintaining human growth and continuously increasing worker competence (Salston & Figley, 2003).

In addition to utilising the model, it is also believed that new appointees in claims positions should be screened more carefully and should be informed of the potential difficulties of dealing with

traumatised individuals. The author realises that revealing these aspects might dissuade prospective applicants from taking claims positions or intimidate suitable candidates. However, informing potential claims workers in a responsible manner will place them in the best possible position to decide whether they want to enter into these challenges or not. Candidates being dissuaded once they learn about the associated difficulties are not necessarily a negative – it might be more likely that the *wrong* candidate would be dissuaded. It is better to take more time and put more thought and energy into the screening process than to later lose the worker the moment they are blind-sided by vicarious trauma. If prospective complications are unanticipated, workers could soon be disillusioned and disheartened, compromising job satisfaction and placing them at greater risk for negative outcomes, or even resigning.

It has already been mentioned that attrition is particularly high in workers where stress exceeds their expectations and capabilities. Attrition was most apparent for claims workers, showing that they are indeed overwhelmed. Therefore, the *right* candidate, aware of the challenges, might desire and even look forward to assisting clients in crisis, and would most certainly fare better and demonstrate greater commitment. Insurers and other at risk administrative populations already utilising screening practices and educating workers sensibly about the perils of working with traumatised clients are also congratulated for their foresight, and should continue to do so. Those not aware of the perils of vicarious trauma are implored to start thinking of employing the aforesaid practices and ensuring that applicants and workers are treated with more care and responsibility.

Also, a powerful motivator is that of incentives to back self-care and health-promoting behaviours. For example, a few well-known medical insurance carriers in South Africa have recently started to offer incentives to their clients for buying into health-supporting behaviours. They offer premium rebates as well as special offers on gym memberships, vitamins and supplements, alternative remedies, certain prophylaxes and even some healthy food options. Similar incentives could perhaps be bought into or even brokered by employers to motivate their workers to also embrace health-promoting behaviours. Moreover, a considerable percentage of the sample suggested incentives for merit, suggesting that workers might be open to incentives as motivators.

There is furthermore an increasing movement towards creating greater wellness in the workplace in South Africa (*e.g*. Els, 2005; Fourie *et al*., 2008; Lutrin, 2005). Another prudent alternative is for organisations to perhaps move away from vicarious trauma as being the *main* or *only* point of focus, by rather aligning themselves to the broader goal of increasing overall wellness in the workplace.

Therefore, employers committed to relieving work-stress in general would simultaneously promote the goal of alleviating secondary traumatic stress. Focusing on creating a more positive and happy work environment would address a myriad of work-related stresses, including secondary traumatic stress, whilst creating and disseminating benefits more widely. As explained before, increasing the positivity-negativity ratio in workers' lives holds tremendous potential benefits that not only extend to workers, but also their employers. Radey and Figley (2007) point out that research has shown that work-teams with high positivity ratios are significantly more adroit, productive, flexible, resourceful and innovative in problem-solving. They also exhibit better morale and deliver higher quality service.

In conclusion, changes could initially be modest, before resorting to utilising company resources to invest in costly strategies or formal programmes and services. However, organisations with the financial capabilities of acquiring such programmes should definitely proceed. Organisations with less financial leeway should not feel compelled to follow suit as there are many other options. The expanded model produced by the present research, for one, offers a comprehensive educational and ameliorative set of solutions. Also, the many simpler, less costly strategies outlined above could be beneficial either way, as they would promote wellness in the workplace and health in general, whilst diminishing vicarious traumatisation at the same time.

Organisations that do deicide to invest in more formal services should perhaps look into their efficacy, as research into these areas is crucial in yielding much needed data on the suitability and effectiveness of these programmes in administrative settings. As stated earlier, employers should ensure that programmes are accessible and utilised optimally. Elwood *et al*. (2011) strongly emphasise the judiciousness of preceding any changes with research on the proposed strategy/service, as well as studies examining the influence of the prospective changes. Therefore, not only the phenomenon that has to be remedied needs intensive studying, but also possible ameliorative strategies. If the self-care practices proposed here are backed by support and care from organisations, it might be all that is required to ensure that administrative populations flourish despite trauma exposure. Or they could, at a minimum, bring alleviation in the interim, while research catches up to the goals of completely understanding and amelioration vicarious trauma.

2 Limitations of the Study

No study is ever perfect, and the present study similarly encountered several challenges that added their own tensions and limitations, some of which are considered next.

2.1 Ex post facto group comparison design.

Firstly, finding a design to best respond to the research questions, was challenging. Of course, the ever-present problem of the ideal laboratory situation not translating to the real world of workers and the work environment was pertinent. Of course, a pre-test post-test design measuring each variable before and after prolonged trauma exposure or a longitudinal design would have served the study best. However, both of these options were impractical and unattainable in this particular instance. As a result, one is often forced by the real-world position to select weaker measurement designs, such as the ex post facto multi-method design opted for (Hasset, 2006). Based on the results derived from this weaker design, it is not possible to reach unequivocal conclusions on the impact of vicarious trauma. For one, it is impossible to say what influence organisational climate might have exerted on the study. Not having pre-test data makes it impossible to say what levels of negativity in cognitive schemas and secondary traumatic stress were present prior to embarking upon working with traumatised individuals.

Although the measures utilised were very carefully formulated to focus on vicarious trauma in the work-place in particular, it is also impossible to say what percentage of secondary traumatic stress, negative cognitive schemas as well as the health complaints observed by the study can be contributed solely to trauma exposure and what percentage to other stressors in the work-place. Data from the control group showed that other forms of emotional stress can in fact contribute to secondary traumatic stress to some extent. However, a best effort was made and the study nonetheless offered insight and invaluable data.

2.2 Research approach

In addition, some might argue that the way in which Figley's model was approached in the present study might not have been the most effective. In hindsight, performing a purely quantitative study utilising path analysis or structural equation modelling to test Figley's model, were other possible options. Path analysis is a special type of multiple regression technique aimed at drawing causal inferences and offering a strong basis for ordering predictor variables by causal priority (Rosenthal & Rosnow, 1991). Structural equation modelling is a method used to represent, estimate and test a theoretical network of mainly linear relationships between variables, by utilising several statistical tests to determine the adequacy of model fit to data (E.E. Rigdon, as cited in Suhr, 2002).

However, neither of the two methods would have come without considerable challenges. For one, locating pre-existing, reliable measures to collect data on all eleven variables expressed by Figley's

model would indeed have bee a tall order. Furthermore, participant time and cooperation issues would have made investigating eleven variables challenging and likely over-ambitious. Also, structural equation modelling, for instance, require that an ideal of 20 participants for each model parameter be met, necessitating substantial sample sizes (Suhr, 2002).

Furthermore, the various goals explicated by the present study called for a mixed methods approach to best answer the research questions. Although the approach opted for in the end was perhaps flawed or even less effective, it did, however, add a different level of understanding and produced interesting results. The more qualitative data undoubtedly contributed to the study by yielding subjective information and a clear sense of typical worker experiences, which a quantitative approach alone would not have been able to realise.

2.3 Group differences.

Chi-square tests of independence detected significant group differences for the biographical variables which were discussed in chapter five. However, these variables were not central to the study and their influence therefore remains undetermined. The author did attempt to increase group homogeneity, by sourcing all participations from call centres as well as screening for influences from other forms of trauma work and severe personal traumas. Despite these measures, significant group differences in group composition were encountered that were beyond the control of the study, which could not be remedied. All that could be done, was to acknowledge with some resignation that group differences might have influenced the study results, and move forward.

2.4 Measuring instruments.

Finding suitable measuring instruments to cover central variables was quite challenging. A best effort was made to select popular, previously validated instruments as far as possible. Despite these efforts, unexpected problems were nonetheless encountered. For one, each instrument presented a snapshot of a particular point in time, without revealing more on the true impact of vicarious trauma. This is not any fault on the part of the instruments, but can rather be attributed to the absence of pre-test data. Without pre-test data to make comparisons to, the true impact of vicarious trauma cannot be determined. Also, the instrument used for measuring social support proved to be problematic. Owed to the high levels of satisfaction with non work-based support expressed in the present study, one of the sub-scales was rendered unusable due to high kurtosis and skewness, which limited statistical analysis and information on this aspect.

Furthermore, another problem associated with the quantitative measures relates to Likert-type rating scales in general. These types of instruments are inherently subject to distortion and rating errors. To name a few, respondents might have avoided using extreme response categories, presenting with central tendency bias (Rosnow & Rosenthal, 1991). An acquiescent response set might also have been produced by participants opting to mostly agree with statements. Other possibilities are those of social desirability and lenience biases where participants attempt to portray themselves or their organisation in a more favourable light (Rosnow & Rosenthal, 1991).

Even though scale developers usually make efforts to combat these biases, central tendency and social desirability biases remain obstacles. In all fairness, acquiescence, social desirability and leniency biases might also have influenced qualitative responses to the self-constructed questionnaire in the present study. Participants might likewise have attempted to portray themselves and their organisation more favourably. Or they might have stated what they felt to be more polite and socially desirable. They might also have stated their estimation of what the researcher might have wanted to hear. Again, these challenges had to be accepted as unresolvable realities of research.

Also, as previously discussed, participant time and cooperation issues resulted in only a few central variables being measured quantitatively. In addition the study opted to utilise a self-constructed questionnaire to cover other areas. Even though it was felt that some qualitative data would considerably add to the study, this objective presented problems of its own. Despite care in developing and piloting the questionnaire, its validity remains undetermined. Also, despite efforts to increase the clarity of each item, one item in particular proved to be slightly ambiguous, which rendered data from this question less informative. Employing a self-report measure also posed other challenges. For one, what participants report cannot always be accepted at face value, especially in relation to sensitive topics. All things considered, it is nonetheless believed that the questionnaire added a valuable dimension to the study as well as to the elements investigated. However, the practice of mixed methods research spurs its own debate, which is considered next.

2.5 Qualitative versus quantitative research designs.

The quantitative versus qualitative debate is largely based on a philosophical distinction, with researchers often disagreeing about the cogency and merits of the two approaches (Hasset, 2006). Many qualitative researchers argue that there is no objective social reality, and that knowledge is constructed by observers embedded within their own traditions, beliefs and their social and political

environments (Hasset, 2006). Quantitative researchers, by contrast, stand by the scientific model, striving to develop increasingly sophisticated techniques and tools to optimise the objective measurement of social phenomena (Hasset, 2006). Subsequently, each of the two approaches also presents with different strengths, weaknesses, merits and requirements.

Mixed methods research was opted for as the best approach to answer the research questions herein. As was discussed previously, many respected and experienced researchers have argued for integrating the two approaches as, when done correctly, the strengths of each approach can combine in a complementary way without converging weaknesses. Others have stressed the advantages of linking qualitative and quantitative methods when performing research, believing that both the validity and usefulness of findings benefit (Hasset, 2006). However, there are theorists who vehemently object to the two research traditions being blended, believing that they are inherently separate epistemological and ontological world-views (Johnson & Onwuegbuzie, 2004).

Looking at the study results, an interesting blend of the objective environment as well as participant perceptions evoked within the context of dealing with traumatised clients and their unique work environments was produced. Useful insights were gained into participants' feelings, thoughts and behaviours elicited by ongoing trauma exposure, unearthed by thematic content analysis. However, qualitative analysis is often spurned for being a "*soft option*" chosen by those who shy away from the rigours of statistical analysis (Wilbraham, 1995, p.5). It is often viewed as overly a-theoretical and descriptive, too open to manipulation and interpretation as well as obviating rigorous statistical analytic methods (Wilbraham, 2005). Despite these weaknesses, the qualitative data lent a dimension of humanness to the study and produced information that both enriched and completed the study.

To assist in curtailing these weaknesses, several measures were taken by the study to increase the quality, reliability and validity of the data, which was discussed in the methods chapter. Hasset (2006) points out that another strong criticism is that categories usually neither emerge nor do data fall into categories, but are rather pushed into categories birthed from the researcher's expectations, interests and agendas. Even though the researcher did all in her power not to misrepresent or manipulate data and to let the data also speak unrestrainedly, results still need to be viewed within the context of these limitations and the qualitative-quantitative debate.

2.6 Measurement of complex, multi-dimensional variables.

As stated throughout the study, another difficulty encountered was that of measuring complex, multidimensional constructs. The first complexity stems from the fact that there is no single, universal definition for each of the concepts. Secondly, owing to the static nature of quantitative measures, it is difficult to accurately capture dynamic and multilevel variables (Hasset, 2006). Furthermore, quantitative measures often disregard the uniqueness, dynamics and variability of the context from which the phenomenon is engendered.

Reigning controversies and points of dispute regarding each of the variables highlighted by literature naturally also had an effect on the study. Also, the dearth of literature on short-term insurance claims workers as well as vicarious trauma in the administrative sector often necessitated conjectures to be made from literature on other well-researched groups. However, it is believed that as research into more diverse groups gains momentum, this research will in time come to stand on its own, firmly rooted within a highly relevant body of literature of its own.

3 Future Research

Although the study might attract criticism, it nonetheless achieved the central aim of contributing new information from a different perspective, on a largely unknown population of workers. The research questions were answered and each of the study goals was met, as expounded at the beginning of the previous chapter. Moreover, the study has helped pave the way to understanding vicarious trauma in a greater diversity of groups as well as having excavated, by means of the emergent qualitative themes, a myriad of new areas that could each facilitate further research. Future studies could further build and expand upon existing research, especially utilising much needed longitudinal and pre-test post-test designs, to eventually capture the full nature and impact of this dynamic and complex process.

Schnurr (2006) concludes that we have a responsibility to continue to uphold the field's diverse focus and constituency and to continuously move the field forward through multidisciplinary and international studies. She also feels that research should not merely be repeated but should offer content and contributions that go beyond replication. Salston and Figley (2003) agree that, to advance knowledge and understanding of vicarious trauma, its full reach, as well as underlying contributing factors, it is crucial for research to continue. These authors stress that not nearly enough research has been carried out on vicarious traumatisation and that we are still a considerable distance away from gaining the insight and understanding we need. The present study also

succeeded in contributing in ways that helped bring research one incremental step closer to these shared goals.

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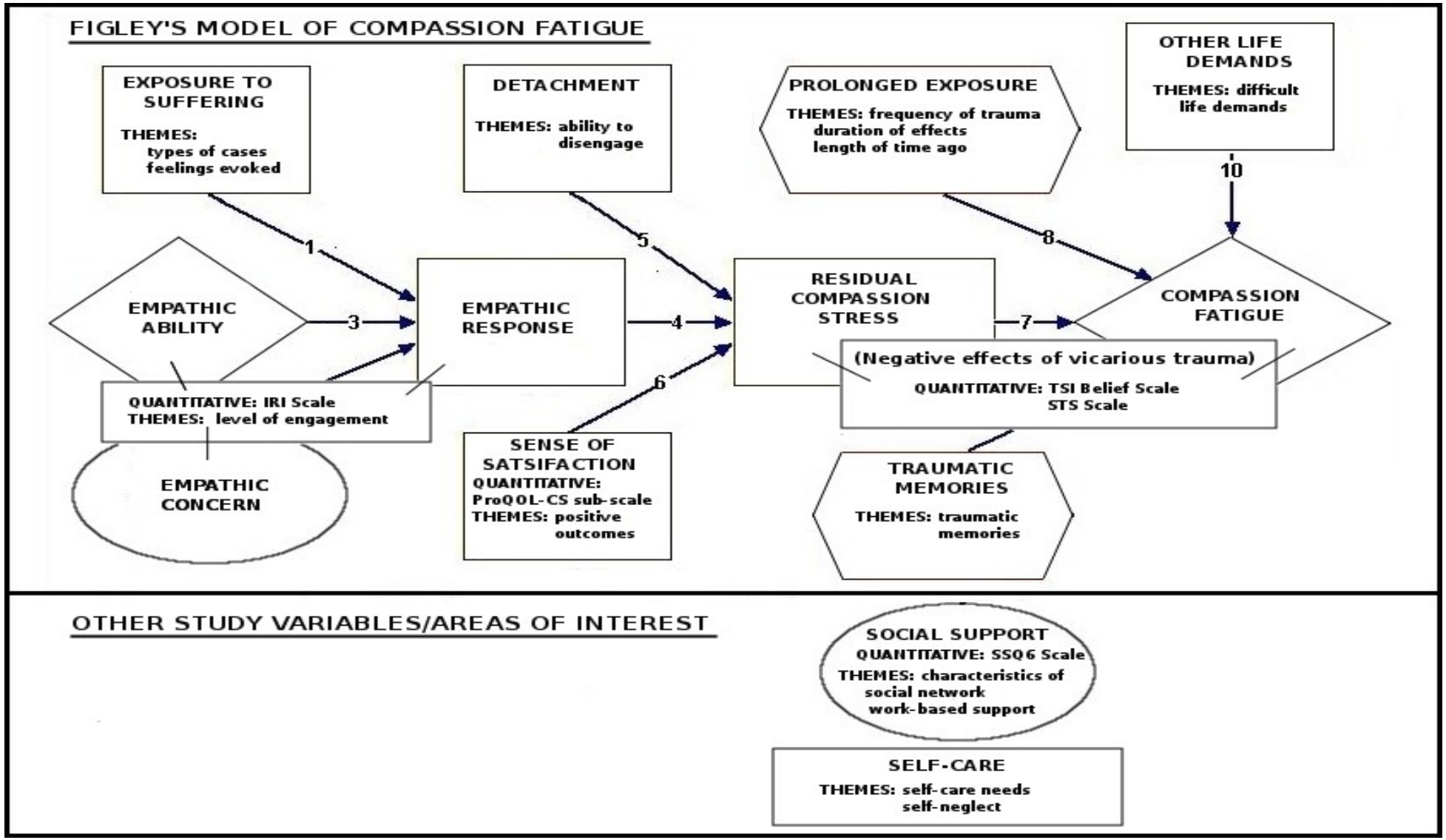
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APPENDIX A: Summary of the Study Variables/Areas of Interest



APPENDIX B: Constructivist Self-Development Theory Overview

Frame of Reference

Framework of beliefs through which the individual interprets experience

- Identity: inner experience of self and self in the world, includes customary feeling states
- World view: life philosophy, general attitudes and beliefs about others and the world; values and moral principals; causality
- Spirituality: meaning, hope, faith; connection with something beyond oneself, awareness of all aspects of life including the non-material

Self Capacities

Abilities that enable the individual to maintain a sense of self as consistent and coherent across time and situations; intrapersonal

- Ability to experience, integrate and tolerate strong affect
- Ability to maintain a sense of self as viable, benign and positive, deserving of life and love
- Ability to maintain an inner sense of connection with others

Ego Resources

Abilities that enable the individual to meet psychological needs and to relate to others; interpersonal

- Self-awareness skills
  - Intelligence
  - Ability to be introspective
  - Willpower and initiative
  - Ability to strive for personal growth
  - Awareness of psychological needs
  - Ability to take perspective
- Interpersonal and self-protective skills
  - Ability to foresee consequences
  - Ability to establish mature relations with others
  - Ability to establish interpersonal boundaries
  - Ability to make self-protective judgements

Psychological needs and cognitive schemas

- Safety
  Self: to feel reasonably invulnerable to harm inflicted by oneself or others
  Other: to feel that valued others are reasonably invulnerable to harm inflicted by oneself or others
- Esteem
  Self: to feel valued by oneself and others
  Other: to value others
- Trust/dependency
  Self: to have confidence in one's own judgement and ability to meet one's needs
  Other: to have confidence in others to meet one's needs
- Control
  Self: to feel able to manage one's feelings and behaviours in interpersonal situations
  Other: to feel able to manage or exert control over others in interpersonal situations
- Intimacy
  Self: to feel connected to oneself
  Other: to feel connected to others

Memory and perception

- Verbal: the narrative of what happened before, during, and after the trauma
- Imagery: the mental pictures of traumatic events
- Affect: the emotions related to the trauma
- Somatic: the bodily experiences that represent the traumatic events
- Interpersonal: the relational patterns and behaviours that reflect the abusive traumatic relationship(s)

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APPENDIX C: Letter to Insurers

Date
Insurer
Human Resources Department
Telefax:
Attention:

Dear

RE: PROPOSED RESEARCH PROJECT

My name is Marné Ludick and I am doing a doctoral degree at the University of Witwatersrand, which involves the writing of a thesis under the supervision of the university. I would like to do research focusing on the short-term insurance industry, in continuance of previous research conducted by me.

In South Africa, violent crime is contributing significantly to stress caused by trauma. These traumas have the potential to affect those who deal with trauma survivors, a phenomenon known as indirect trauma. Sadly, the high levels of violence in our country are now also reaching administrative workers not previously associated with the risk of indirect trauma, such as short-term insurance claims workers. The previous research conducted indicated that claims workers are at risk of indirect traumatisation due to their unintentional, but constant exposure to a growing population of traumatised insurance clients. I would like to take these ideas further in establishing the extent and nature of these effects.

Moreover, indirect trauma not only holds implications for workers, but also for their employers. It has been found in more well-researched populations, that indirect trauma continuously erodes the morale of workers, affecting their loyalty, attendance, productivity and eventually, company profits. Even though insurers are not to blame for the indirect trauma in claims workers, they are nonetheless in a vulnerable position, as psychological harm has not been considered as comprehensively in this industry as in other groups dealing with traumatised clients. At the same time, you as an insurer are also in a powerful position whereby you can assist in shedding much needed and valuable light on indirect trauma within the insurance industry.

We aim to facilitate a deeper understanding of the working conditions of claims workers and from this to eventually make some suggestions about intervention that is cost efficient, effective and specific to the problems revealed by the study. Through continued research, insurers can, in time, gain substantially from more effective, healthy and satisfied workers, reduced staff fallout, curbed absenteeism and especially enhanced productivity. We therefore extend our invitation to you as an organisation to take part in the upcoming study. Participation will require a one and a half hour long test completion session with workers made available by you. Participation will entitle you to a report and the recommendations about intervention developed from the thesis, which will be provided to you after the research has been completed and examined.

The ethical standards of the university will be strictly adhered to. The identity of all participants/organisations will be protected by strict confidentiality and pseudonyms/codenames will be used to protect and conceal the identities of all participating parties. All materials will be treated with integrity and responsibility, and only my supervisors and I will have access to coded data. Your workers will be assured that their participation will not have any bearing on or pose any risk to their employment. Great care has been taken to ensure that all questions posed are not unnecessarily intrusive, insulting or harmful. Neither you, nor your workers will run any risk of being singled out, portrayed negatively, or being identified in any way. As insurers are not to blame for the unique challenges within your domain, the industry will be portrayed fairly and respectfully. All data will be destroyed after the compulsory 6 year audit/verification period specified by the university and no identifying information will be used in the final report.

It is hoped that your decision will be favourable as your contribution will be immensely valuable and this project can only materialise with your help, and the help of all who agree to participate.

I await your earliest response.

Yours sincerely

(Signed)

Marné Ludick
PhD Student
Cell:
Email:

Dr Dinah Alexander
Primary Supervisor
Tel:
Email:

Prof Gillian Finchilescu
Co-supervisor
Tel:
Email:

APPENDIX D: Letter to Trauma Counselling Organisations

Date

Human Resources Department
Telefax:
Attention:

Dear

RE: PROPOSED RESEARCH PROJECT

My name is Marné Ludick and I am doing a doctoral degree at the University of Witwatersrand, which involves the writing of a thesis under the supervision of the university. I would like to do research in the short-term insurance industry as well as that of trauma counselling, in order to build on research previously conducted by me.

In South Africa, violent crime is contributing significantly to stress caused by trauma. These traumas have the potential of affecting those who deal with trauma survivors, a phenomenon called indirect trauma, which is well known by most trauma counselling organisations. The high levels of crime and violence in our country are now also reaching administrative workers not previously associated with the risk of indirect trauma. Prominent figures in the field of vicarious trauma have recently urgently incited that research into more diverse, less commonly associated groups be undertaken to establish the full reach of this phenomenon. The study intends to examine the experiences of such a group of workers, being short-term insurance claims workers, compared to the experiences of trauma counsellors.

The previous research conducted indicated that claims workers are at risk of indirect trauma due to their unintentional but continued exposure to a growing population of traumatised insurance clients. I would like to take these ideas further in establishing the extent and nature of the effects. To make sense of their experiences, it is the intention to compare the results from a group of claims workers to those of a group of trauma counsellors, who are more commonly associated with the risks of vicarious trauma. The goal is to search for significant differences and similarities between the two groups of workers and to expand the views on indirect trauma into a less familiar territory.

It is imperative to systematically broaden the view of exactly who is affected, under which circumstances and under which working conditions. In doing so, less obvious groups are also reached in the growing global endeavour to ameliorate the effects of indirect trauma. For this study to materialise, you are invited to participate. The information that will be obtained from you or your employees will be invaluable and greatly insightful to the study. Participation will require a single one and a half hour long test completion session with some of your trauma counsellors.

The ethical standards of the university will be strictly adhered to. The identity of all participants/organisations will be protected by strict confidentiality and pseudonyms/codenames will be used to protect and conceal the identities of all participating parties. All materials will be treated with integrity and responsibility, and only my supervisors and I will have access to coded data. Your counsellors will be assured that their participation will not have any bearing on or pose any risk to their employment. Neither you, nor your counsellors will run any risk of being singled out, portrayed negatively, or being identified in any way. Great care has been taken to ensure that all questions posed are not unnecessarily intrusive, insulting or harmful. All data will be destroyed after the compulsory 6 year audit/verification period specified by the university and no identifying information will be used in the final report. Research findings can be provided to you, upon your request.

It is hoped that your decision will be favourable as your contribution will be immensely valuable and this project can only materialise with your help, and the help of all who agree to participate.

I await your earliest response.

Yours sincerely

(Signed)

Marné Ludick
PhD Student
Cell:
Email:

Dr Dinah Alexander
Primary Supervisor
Tel:
Email:

Prof Gillian Finchilescu
Co-supervisor
Tel:
Email:

APPENDIX E: Letter to Holiday Booking Consultancy Firms

Date

Human Resources Department
Telefax:
Attention:

Dear

RE: PROPOSED RESEARCH PROJECT

My name is Marné Ludick and I am doing a doctoral degree at the University of Witwatersrand, which involves the writing of a thesis under the supervision of the university. I would like to do research in the short-term insurance industry as well as that of trauma counselling, in order to build on research previously conducted by me.

In South Africa, violent crime is contributing significantly to stress caused by trauma. These traumas have the potential of affecting those who deal with trauma survivors, a phenomenon called indirect trauma, which is well known by most trauma counselling organisations. The high levels of crime and violence in our country are now also reaching administrative workers not previously associated with the risk of indirect trauma. Prominent figures in the field of vicarious trauma have recently urgently incited that research into more diverse, less commonly associated groups be undertaken to establish the full reach of this phenomenon. The study intends to examine the experiences of such a group of workers, being short-term insurance claims workers, compared to the experiences of a control group of holiday booking consultants.

The previous research conducted indicated that claims workers are at risk of indirect trauma due to their unintentional but continued exposure to a growing population of traumatised insurance clients. I would like to take these ideas further in establishing the extent and nature of the effects. To make sense of their experiences, it is the intention to compare the results from a group of claims workers to those of the control group, sourced from your organisation, who do not routinely deal with traumatised clients. The goal is to search for significant differences and similarities between the two groups of workers and to expand the views on indirect trauma into a less familiar territory.

It is imperative to systematically broaden the view of exactly who is affected, under which circumstances and under which working conditions. In doing so, less obvious groups are also reached in the growing global endeavour to ameliorate the effects of indirect trauma. For this study to materialise, you are invited to participate. The information that will be obtained from you or your employees will be invaluable and greatly insightful to the study. Participation will require a single one and a half hour long test completion session with some of your booking consultants.

The ethical standards of the university will be strictly adhered to. The identity of all participants/organisations will be protected by strict confidentiality and pseudonyms/codenames will be used to protect and conceal the identities of all participating parties. All materials will be treated with integrity and responsibility, and only my supervisors and I will have access to coded data. Your booking consultants will be assured that their participation will not have any bearing on or pose any risk to their employment. Neither you, nor your counsellors will run any risk of being singled out, portrayed negatively, or being identified in any way. Great care has been taken to ensure that all questions posed are not unnecessarily intrusive, insulting or harmful. All data will be destroyed after the compulsory 6 year audit/verification period specified by the university and no identifying information will be used in the final report. Research findings can be provided to you, upon your request.

It is hoped that your decision will be favourable as your contribution will be immensely valuable and this project can only materialise with your help, and the help of all who agree to participate.

I await your earliest response.

Yours sincerely

(Signed)

Marné Ludick	**Dr Dinah Alexander**	**Prof Gillian Finchilescu**
PhD Student	Primary Supervisor	Co-supervisor
Cell:	Tel:	Tel:
Email:	Email:	Email:

APPENDIX F: Participant Information Sheet

Dear claims worker/trauma counsellor/administrative worker,

My name is Marné Ludick and I am a Doctor of Philosophy student at the University of Witwatersrand. As part of the requirements for the degree, I have to conduct research. My study will focus on you perceptions about your work, especially when dealing with traumatised clients on a daily basis, whereas others of you might not. You have been selected for this reason, as the study compare the different experiences from dealing with diverse groups of clients. Experiences, feelings thoughts and beliefs that arise from dealings with your clients will be looked into to determine how each group might be affected by their distinct groups of clients.

I wish to invite you to participate in this study. Please note that your participation is voluntary and non-participation will not have any consequences. Should you decide to participate, you will be required to complete the attached questionnaires that will take approximately one and a half hours.

Please note that you reserve the right to withdraw from the study at any time. None of the questions are intended to be harmful, insulting or unnecessarily intrusive. Please try to answer all the questions, but if you are uncomfortable answering any of them, you have the right to refrain from doing so. Those who might wish to seek professional counselling, will be referred to an organisation in Johannesburg that performs counselling free of charge. All information obtained during the study will be treated as strictly confidential and codes/codenames will be used to conceal and protect your identity at all times. Only I will have access to your completed questionnaires, and only my supervisors and I will have access to the coded data. The aforesaid will be destroyed after the compulsory 6 year audit/verification period specified by the university. No identifying information will be included in the final report. Please be aware that your participation will not pose any risk to your employment. UNDER NO CIRCUMSTANCES WILL YOUR EMPLOYER HAVE ACCESS TO YOUR COMPLETED QUESTIONNAIRES, OR ANY OTHER INFORMATION PROVIDED BY YOU. UNDER NO CIRCUMSTANCES WILL YOU OR YOUR RESPONSES BE DISCUSSED WITH YOUR EMPLOYER.

Thank you very much for your time and interest in the study.

(Signed)

Marné Ludick	Dr Daleen Alexander	Prof Gillian Finchilescu
PhD Student	Primary Supervisor	Co-supervisor
Cell:	Tel:	Tel:
Email:	Email	Email

APPENDIX G: Participant Consent Form

Informed consent

Please read and sign the consent statement below:

I _____ hereby confirm that I have been fully informed about the study and have been given the opportunity to ask questions. I participated in the completion of the questionnaires completely voluntarily and 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 completely anonymous and my responses confidential. None of my responses, or the information I have provided during the test completion session, will be shown to or shared with my employer under ANY circumstances. No one other than the researcher will have access to the forms I have completed and a codename will be used to conceal my identity. Only the researcher and research supervisors will have access to the coded data. The particulars of a qualified trauma counsellor will be made available to me, should I wish to seek professional counselling.

_____

Signature

Thank you very much for your time and effort in participating in my study, you have made a very valued contribution. If you wish to discuss anything with me, please tear off my personal details at the bottom of the page and feel free to contact me.



Marné Ludick (Researcher/PhD Student)

Cell: (removed)
E-mail: (removed)
Fax: (removed)

APPENDIX H: Biographical Information Sheet

Please answer a few brief questions about your background:

Please mark your work category with an X:

	Short-term insurance claims worker
	Trauma counsellor
	Administrative worker

How long have you been doing this particular work?

Years_____ Months_____

Are you doing this work full-time or part-time? Please mark with an X:

	Full-time
	Part-time

If you answered "part-time" to the previous question, please state what other jobs you do?

_____

Please mark your age group with an X:

	Younger than 25
	25-30
	31-35
	36-40
	41-45
	46-50
	Older than 50

Please mark your gender group with an X

	Male
	Female

Please mark your race group with an X
(Please Note: This is used solely for statistical analysis, and is not meant to be offensive)

	Black
	White
	Coloured
	Indian
	Other (Please Specify):

APPENDIX I: TSI Belief Scale

This questionnaire is used to learn how individuals view themselves and others. As people differ from one another in many ways, there are no right or wrong answers. Please answer by writing an X in the box corresponding to the statement that most accurately reflects your feelings and experiences. Try to complete every item.

	Strongly Disagree	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Agree Strongly
1. I generally feel safe from danger						
2. People are wonderful						
3. I can comfort myself when I'm in pain						
4. I find myself worrying a lot about my safety						
5. I don't feel like I deserve much						
6. I can usually trust my own judgement						
7. I feel empty when I am alone						
8. I have a lot of bad feelings about myself						
9. I'm reasonably comfortable about the safety of those I care about						
10. Most people destroy what they build						
11. I have a difficult time being myself around other people						
12. I enjoy my own company						
13. I don't trust my instincts						
14. I often think the worst of others						
15. I believe I can protect myself if my thoughts become self-destructive						
16. You can't trust anyone						
17. I am uncomfortable when somebody else is leading the group						
18. I feel good about myself most days						
19. Sometimes I think I'm more concerned about the safety of others than they are						
20. Other people are not good						
21. Sometimes when I'm with people I feel disconnected						
22. People shouldn't place too much trust in their friends						
23. Mostly, I don't feel like I'm worth much						
24. I don't have much control in relationships						
25. My capacity to harm myself scares me sometimes						
26. For the most part, I like other people						
27. I deserve to have good things happen to me						
28. I usually feel safe when I'm alone						

	Strongly Disagree	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Agree Strongly
29. If I really need them, people will come through for me						
30. I can't stand to be alone						
31. This world is filled with emotionally disturbed people						
32. I am basically a good person						
33. For the most part; I protect myself from harm						
34. Bad things happen to me because I'm bad						
35. Some of my happiest experiences involve other people						
36. There are many people to whom I feel close and connected						
37. Sometimes I'm afraid of what I might do to myself						
38. I am often involved in conflicts with other people						
39. I often feel cut off and distant from other people						
40. I worry a lot about the safety of loved ones						
41. I don't experience much love from anyone						
42. Even when I'm with other people, I feel alone						
43. There is an evil force inside me						
44. I feel uncertain about my ability to make decisions						
45. When I'm alone I don't feel safe						
46. When I'm alone, it's like there is no one there						
47. I can depend on my friends to be there when I need them.						
48. Sometimes I feel like I can't control myself						
49. I feel out of touch with people						
50. Most people are basically good at heart						
51. I sometimes wish that I don't have any feelings						
52. I am often afraid I will harm myself						
53. I am my own best friend						
54. I feel able to control whether I harm others						
55. I often feel helpless in my relationships with others						
56. I don't have a lot of respect for the people closest to me						

	Strongly Disagree	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Agree Strongly
57. I enjoy feeling like part of my community						
58. I look forward to time I spend alone						
59. I often feel others are trying to control me						
60. I envy people who are always in control						
61. The most important people in my life are relatively safe from danger						
62. The most uncomfortable feeling for me is losing control over myself						
63. If people really knew me, they wouldn't like me						
64. Most people don't keep the promises they make						
65. Strong people don't need to ask for others' help						
66. Trusting other people is generally not very smart						
67. I fear my capacity to harm others						
68. I feel bad about myself when I need others' help						
69. To feel at ease I need to be in charge						
70. I have sound judgement						
71. People who trust too much are foolish						
72. When my loved ones aren't with me, I fear they may be in danger						
73. At times my actions pose danger to others						
74. I feel confident in my decision-making ability						
75. I can't work effectively unless I am the leader						
76. I often doubt myself						
77. I can generally seize up my situations pretty well						
78. I generally don't believe the things people tell me						
79. Sometimes I really want to hurt someone						
80. When someone suggests I relax, I feel anxious						

APPENDIX J: STS Scale

The following is a list of statements made by persons who have been impacted by certain aspects of their work. Please read each statement, then indicate how frequently the statement was true for you in the past thirty (30) days by writing an X in the box that most accurately reflects how you feel. Try to complete every item.

	Never	Rarely	Occasionally	Often	Very Often
1. I felt emotionally numb					
2. My heart started pounding when I thought about my work with clients					
3. It seemed as if I was reliving the trauma(s) of my client(s)					
4. I had trouble sleeping					
5. I felt discouraged about the future					
6. Reminders about my work with clients upset me					
7. I had little interest in being around others					
8. I felt jumpy					
9. I was less active than usual					
10. I thought about my work with clients when I didn't intend to					
11. I had trouble concentrating					
12. I avoided people, places or things that reminded me of my work with clients					
13. I had disturbing dreams about my work with clients					
14. I wanted to avoid working with some clients					
15. I was easily annoyed					
16. I expected something bad to happen					
17. I noticed gaps in my memory about dealing with clients					

APPENDIX K: IRI Scale

The following statements enquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by writing an X in the box that corresponds to the statement that most accurately reflects what your experiences are or how you feel. Try to complete every item.

	Never	Rarely	Some-times	Often	Very often
1. I daydream and fantasize, with some regularity, about things that might happen to me					
2. I often have tender, concerned feelings for people less fortunate than me					
3. I sometimes find it difficult to see things from the "other guys" point of view					
4. Sometimes I don't feel very sorry for other people when they are having problems					
5. I really get involved with the feelings of the Characters in a novel					
6. In emergency situations, I feel apprehensive and ill-at-ease					
7. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it					
8. I try to look at everybody's side of a disagreement before I make a decision					
9. When I see someone being taken advantage of, I feel kind of protective towards them					
10. I sometimes feel helpless when I am in the middle of a very emotional situation					
11. I sometimes try to understand my friends better by imagining how things look from their perspective					
12. Becoming extremely involved in a good book or movie is somewhat rare for me					
13. When I see someone get hurt, I tend to remain calm					
14. Other people's misfortunes do not usually disturb me a great deal					
15. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments					
16. After seeing a play or movie, I have felt as though I were one of the characters					
17. Being in a tense emotional situation scares me					
18. When I see someone being treated unfairly, I sometimes don't feel very much pity for them					
19. I am usually pretty effective in dealing with emergencies					
20. I am often quite touched by things that I see happen					
21. I believe that there are two sides to every question and try to look at them both					
22. I would describe myself as a pretty soft-hearted person					

23. When I watch a good movie, I can very easily put myself in the place of a leading character					
24. I tend to lose control during emergencies					
25. When I'm upset at someone, I usually try to "put myself in his shoes" for a while					
26. When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me					
27. When I see someone who badly needs help in an emergency, I go to pieces					
28. Before criticizing somebody, I try to imagine how I would feel if I were in their place					

APPENDIX L: ProQOL-CS Sub-scale

Helping people puts you in direct contact with their 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 specifically about how positive or negative your work experiences with clients are. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these feelings in the last 30 days, by marking and marking the corresponding box with an X. Please try to complete every item.

	Never	Rarely	A Few Times	Somewhat Often	Very Often
1. I get satisfaction from being able to help people					
2. I feel invigorated after working with those I help.					
3. I like my work as a helper					
4. I am pleased with how I am able to keep up with work techniques and protocols					
5. My work makes me feel satisfied					
6. I have happy thoughts and feelings about those I help and how I could help them					
7. I believe I can make a difference through my work					
8. I am proud of what I can do to help					
9. I have thoughts that I am a “success” as a helper					
10. I am happy that I chose to do this work					

APPENDIX M: SSQ6 Scale

The following questions ask about people in your environment who provide you with help and support. Each question has 2 parts: <u>For the fist part</u>, list all the people you know, excluding yourself, whom you can count on for help and support in the manner described. Write down the person's initials and their relationship to you (e.g. spouse, sister, friend, supervisor, colleague, employer, therapist etc.).
<u>For the second part</u>, circle how satisfied you are with their support. If you have no support, please circle "No One", but still rate your level of satisfaction. Please do not list more than 9 persons per question. Please try to answer every item.

Example:

Who do you know whom you can trust with information that could get you into trouble?

No One
1) N.L. (Husband)
2) M.L. (Mother)
3) R.P. (Friend)
4) T.N. (Colleague)
5) L.M. (employer)
6)
7)
8)
9)

How satisfied are you with their support?

6 – very satisfied | 5 – fairly satisfied | (4) – a little satisfied | 3 – a little dissatisfied | 2 - fairly dissatisfied | 1 - very dissatisfied

1. Whom can you really count on to be dependable when you need help?

No One
1) 4) 7)
2) 5) 8)
3) 6) 9)

2. How satisfied are you with their support?

6 – very satisfied | 5 – fairly satisfied | 4 – a little satisfied | 3 – a little dissatisfied | 2 – fairly dissatisfied | 1 – very dissatisfied

3. Whom can you really count on to help you feel more relaxed when you are under pressure of stressed?

No One
1) 4) 7)
2) 5) 8)
3) 6) 9)

4. How satisfied are you with their support?

6 – very satisfied | 5 – fairly satisfied | 4 – a little satisfied | 3 – a little dissatisfied | 2 – fairly dissatisfied | 1 – very dissatisfied

5. Who accepts you totally, including both your best and worst points?

No One
1) 4) 7)
2) 5) 8)
3) 6) 9)

6. How satisfied are you with their support?

6 – very satisfied | 5 – fairly satisfied | 4 – a little satisfied | 3 – a little dissatisfied | 2 – fairly dissatisfied | 1 – very dissatisfied

7. Whom can you really count on to care about you, regardless of what is happening to you?

No One	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

8. How satisfied are you with their support?

6 – very satisfied	5 – fairly satisfied	4 – a little satisfied	3 – a little dissatisfied	2 – fairly dissatisfied	1 – very dissatisfied

9. Whom can you really count on to help you feel better when you are feeling generally down-in-the-dumps?

No One	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

10. How satisfied are you with their support?

6 – very satisfied	5 – fairly satisfied	4 – a little satisfied	3 – a little dissatisfied	2 – fairly dissatisfied	1 – very dissatisfied

11. Whom can you count on to console you when you are very upset?

No One	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

12. How satisfied are you with their support?

6 – very satisfied	5 – fairly satisfied	4 – a little satisfied	3 – a little dissatisfied	2 – fairly dissatisfied	1 – very dissatisfied

13) Does your employer make a therapist/counsellor available to you to discuss work related stresses with? *

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14) Do you think you could benefit from professional counselling/therapy? *

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15) If you had a counsellor/therapist made available by your employer, would you consider making use of the service? *

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* Additional questions added to collect information on attitudes towards professional counselling

APPENDIX N: Self-constructed Questionnaire

Please answer the following questions in the space provided. If the space provided is not enough, please continue writing on the reverse side of the page, but please remember to write down the number of the question before you continue writing. Please write clearly.

A. Were you the victim of trauma in the past 6 months? YES NO (please circle "YES" or "NO")

B. If yes, please describe very briefly what the event was:

C. Describe, by using the most appropriate number, how you felt shortly after the event
(1-not traumatised; 2-slightly traumatised; 3-quite traumatised; 4-very traumatised)_____

D. Describe, by using the most appropriate number, how you feel about the incident now
(1-not traumatised; 2-slightly traumatised; 3-quite traumatised; 4-very traumatised)_____

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1. Describe your feelings about having to deal with traumatised clients

2. Describe the case that affected you most negatively

3. How did this case affect you?

4. What about this case affected you?

5. How long ago was this case?

6. How long after the case did you feel affected by it?

7. When you deal with a traumatised client, do you mostly try to offer comfort to the person by talking a little about what happened to them, or do you rather try to focus on the work at hand and not talk about what happened to them?

8. After having dealt with a traumatised client, does it trouble you afterwards for some time, or can you mostly forget about it and go on with your day?

9. Do you often feel that you take your clients' traumas home with you, or can you effectively leave work matters at work?

10. What other difficult life demands did you have to deal with in the past 3 months?

11. How have these life demands affected you?

12. Did these life demands affect you a little or quite a lot?

13. How often have you taken sick leave in the past 6 months?

14. Would you say that difficulties at work have contributed to you taking sick leave?

15. Have you ever used sick leave because you felt overwhelmed or needed a break from work?

16. How often has this happened?

17. What else in your work context affects you negatively?

18. Please explain how your work context affects you?

19. How does your work context support you?

20. Is there anything your employer/work context could do that would help you cope better with your work demands?

APPENDIX O: Additional MANOVA Results (Sub-scales)

Table 34. MANOVA Result: Secondary Traumatic Stress Sub-scales by Group

INDEPENDENT VARIABLE		VALUE	DF	F
Group	Wilk's Lambda	0.70	2:141	21.47*

* $p<0.0001$

Table 35. MANOVA Result: Empathy Sub-scales by Group

INDEPENDENT VARIABLE		VALUE	DF	F
Group	Wilk's Lambda	0.80	2:141	4.22*

* $p<0.01$

Table 36. MANOVA Result: Negative Cognitive Schema Sub-scales by Group

INDEPENDENT VARIABLE		VALUE	DF	F
Group	Wilk's Lambda	0.58	2:141	10.76*

* $p<0.0001$

APPENDIX P: Transformed Data

Table 37. Descriptive Statistics: Transformed Negative Cognitive Schema Sub-scale Data by Group

	Claims Workers			Trauma Counsellors			Holiday Booking Consultants		
DEPENDENT VARIABLE	**N**	**MEAN**	**SD**	**N**	**MEAN**	**SD**	**N**	**MEAN**	**SD**
Self-Esteem Sub-scale (transformed)	50	0.61	0.31	46	0.41	0.24	48	0.44	0.28
Other-Esteem Sub-scale (transformed)	50	1.03	0.25	46	0.88	0.19	48	0.88	0.21
Other-Control Sub-scale (transformed)	50	1.03	0.36	46	0.80	0.23	48	0.71	0.26
Self-Intimacy Sub-scale (transformed)	50	0.88	0.33	46	0.70	0.31	48	0.75	0.32

APPENDIX Q: Fisher's *z* Results

Table 38: Fisher's z Analysis Results: Differences Among Group Correlation Coefficients

CORRELATIONS	GROUPS		
	Claims workers* Trauma counsellors	**Trauma counsellors* Holiday booking consultants**	**Claims workers* Holiday booking consultants**
Secondary traumatic stress* Negative cognitive schemas	0.440	-0.120	0.322
Secondary traumatic stress* Empathy	1.134	-0.142	1.003
Secondary traumatic stress* Compassion satisfaction	-2.363*	-0.266	-2.664**
Secondary traumatic stress* Social support	0.357	0.562	0.214
Negative cognitive schemas* Empathy	0.625	-0.570	0.049
Negative cognitive schemas* Compassion satisfaction	-1.673	-1.217	-2.936**
Negative cognitive schemas* Social support	-1.428	-0.326	-1.778

* $p<0.05$ ** $p<0.01$

APPENDIX R: Etic and Emic Voice Overview

