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The perceived impact of services rendered by Lay Counsellors

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Chapter 2

Literature review

Introduction

It is considered essential to gain a more in-depth understanding of literature pertinent to this study, in order to formulate a more precise area of enquiry which could then be used to guide more extensive research in the future. This literature review will therefore focus on literature which gives a definition and explanation of trauma, looks at crime statistics in South Africa, defines what a victim support centre is, what lay counselling is and what these counsellors do. It also defines debriefing or short-term interventions, focuses on relevant theories and finally considers the models used by trauma counsellors.

1 Trauma

Trauma can be defined as '…a powerful psychological shock that has damaging effects' (Colman, 2002, p.755). These effects could last for an extended period and may even continue for several years ("Victims Will Be", 2004). Trauma is also defined as a response or reaction to an unforeseen incident, which is due to the fact that an individual's reaction to a trauma cannot be predicted or planned (Everstine & Everstine, 1993; Hybels-Steer, 1995; Pearlman, 2001). Several authors discussed the reality that there are often no physical scares or injuries that can simply be identified, recognised and sewn up, and that the wounds are more likely to take on an internalised emotional form. This makes recovery even more difficult (Everstine & Everstine, 1993; Hybels-Steer, 1995; Waites, 1993; Wilson & Raphael, 1993). Psychological trauma therefore becomes more complex as healing becomes a covert process, where recovery is more difficult to envisage.

Although many authors have identified and categorised some incidents which could be considered traumatic, it should be remembered that this list is not exhaustive and that there are many other incidents which can adversely affect individuals.

Individuals often have a sense of ‘it will never happen to me’, which can be considered an incorrect assumption, as anybody can be affected at any time by any one of these traumatic incidents, and nobody is exempt from being affected. Victimisation is something that has no race, class or political boundaries, according to Simpson (1996). Examples of traumatic incidents are natural or man-made disasters, physical assault, sexual assault, property loss, physical loss, violent agency, being kidnapped, loss by death, loss of relationship, bearing witness to tragedy, prediction of danger and loss of status (Everstine & Everstine, 1993; Scott & Palmer, 2000). These incidents all seem so vastly different, yet some similarities have been identified in the reactions of individuals to these incidents. McFarlane, Atchison, Rafalowicz and Papay (1994), have also recognised that there may even be a reactive pattern to trauma, which is related to a universal response, rather than a specific response. It has further been identified that victim’s reactions may be similar in nature, as they would have been exposed to an incident which is outside of their usual experience and where they may have been confronted by threats of their own or other’s death or serious injury (American Psychiatric Association, 2000; Wilson & Raphael, 1993).

According to Hybels-Steer (1995), trauma leaves the victim feeling weak, defenceless and paralysed after an incident in which extreme fear was experienced. Individuals who have experienced a traumatic incident may also experience symptoms such as feeling emotionally numb, angry, tearful, anxious, irritable, restless, enraged and panicked, and often experience reactions such as denial, disbelief, disorientation, confusion, hyper-vigilance and even depression (Barlow & Durand, 1999; Hybels-Steer, 1995). According to Everstine and Everstine (1993), these symptoms should not be considered harmful or destructive, but rather that their purpose is to heal, and that the process of restoring the disequilibrium in the victim’s emotional life has begun through these experiences. The reaction of shock to an unexpected and often overwhelming incident is considered by Hybels-Steer (1995) to be a very normal reaction to a traumatic incident and it is considered to affect both the victim’s body and mind. Hybels-Steer notes that some effects on the

mind may include numbing, confusion, unusual thoughts, forgetfulness and disrupted memories and that physiological reactions could include digestive problems, headaches, allergic reactions and even disrupted menstrual patterns in women. According to Sue, Sue and Sue (1997), those who have experienced a stressful incident, could become more prone to infections, as stress directly affects the immune system. Van der Kolk and Greenberg (1987, in Waites, 1993) affirm that there are alterations in the immune system as a result of a stressful incident, which make victims more susceptible to disease and infection. According to Barlow and Durand (1999) and Waites (1993), being exposed to a shocking incident may also lead to a lowered level of norepinephrine in the brain, which not only has a relationship with a person's reaction of panic, but may even lead to depression. This may be one of the reasons that depression is often found in those who have experienced a traumatic incident (Hybels-Steer, 1995; Scott & Palmer, 2000). It can therefore be seen that traumatic reactions affect every aspect of the victim's being, as reactions can be physiological, emotional, cognitive and behavioural (Kinchin, 1994).

According to Sadock and Sadock (2003) and Scott and Palmer (2000), an individual who has experienced a traumatic incident is likely to experience Acute Stress Syndrome (ASS), which may in turn lead to Post-Traumatic Stress Disorder (PTSD). Although trauma plays a significant role in the development of mental disorders, it should be clear that not all trauma reactions lead to anxiety disorders such as ASS or PTSD (Perrin et al., 2000). The symptoms of ASS are similar to those in PTSD, except that the symptoms of ASS occur within the first 4 weeks of exposure to a traumatic incident and only last between 2 and 30 days (Sadock & Sadock, 2003). Should the symptoms persist beyond this time, the diagnosis of PTSD becomes more relevant or appropriate. If the onset of the symptoms is only 6 months after the traumatic incident, then the PTSD is considered to have a delayed onset. If there are additional symptoms such as somatization, re-victimization, relationship difficulties or identity disruptions, then the PTSD could be considered to be complex in nature (Pearlman, 2001; Smyth, 1999). The difficulty in

diagnosing PTSD following a traumatic incident could also be further complicated by the fact that PTSD shares many symptoms with other disorders, such as major depressive disorder and generalised anxiety disorder and may even co-exist with other disorders (Keane, Taylor & Penk, 1997).

According to literature, individuals with ASS may experience symptoms of detachment, derealization, dissociative amnesia and/or depersonalization (American Psychiatric Association, 2000; Sadock & Sadock, 2003). Furthermore, experiencing a traumatic incident often results in dissociation, intrusively reliving the experience, attempts to avoid reminders of the incident, as well as persistent psychological arousal (Perrin et al., 2000; Sue et al., 1997).

According to Scott and Palmer (2000), PTSD can therefore be divided into the three symptom clusters of intrusion, avoidance and disordered arousal. According to Hybels-Steer (1995), the effects of this arousal may cause victims to have difficulty sleeping or concentrating, they may be easily startled, panicked, extremely emotional, tearful, anxious or even show excessive alertness. Scott and Palmer (2000) explain the recurrent, distressing and intrusive recollections of the incident as spontaneous, unwanted and uninvited thoughts about the incident that victims cannot control or stop. When victims try to avoid reminders of the traumatic incident, they do this in order to protect themselves from being overwhelmed by the incident. This defence is however not always successful in reducing the distress they experience (Scott & Palmer, 2000).

Barlow and Durand (1999), Keane et al. (1997) and Sadock and Sadock (2003), further explain that symptoms associated with PTSD only develop after a traumatic incident or extreme stressor has been experienced. These authors also maintain that not only does the incident have to occur, but that the victim has to react to this experience with fear, helplessness or horror. The victim also has to recollect or re-experience the incident when awake or asleep and attempt to avoid reminders of the incident, in order to diagnose PTSD. According to Perrin et al. (2000), a traumatic

incident or extreme stressor is therefore necessary to cause PTSD, but not sufficient. It is important to remember that the incident in itself may not be traumatic, but that it is the victim's perception of the incident that makes it traumatic and therefore, the more intense their perception, the more severe the experience (Barlow & Durand, 1999; Everstine & Everstine, 1993). The victim's subjective experience is at least as important as the objective aspects of the incident, according to Perrin, Smith and Yule (2000).

Finally, the incident does not have to be experienced first-hand in order to be traumatic. The different types of trauma considered here are called secondary or vicarious traumatization, which can be experienced by anyone in the helping profession who deals with trauma survivors, or anyone who bears witness to another's trauma (Nelson, 1996). By bearing witness to victim's traumatic experiences, these helpers take on some of the emotional pain and suffering that the victims have experienced and they themselves become susceptible to being traumatised as a result. According to Nelson (1996), both professional and volunteer helpers therefore need to be informed about and recognise the symptoms of PTSD, as they too can be impacted by this disorder.

While trauma has been defined and the symptoms resulting from a traumatic incident have been discussed, it would be helpful to establish who is at risk of developing these symptoms. It has been maintained by Simpson (1996) that anybody could become a victim of crime at any time, and that everybody is therefore vulnerable to develop the symptoms following a traumatic incident. Before considering how vulnerable individuals are of becoming victims of crime in South Africa, it is essential to define what a victim of crime is. This definition will then be followed by a discussion on the crime statistics in South Africa and how these statistics relate to the vulnerability of individuals becoming victims in this country.

2 Victims of crime and Crime Statistics in South Africa

As this study aims to investigate and describe how victims of crime perceive services rendered by lay counsellors, it seems important to define what is meant by victims of crime. Once defined, the vulnerability of individuals to become victims of crime can be considered, by taking into account the overwhelming statistics of crime in South Africa.

Victims of crime

Various dictionaries have been referred to in order to semantically clarify the meaning and gain a better understanding of certain psychological terms used in this study. According to The American Heritage Dictionary of the English Language (2000), a victim can be defined as 'one who is harmed or killed by another' or as 'one who is harmed by or made to suffer from an act, circumstance, agency, or condition'. The Cambridge Advanced Learner's Dictionary (2003), defines a victim as 'someone or something which has been hurt, damaged or killed or has suffered, either because of the actions of someone or something else, or because of illness or chance'. The Cambridge Advanced Learner's Dictionary (2003) also explains that falling prey or victim to something or somebody means 'to suddenly begin to suffer as a result of something or someone bad'. These definitions explain what is meant by the term victim. In order to clearly define a victim of crime, it seems appropriate to establish what is meant by a crime. The Cambridge Advanced Learner's Dictionary (2003) defines crime as 'illegal activities … an illegal act … [and/or] … an immoral or very foolish act or situation'. These definitions will be integrated in this study to refer to victims of crime in South Africa as individuals who have suffered emotionally, or who have been traumatised due to a criminal or illegal act. In order to understand how vulnerable South Africans are in becoming victims of crime, it may be beneficial to consider the crime statistics of this country.

Crime statistics

These crime statistics have been included to highlight the high rate of crime in South Africa and to emphasise the reality and extent of victimisation. A summary

of crime statistics supplied for the period of April to March 1994/1995 to 2003/2004 by the Crime Information Analysis Centre and the South African Police Service for both the Republic of South Africa and for Sandton, Gauteng is included in Appendix A of this study ("Crime in the RSA", 2004). According to these statistics, there has been an increase in rapes, common assaults, robberies with aggravating circumstances, common robberies, indecent assaults, neglect and ill treatment of children, burglaries at business properties, public violence, arson, stock theft, commercial crimes and drug-related crimes in the Sandton area from the period of April to March 1994/1995 to 2003/2004. For the same time period in this area, there has however been a decrease in the number of murders, attempted murders, assault with the intent to inflict grievous bodily harm, kidnapping, abduction, culpable homicide, malicious damage to property, burglary at residential premises, theft of or out of motor vehicles and driving under the influence ("Crime in the RSA", 2004).

Although the ratios of some crimes have decreased since 1994/1995, these statistics still indicate the enormous prevalence of crime in South Africa. According to the Crime Information Analysis Centre, the incidence of crime in South Africa is more than double that of the world average. This indicates not only the severity of the problem, but also the increasing need for support for those who are being affected ("Criminal Justice Fact Sheets", 2004). A study done by the International Criminal Police Organisation (Interpol), compares the crime rates across 13 countries including Columbia, Brazil, Russia, Spain, Swaziland, Namibia, South Africa, Zimbabwe, Hungary, Australia, Canada, France and Jamaica for the year 1998 ("South Africa: World", 2001). These results were compared with statistics released by the Crime Information Analysis Centre of South Africa (CIAC) and it was found that for some categories of crime, South Africa does have the highest crime rate. This is not the case for all categories however, and South Africa therefore does not rate as the most crime-ridden country. Although it was concluded that South Africa compares favourably with other countries in general, it has still been found to have an astoundingly high level of violent crime. This sets it apart from the other

countries investigated, and implies that it would need to drop these levels substantially, in order to loose the label of being 'the world crime capital' ("South Africa: World", 2001).

An article published in the Nedbank ISS Crime Index highlights the severity of the crime problem, by maintaining that a substantial amount of crimes go unreported. It further focuses on two reasons which may explain the underreporting of crimes ("South Africa: World", 2001). The first reason is attributed to the perception that victims have of the police force. More crimes are reported if the police are perceived as supportive and trustworthy and less if the police are perceived as repressive or ineffective. The second reason could be that victims may have to travel a great distance to report the crime and they may not readily have transport available in order to get to the police station ("South Africa: World", 2001).

When making comparisons between crime statistics, it is important be bear in mind that, according to the national census done in 2001, the population of Gauteng alone has risen by 20 percent between 1996 and 2001, and that the overall South African population has risen from 40.5 million in October 1996 to 44.8 million in October 2001 ("South Africa Grows", 2003). It should therefore be kept in mind that this increase in population may have had an influence on the increase in the rate of crime in South Africa. Nevertheless, these crime statistics highlight the high rate of crime in South Africa and in turn emphasise the reality and extent of possible victimisation. It seems that this high rate of crime will therefore have to be minimised in order to minimise the risk of becoming a victim.

In order to minimise the effects of trauma due to criminal acts and to maintain the optimal functioning of individuals in a country ridden with crime, it is imperative that victims of crime receive available, suitable and accessible support, as offered by victim support centres. While the perceptions of victims about the services rendered by these centres may differ, it is considered valuable to explore what role

these support centres aim to fulfil. Victim support centres will therefore be considered in more detail in the following discussion.

3 Victim Support

According to the Cambridge Advanced Learner's Dictionary (2003), victim support can be defined as 'the practice of providing emotional and practical help for people who suffer because of a crime'. More specifically, victim support is an organisation that makes use of volunteers, who offer free counselling and practical help to victims of crime, in order to relieve their symptoms through supportive interventions ("Can Anyone Help", 2004).

The concept of a victim support centre was first started in Bristol in the United Kingdom (UK) in 1972, when members of the National Association for the Care and Resettlement of Offenders (NACRO) embarked on the first victim support project ("Victim Support", 2005). The project began with a needs analysis, which determined that victims of crime were suffering at various levels, namely, emotionally, physically and financially, and that there was no agency or organisation which undertook to help alleviate this suffering. As a result of this initial project, the first victim support group was established in Bristol in 1974 and other centres across Britain soon followed.

According to Holtmann (1999), victim support in South Africa began to take shape in 1988 when two pilot studies were undertaken as a joint initiative between Business Against Crime in Gauteng and the Rosebank Community Policing Forum. The study was done in order to develop a victim support initiative that trained volunteers with basic counselling skills, so that they could be equipped as lay counsellors to address the needs of victims of crime. The two pilot studies took place in Rosebank and Alexandra Township, under the management of representatives from the state, non-governmental organisations, community-based organisations and Kathy Hobdell, who had 21 years experience with victim support in the UK. Volunteers were trained according to criteria established in the UK, and

other relevant stakeholders were trained under the guidance of the Centre for the Study of Violence and Reconciliation's Trauma Clinic (Holtmann, 1999). Kathy Hobdell assisted not only in establishing and assessing the pilot studies, but also in the establishment of guidelines for victim support programmes in South Africa. These programmes were developed in order to facilitate the sustainable ongoing process of adequate and effective services as rendered by these lay counsellors, to victims of crime in the area. The process of implementing the programmes was discussed at a workshop held in April 1999, where the minimum requirements and criteria with regards to training were agreed upon (Holtmann, 1999).

The victim support centre used for this study was established in February 2000 and is funded by the local precinct and community police forum. It is based at a police station in a Gauteng suburb, where lay counsellors work in close collaboration with the police to optimally help victims affected by crime. Some of the limitations regarding the functions of victim support centres in general, are also considered relevant to the support centre used in this study, and will therefore be considered here (Reeves, 2003). Firstly, the services rendered by the lay counsellors may not reach victims who do not report the incident to the police. Secondly, lay counsellors rely on information obtained from the police, which may be unavailable or insufficient. This may be due to technical difficulties such as computer systems being off-line or human error. At times, cases may not be entered into the system in time, due to an excessive workload or victim's contact details may be noted incorrectly. Thirdly, victims who have experienced secondary traumatization due to witnessing a crime are often unknown and therefore cannot be contacted, as information obtained from the police is directly linked to the primary victim. Finally, lay counsellors at this centre are often faced with a great number of victims to contact and may therefore need to screen which crimes appear to be more severe, which means that some victims in need of interventions may inadvertently be overlooked (Reeves, 2003).

These limitations imply that there may be many victims who do not make use of the services available to them. This could be due to not reporting the incident, unavailable or insufficient information obtained by the lay counsellors from the police, secondary traumatization or an overwhelming amount of cases that the lay counsellors have to work with. There may also be victims who do not make use of these interventions as they simply do not have knowledge of or access to these services. Future research into these limitations may therefore be necessary, in order to make these services more accessible and visible. It has briefly been mentioned above that support centres train volunteers to be lay counsellors who offer supportive interventions to victims of crime. In order to gain a better understanding of who these volunteers are and what their roles are, it is beneficial to review further literature on lay counsellors.

4 Lay Counsellors

According to Louw (2002, in Painter & Terre Blanche, 2004), there are only around 8000 registered psychologists in South Africa, which has an overall population estimated at 44 million. This means that there are simply not enough professional resources to reach those in need and alternative sources of support had to be found. Lay counsellors, who provide a support service which is more cost-effective, fast, available and accessible than the limited professional services offered to the many that are in need of support, have been recognised to fill that gap (Golden, 1991; Hamling, 1997). Lay counsellors are often volunteers from the community who are trained to skilfully provide a variety of services in different settings, which in turn help ease the workload of already overworked psychologists. As this study aims to describe how victims of crime in South Africa perceive services rendered by lay counsellors at a victim support centre, the focus will be specific to lay counsellors in this field and at the support centre used in this study. While lay counsellors at support centres in Britain have been highly commended for their ‘dedication and professionalism’ (p.4) by the National Audit Office, little research has been done on the effectiveness of the services rendered by lay counsellors in the South African context (Reeves, 2003).

The lay counsellors at the support centre used in this study are trained to fulfil a supportive role, and are the link between the victim, the South African Police Services (SAPS) and referral agencies. These lay counsellors make telephonic contact with victims shortly after the crime and offer a range of free services including emotional, moral and practical support relevant to the traumatic incident (Potter, 2000). They may also inform victims of their rights, provide information on judicial procedures and assist in opening a case ("Victim Support", 2005). Their main function therefore, is to support victims who have been traumatised by crime-related incidents (Snyman, 1996). Although the initial contact is primarily telephonic, lay counsellors do offer face-to-face interventions for those victims who are in need of more in-depth counselling. As a result of their limited training however, lay counsellors offer a maximum of four face-to-face interventions with victims of crime and do not counsel those who are in need of interventions which exceed the lay counsellor's abilities. Victims who require longer-term interventions are subsequently referred by the lay counsellors to more experienced psychotherapists (Golden, 1991).

According to criteria stipulated by victim support in the UK, volunteers at this centre need to be over the age of 18 years and do not need to have any formal qualifications to become a lay counsellor ("Victim Support", 2005). Recruitment of lay counsellors at the support centre used in this study is done primarily through newspaper advertisements and word of mouth. Volunteers who respond are then interviewed at the centre, before being selected to join the team. Prospective lay counsellors need to be available for at least two shifts a month, each shift lasting for the duration of 4 to 5 hours, either during the week or on weekends. Volunteers are further screened to assess their aptness and ability to effectively fulfil the role of a lay counsellor. Once lay counsellors have been chosen, they undergo training in basic counselling, which is done over a period of 2 days. This is done in order to equip them with the skills necessary to offer adequate and appropriate support to victims of crime immediately following the incident. This training includes not only basic counselling skills, but also provides information on trauma and police

procedures, so that lay counsellors are able to offer emotional, practical and relevant information to those in need. Once the lay counsellors have acquired the necessary basic knowledge, they observe more experienced volunteers before offering support to victims on their own. Ongoing training is offered by guest speakers on a monthly basis, so that lay counsellors are given the opportunity to learn advanced skills in areas such as bereavement, trauma, domestic violence and rape, to name but a few. Lay counsellors are interviewed again 6 months after their initial training, in order to assess their progress and to discuss any difficulties they may be experiencing.

Further support is given to all lay counsellors at the support centre. This is done by offering supervision by means of monthly small group meetings run by core group leaders, who are lay counsellors selected from the volunteer group using rigorous criteria. Core group leaders in turn receive monthly supervision by professional psychologists. It is imperative that lay counsellors are monitored and continue to receive supervision, since the value of debriefing depends on the skills and motivation of these lay counsellors (Hamling, 1997). In order to further assess the value of this debriefing, it would be valuable to consider what debriefing is and how it is used by lay counsellors in this context.

5 Debriefing

Considering the fact that there is a shortage of registered psychologists in South Africa, it seems that offering therapeutic interventions which are more time, cost and energy efficient would be highly beneficial. Molnos (1995) agrees that when considering the universal lack of resources, which includes South Africa, long-term psychotherapy is just not viable in many instances. According to Molnos (1995) as well as Peake, Borduin and Archer (1988), brief psychotherapy therefore grew out of necessity. Although psychological debriefing became an acceptable brief psychotherapeutic practice during the 1970's, it only gained popularity and became the preferred method of intervention in the case of traumatic incidents during the mid 1980's, with the establishment of Mitchell's Critical Incident Stress Debriefing

model (Rose, Bisson & Wessely, 2003). This model, as well as other models which have subsequently been established, will be considered in later discussions. For this study, the definition of brief psychotherapy as 'any form of psychotherapy limited to a small number of sessions … usually aimed at dealing with a circumscribed symptom or achieving a narrow and specific objective', will be used (Colman, 2002, p.102).

According to the Centre for Crisis Psychology, there is a difference between longer-term counselling and psychological debriefing ("Trauma Counselling", 2000). During longer-term counselling, the counsellor or therapist generally helps the client explore various issues and personal difficulties, continuing over a number of sessions. This is often done in a non-directive manner, where the sessions focus on the client's needs and agenda. Psychological debriefing on the other hand is a highly structured and very directive short-term intervention, which is used specifically for clients who have experienced a traumatic incident. In addition, it has been suggested that the difference between longer-term counselling and debriefing, is that in the latter, the goals of therapy are more specific, the therapist more active and the interventions planned in greater detail (Peake et al., 1988). The interventions focus specifically on the victim's reactions to this traumatic incident and often include an educational element ("Trauma Counselling", 2000). Brief psychotherapy, has to have a limited focus in order to achieve change, which is one of the reasons it is considered relevant for the treatment of victims after a traumatic incident, according to Peake et al. (1988). Although psychological debriefing following a traumatic incident differs from long-term psychotherapy, it is important to acknowledge that psychological debriefing can be used as part of longer-term interventions should the need arise (Labardee, 2002). Since this study aims to focus specifically on the effectiveness of shorter-term interventions, psychological debriefing will be discussed in greater detail.

The aim of psychological debriefing is to establish the victim's reactions to the trauma, to discuss these reactions, and to identify coping strategies in order to

prevent future difficulties ("Psychological Debriefing", 2000). In this way, debriefing can be considered to be a structured intervention where victims are given the opportunity to review the traumatic incident and their response to it ("Trauma counselling", 2000). More specifically, debriefing is considered by Fullerton et al. (2002) to be a methodical process of 'education, emotional expression and cognitive reorganization accomplished through the provision of information and … shared common experiences' (p.2), under the auspices of an informed facilitator. In the same way, Hodgkinson and Stewart (1998, in "Trauma Counselling", 2000), maintain that the aim of debriefing is to promote cognitive organisation, decrease the sense of uniqueness, mobilise resources, reduce symptoms and identify further avenues for help. In other words, debriefing can be considered an opportunity for victims to explore their traumatic experience and establish ways to cope with the traumatic incident with the help of an experienced counsellor.

Despite these definitions and explanations of psychological debriefing, the debate continues as to whether debriefing is actually effective or not (Fullerton et al., 2002). Although the aim of this study is to determine whether victims of crime in South Africa, who have experienced psychological debriefing with lay counsellors, perceive these interventions as helpful, hindering or having no effect in their ability to cope after a traumatic incident, it does not intend to conclude this long standing debate. However, before discussing the results of this study, it would be useful to consider some arguments for and against psychological debriefing in general, in order to gain a better understanding of the controversy behind this debate.

According to Friedman (2003), early interventions aimed at traumatic stress, such as psychological debriefing, help interrupt the onset of more serious disorders, prevents acute stress disorder (ASD) from developing into chronic Post-Traumatic Stress Disorder (PTSD), and reduces the severity and duration of PTSD, should this disorder emerge. There is little evidence that psychological debriefing alleviates the symptoms of ASD, or prevents PTSD however, and some studies have indicated

that these interventions worsen instead of improve symptoms experienced by victims (Friedman, 2003; Fullerton et al., 2002; Rose et al., 2003).

The debate continues as Lindy, Green, Grace and Titchener (1983, 1986, in Everstine & Everstine, 1993) maintain that early interventions are imperative in lessening the severity and duration of traumatic incidents. Everstine and Everstine (1993) are not in favour of short-term interventions however, and maintain that these interventions are rarely helpful in minimising the severity of the incident. They go as far as to say that individuals who participate in such interventions view these as intrusive and that they may avoid further psychotherapy after this type of intervention.

According to an article published by the Centre for Crisis Psychology, debriefing interventions were not meant to be used as once-off sessions and have therefore shown to be harmful when used in this manner ("Trauma Counselling", 2000). It is further argued that debriefing is only one element of trauma counselling. It is therefore considered helpful when used as part of other longer-term intervention strategies, where counsellors can monitor how victims are coping over time and refer them for additional interventions if necessary (Labardee, 2002). It is further maintained that it is essential that the interventions be appropriately timed, as incorrectly timed interventions may result in re-traumatization, which is contrary to the aim of debriefing (Friedman, 2003; "Psychological Debriefing", 2000). Some authors agree that debriefing may actually interfere with the natural way victims react to the incident and that debriefing may not only re-traumatise victims due to the early re-exposure to traumatic material, but may actually delay the normal healing process and prolong trauma in victims (Fattah, 1986, in Frieberg, 2001; Friedman, 2003).

Despite the attempts to validate the effectiveness of psychological debriefing, there is no empirical evidence that debriefing following an incident has a positive effect

(Friedman, 2003; Rose et al., 2003). There seems to be an increased amount of scientific literature indicating that debriefing is ineffective in the recovery process, yet formal evaluation of the effectiveness of debriefing is still lacking (Fullerton et al., 2002; "Trauma Response", 2002). Even with the inability to resolve the long standing debate about the effectiveness debriefing, these interventions are still being used by lay counsellors at support centres. The debate about the effectiveness of debriefing focuses on research relating to the lay counsellor's perceptions of the interventions, the models used, and the victim support centres. This study will focus on the victim's perceptions however, as this is a reasonably unfamiliar area of research. This will be done in order to determine how victims of crime perceive the services rendered by lay counsellors, and so contribute to this long standing debate.

Frank (1985, in Peake et al., 1988) has acknowledged some requirements of any form of brief psychotherapy, irrespective of the therapeutic approach employed by the therapist, in order for it to be successful. This author maintains that a 'confiding' therapeutic relationship be formed in a 'healing setting' where the therapist uses a 'conceptual scheme' or theoretical framework to explain the symptoms and prescribed treatment, and where both the therapist and client participate and believe in the healing process (Frank, 1985, in Peake et al., 1988, p.14). This is supported by Molnos (1995), who agrees that there are certain intermediate and immediate aims of brief psychotherapy and mentions that the therapist's neutrality is essential. Although a person's values and morals operate unconsciously, it is essential that the therapist or counsellor becomes aware of their own biases so that these do not influence the therapeutic interventions. Molnos (1995) also maintains that striving for perfection in any therapeutic intervention is a 'neurotic goal' (p.79), where both the counsellor and the client can become stuck. Often this striving for perfection leads to an unnecessarily long therapeutic process, as unrealistic expectations about the process can not be met in the process at hand (Molnos, 1995).

Regardless of the debate about whether brief psychotherapy is beneficial or not, one should always remember that individuals are unique and that not all approaches to psychotherapy are suited to all individuals. While some individuals prefer long-term interventions, others prefer brief psychotherapy and this preference needs to be respected by all therapists, despite their own biases. According to Molnos (1995), there are many cases where long-term psychotherapy is more suitable, especially when the damage occurred early on. Peake et al. (1988) agree and note that individuals who have not resolved early developmental issues, specifically around trust, are more likely to be harmed than healed through brief psychotherapy. Molnos (1995) does remind therapists of their responsibility as professionals to treat clients only for the duration that they really need it, and not to continue therapy because of the therapist's own agenda or needs. Pearlman (2001) further maintains that having a sound theoretical background is essential when doing therapeutic interventions. Consideration will therefore be given to the theories which guide the lay counsellors at the support centre in their interventions.

6 Theories of interventions

According to Pearlman (2001), theory is invaluable in the therapeutic setting as it provides a framework within which counsellors can formulate not only a better understanding of their clients and their presenting concerns, but also hypothesises about what is being presented in the therapeutic setting. They can then be further guided to decide upon the most appropriate therapeutic interventions. Pearlman (2001) also maintains that working from a theoretical background is what makes clinicians or counsellors more useful than just 'any other interested, kindly individual' (p.207).

All crisis intervention models therefore have a theoretical basis (Gilliland & James, 1993). Although there are many different theories used in short-term interventions, the two considered most appropriate for this study are the psychodynamic approach and the cognitive-behavioural approach. These approaches have been integrated and used as the grounding theory for the Wits Trauma Intervention Model used by the

lay counsellors in this study. While the model will be further discussed in Section 7 of this chapter, the appropriate theories will also be the focus of this section.

6.1 Psychodynamic approach

The psychodynamic approach is considered by Wilson and Raphael (1993) to be a very important approach to traumatic stress, as works by Freud and other theorists in this approach were very influential in future thinking about PTSD. Freud was one of the first theorists to recognise the impact of trauma in his theories and to consider both the severity of the incident and the meaning given to the incident by the individual (Kleber & Brom, 1992).

The psychodynamic theory therefore focuses mainly on the balance of the psyche (Friedman, 2003). When individuals are exposed to a traumatic incident, they are confronted by an overwhelming threat such as the threat of death, and the balance of the psyche is thrown into disequilibrium, often leading to psychic trauma (Bailly, 2003; Gilliland & James, 1993). In an attempt to control this overwhelmingly disorganizing effect or disequilibrium, the individual forces intolerable thoughts and feelings about the incident out of their conscious awareness. This is done through a process called ‘repression’ (Kleber & Brom, 1992, p.229).

Freud (1914, 1920, in Horowitz, 1999) originally maintained that the repression of traumatic memories is a ‘pathological defense’ that ‘preserved emotional equilibrium but prevented mastery of the shocking experience’ (p.3). Repression is therefore used as a defense mechanism (Wilson & Raphael, 1993). Although the aim of the defense mechanisms is to temporarily interrupt the coping process, which results in less intense emotions as well as leading to an increase in the victim’s motivation to continue coping, this is not always the case (Kleber & Brom, 1992). The victim may be successful in repressing emotions and memories related to the traumatic incident, but these are still considered powerful enough to

become expressed as symptoms (Friedman, 2003). It has further been recognized by Eagle (2000) that traumatic incidents are related to 'unconscious associations and anxieties' (p.301) and by Horowitz (1999) that the symptoms that victims experience are formed through an unconscious process. This is associated with the ego's inward focus, on imagery associated with the traumatic incident, instead of an outward focus on reality, which leads to symptoms such as nightmares and anxiety (Kleber & Brom, 1992).

Freud further observed that after traumatic incidents, victims often re-experienced parts of the incident, which he referred to as 'compulsion repetition' (Kleber & Brom, 1992, p.224). The compulsion of the human psyche to repeat traumatic incidents over and over again is considered to be an attempt to integrate conflicting information gained during the incident with the existing schema, and to enable victims to come to terms with the incident. Although the recollection of the incident is considered by Freud to be a vital part of the coping process, it triggers very strong emotions (Kleber & Brom, 1992). Freud maintained that an individual has a 'stimulus barrier' and that the very strong emotions provoked in a traumatic incident are able to overwhelm the healthy ego by breaking through this 'stimulus barrier', which in turn renders the ego incapable of appropriate reality testing (Kleber & Brom, 1992; Wilson & Raphael, 1993). The psychodynamic approach therefore tries to understand the disequilibrium of the psyche and the threatened ego, by gaining access to the victim's unconscious thoughts and past experiences (Gilliland & James, 1993).

6.2 Cognitive-behavioural approach

According to Gladding (2000), the basic premise of the cognitive-behavioural approach is that emotions and behaviours are determined by the way people structure their worlds, and that this is done through their cognitions. The way a person responds to a particular situation is therefore determined by the subjective meaning they attach to that situation (Pilgrim, 2003). In order to understand the

underlying emotions and distress related to a traumatic incident, where the victim's cognitive and analytical abilities are disordered following a traumatic incident, it is therefore necessary to consider the cognitive content of that incident (Corey, 2001; Everstine & Everstine, 1993; Hybels-Steer, 1995).

Pilgrim (2003) explains that individual's schema influence their beliefs. Schema are generally considered to be unconscious mental processes or psychological structures that dictate most of our experiences, help individuals understand the world and are used to interpret or assimilate new information (Horowitz, 1999; Kleber & Brom, 1992). If new information, such as that gained in a traumatic incident, is perceived as overwhelmingly threatening or exceeds what the victim can integrate into their existing schemas, victims can experience changes to this schema and in turn experience symptoms associated with Acute Stress Disorder (Eagle, 1998; Pilgrim, 2003).

Pilgrim (2003) further maintains that the assumptions, perceptions and interpretations given to an incident by those who have experienced trauma, determine how they react to and cope with the incident. The victim's negative or positive perception of their reaction therefore influences their ability to cope. Meichenbaum (1986, in Corey, 2001) adds that disturbing emotions are usually caused by dysfunctional thinking. If these emotions are considered to be negative, victims are more likely to avoid them, which is done by avoiding actual memories of the incident. According to Hybels-Steer (1995), the disrupted memories associated with the traumatic incident are different to other types of memories. Waites (1993, p.26) further maintains that memories are affected by trauma in a variety of ways which includes the 'encoding, storage and retrieval' of the traumatic memories. It has also been recognised that trauma disrupts neurological pathways and the way memories are formed (Van der Kolk & Fisler, 1995, in Eagle, 2000). Should memories be extremely traumatic, the memories are rather avoided as a way of coping with the incident. Victims may use defences such as denial or projection in order to distort the reality of the traumatic incident and may even have no

memory of the incident at all, especially if they were physically injured during the incident (Everstine & Everstine, 1993; Waites, 1993). According to Pilgrim (2003, p.76), the success of therapeutic interventions lies in 'identifying the avoided emotions and associated cognitions'. By normalising victim's reactions, the guilt and shame associated with these reactions is eliminated and victims do not feel like they are going crazy (Perrin et al., 2000; Pilgrim, 2003). Interventions should therefore focus on normalising the victim's reactions, which in turn prevents the avoidance of emotions that may be perceived as undesirable.

According to Pilgrim (2003), cognitive reactions to traumatic incidents could also result in 'intrusive or avoidant responses' (p.74) and that cognitive processes play a role in the suppression of thoughts related to the trauma. It is further maintained that the way a person thinks about an incident could drastically change or even shatter some basic beliefs held about oneself, others and the world (Corey, 2001; Hybels-Steer, 1995; Pilgrim, 2003). The distortion of these beliefs are understood to be due to the disruption of cognitive structures, which often lead to the symptoms experienced by victims (Horowitz, 1999). These considerations have lead to the assumption that the cognitive approach could be very useful when doing interventions following traumatic incidents (Pilgrim, 2003).

Cognitive-behavioural therapy aims at changing distorted beliefs by helping the victims not only gain a more realistic interpretation of the incident, but also help them understand that that their beliefs about an incident may be disruptive to their functioning (Gladding, 2000). Since these interventions aim to deal directly with the symptoms being experienced, they allow victims immediate relief. The deliberate focus on the present helps victims deal with what is currently happening and therefore focus on a specific problem (Corey, 2001; Gladding, 2000). Using the cognitive–behavioural approach to intervene with victims who have experienced a traumatic incident, could therefore be considered extremely helpful. Gladding (2000) does mention some limitations to this type of intervention however. He maintains that the approach does not consider the person as a whole and that

inherent traits, developmental stages, the unconscious and the past are not considered when doing cognitive-behavioural interventions. It can be deduced that an integrated approach, where some of these limitations are addressed by the psychodynamic approach, would therefore be considered more useful.

6.3 Integrative approach

According to Eagle (2000), traumatic incidents evoke disturbances that can manifest both internally and externally. She explains that victims not only respond to an external or real stressor leading to symptoms which can be psychological and/or physiological, but also to internal threats which evoke responses 'linked to unconscious fears, threats of overwhelming impulse, and inchoate fantasies' (Eagle, 2000, p.303). For this reason, an integrative approach incorporating both the psychodynamic school, which focuses on internal processes, and the cognitive-behavioural school, which focuses on external behaviour, is considered a more ideal approach when addressing trauma related symptoms and distress (Eagle, 1998).

According to Horowitz (1999, p.13), it is possible to integrate different approaches to trauma interventions, as all approaches focus on the trauma itself, the association with the victim's 'beliefs, attitudes, expectations and intentions' and the focus on regaining their former functioning. It has also been suggested that the treatment of choice in psychological debriefing therefore considers both psychodynamic interventions, in order to prevent the use of harmful defence mechanisms, and cognitive-behavioural interventions, that prevent the learning of maladaptive cognitions and behaviours (Eagle, 2000).

Despite the above mentioned advantages of adopting an integrative approach within the context of trauma debriefing, there is little formal literature available on this approach (Eagle, 2000). There has also been a criticism that this approach does not take into account the relationship between the traumatised victim and their surroundings (Kleber & Brom, 1992). Support networks, which can be considered to be an aspect of the participant's surroundings, emerged as a theme during this

study, and will be discussed further in Chapter 4. According to Gilliland and James (1993), theory forms the basis for all crisis intervention models, which is true for the Wits Trauma Intervention Model used by lay counsellors at the support centre too. This model is based on this integrative approach and will be discussed in greater detail in order to understand what guides the lay counsellors in their interventions (Eagle, 2000).

7 Model

As previously mentioned, psychological debriefing only gained popularity and became the preferred method of intervention in the case of traumatic incidents during the mid 1980s, with the establishment of Mitchell's Critical Incident Stress Debriefing (CISD) model (Rose et al., 2003). Mitchell defined the CISD process in 1983 as a 'semi-structured group intervention', which was used at that time to debrief emergency services personnel (Rose et al., 2003, p.23). Although other models have since been formulated in order to address the needs of individuals who have experienced a traumatic incident, this study will focus on the Wits Trauma Intervention Model. This model is primarily used by the lay counsellors at the victim support centre where this research was undertaken.

The Wits Trauma Intervention Model was developed by Eagle, Friedman and Shmukler, staff members of the Psychology Department at the University of the Witwatersrand (Eagle, 1998). This short-term model, based on a framework which integrates the psychodynamic and cognitive-behavioural approaches, can effectively be used to treat individuals who have experienced psychological trauma. This model is considered to be appropriate and relevant to the South African context, as it is useful for dealing with a diverse range of clients, from different socio-economic backgrounds and cultures (Eagle, 2000; Hajiyiannis & Robertson, 1999). According to Eagle (1998), the model consists of five components and although these are explained and described in a sequential manner below, they can be used interchangeably by the lay counsellor according to the victim's needs (Hajiyiannis & Robertson, 1999).

The first component of the Wits Trauma Intervention Model is ‘telling the story’ (Eagle, 2000, p307). Lay counsellors at the support centre typically begin the intervention by allowing the victim the space to tell and possibly re-tell their story. According Eagle (1998), the aim of this component is to encourage victims to include as much detail as possible regarding the feelings, cognitions and sensations experienced during the traumatic incident. They are also encouraged to express any previously unexpressed emotions, which allows for emotional catharses and in turn helps prevent ‘repression and displacement into other symptoms’ (Eagle, 1998, p.139). It is similarly suggested by Fullerton et al. (2002, p.2) that the ‘cognitive structure of the event … is modified through retelling, obtaining new information about the event and experiencing emotional release’, which reiterates the importance and relevance of including this component in the debriefing process.

The second component of the Wits Trauma Intervention Model, which focuses on normalizing the symptoms which victims display, is referred to as ‘normalizing the symptoms’ (Eagle, 2000, p.311). Victims are often reluctant to admit that they are feeling certain symptoms and may even deny symptoms, according to Everstine and Everstine (1993). They do this as they feel that the symptoms they are experiencing are unacceptable and a sign of weakness. During this component, the lay counsellor consequently educates the victim about the symptoms they could expect, and links their traumatic experience with the symptoms they are experiencing. Perrin et al. (2000) maintain that in this way, the lay counsellor identifies that the victim is not going crazy and reassures them that what they are experiencing is ‘a normal reaction to an abnormal event’(p.277). Hybels-Steer (1995) agrees that the victims may feel like they are going crazy and that it is important that this be normalised and that victims do not feel like there is something wrong with them for feeling the way they do. Everstine and Everstine (1993) also feel that it is important for counsellors to understand that the symptoms experienced by the victims are reactions to the incident and that they are not necessarily due to underlying pathology. When counsellors understand this, they are better able to aid the victim in their recovery, as they can explain to victims that these reactions are normal and

in so doing not flame fears that they are going crazy. In further writings, Hybels-Steer (1995) explains that the emotions that victims may be feeling can be normalised by explaining the usefulness of each emotion. She explains, for instance, that denial is essential, as it helps the victim cope with overwhelming feelings such as 'terror, helplessness, fear of abandonment ... [and] … fear of dying' and that this disbelief therefore protects the victim from obscure thoughts (Hybels-Steer, 1995, p.34).

According to Hybels-Steer (1995), it is not uncommon for victims to assess what they did prior to and during the traumatic incident. This is an attempt to make sense of what happened, as many victims feel that they have acted inappropriately or that they should have acted differently to change the outcome of the incident. According to Gilliland and James (1993), victims may feel guilty for, amongst other things, surviving while others may not have, for not being able to prevent the death or harm of another, for not being braver or even feeling that they are to blame or that it was their fault. Victims are often unable to comprehend that the way they reacted was instinctive or beyond their control (Hybels-Steer, 1995). Victims therefore question their actions and reactions in an incident and may even believe that they could have prevented the incident, which often leads to intense feelings of self-blame or guilt (Everstine & Everstine, 1993). For this reason, it is beneficial for the counsellor and victim to work through various reaction alternatives and what impact these may have had, so that the victim's reactions are reinforced as the best they could have done under the circumstances. This is related to the third component of the Wits Trauma Intervention Model, namely, 'addressing self-blame or survivor guilt' (Eagle, 2000, p.313). Here, lay counsellors are encouraged to listen actively and try to re-frame any behaviour which is perceived as maladaptive by the victim, or re-affirm any behaviour which was effective in the situation (Eagle, 2000). By bringing doubts about their efficiency to the fore and exploring them in a realistic way, victims are able to restore their self-esteem, dismiss self-blame and achieve self-respect and self-acceptance (Eagle, 1998; Everstine & Everstine, 1993).

The fourth component in the Wits Trauma Intervention Model discussed by Eagle (2000, p.316), is 'promoting mastery'. During this component, the counsellor encourages the victim to get in touch with their existing support networks and to carry on with the activities associated with their daily living (Hajiyiannis & Robertson, 1999). According to Eagle (1998), this not only facilitates victims in returning to their previous level of functioning, but also helps them manage and reduce anxiety and counteract the feelings of helplessness related to the traumatic incident. The process of encouraging victims to get in touch with their support networks is considered particularly important. This becomes apparent when one considers that the process of recovery becomes prolonged when victims do not have a support network to rely on, as they feel more isolated, withdrawn and frustrated in the process of recovery (Hybels-Steer, 1995).

According to Eagle (2000, p.318), the fifth component in the Wits Trauma Intervention Model is 'facilitating creation of meaning'. Hybels-Steer (1995) maintains that making sense of the traumatic incident is important if the victim is to make sense of their shattered world again. By finding meaning in the incident, victims are able to integrate what happened into their lives and as a result, they become better equipped in the journey of recovery. According to Eagle (1998), this is an optional component in the model and is not often utilised by the lay counsellors at the support centre. This is due to the fact that lay counsellors rarely have more than one supportive intervention session with a victim and victims are considered to only give meaning to the experience over time (Eagle, 1998).

Although the counsellors are able to assist victims at various levels, in order to facilitate optimal functioning by coping with the traumatic incident, the model does have some limitations. According to Hajiyiannis and Robertson (1999), one of the limitations of this model is that it assumes that victims have sufficient ego strength and verbal ability to optimally benefit from the intervention. They further maintain that the model is not appropriate or applicable to victims who are extremely anxious, present regressive features or have personality disorders or psychiatric

conditions. The model also appears to neglect victims who have sustained physical injuries or have somatic complaints (Hajiyiannis & Robertson, 1999). The greatest limitation, according to Hajiyiannis and Robertson, is related to the interventions short-term nature. They maintain that not only is the intervention too short for victims to create meaning, but that there may not be an opportunity for clients to address certain emotions or transference issues, which may arise due to the process. This process is further complicated by the increasingly violent, yet random criminal activities, which makes it even more difficult for victims to create meaning in their experiences. Hajiyiannis and Robertson (1999) further maintain that the model may not adequately address the needs of the elderly or the developmental stage predominant in adolescents. Another limitation mentioned is that the model does not address the issues related to traumatic bereavement and anger. Finally, the model has been criticised for focusing on the individual and not taking the broader systemic approach into consideration (Hajiyiannis & Robertson, 1999; Kleber & Brom, 1992). The implications of a number of these limitations will be discussed further in Chapter 4 of this study.

Despite these limitations, the model is still considered to be relevant and appropriate in the South African context, where services which are more cost and time efficient are highly in demand (Golden, 1991; Hajiyiannis & Robertson, 1999; Hamling, 1997). It is therefore also considered appropriate to be used as a guide for lay counsellors at the support centre in this study, as they render services to those in need.