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Oranisational Responses to Compassion Fatigue and Burnout in Trauma Counsellors: A Multi-Organisational Investigation

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CHAPTER 1: INTRODUCTION

This research study consists of an introduction, literature review, methodology, results and analysis, and a conclusion. The general objective of this research study is to provide the reader with information and explanations regarding the phenomena compassion fatigue, burnout and organisational responses to prevent these phenomena.

The first chapter provides the research objectives, rationale and an introduction to the literature. Chapter 2 and 3 discuss the literature relative to the study, and chapter 4 provides the methodology for this study. Chapter 5 discusses the results and chapter 6 provides a discussion and conclusion regarding this study. Limitations and recommendations are provided by chapter 7.

1.1 RESEARCH OBJECTIVES

The general objective of this research is to determine the organisational responses toward possible compassion fatigue and burnout in trauma counsellors. A comparison between organisational responses across a multiple organisation model will be made to explore the effects of the various responses. Furthermore, the study will investigate the influences of organisational responses on compassion fatigue and burnout considering the influences individual differences of the trauma counsellors may have.

1.2 RATIONALE

The importance of this research is evident in the amount of literature found on compassion fatigue and burnout. Not only are there in-depth studies done in a vast majority of health professions, but also in different countries, including South Africa. Most research has been done in the occupational setting of social workers, trauma counsellors and nurses. The primary focus of research in this domain is focused on individual responsibilities towards mental and physical health. Organisational responses have been mentioned in some studies regarding preventative strategies towards compassion fatigue and burnout, although the organisation sets these as secondary to the individual responses or individual responsibilities. The lack of research regarding organisational responses towards trauma counsellors, and multi-organisational studies, was the motivation for the study.

The need to establish the organisational responses towards compassion fatigue and burnout in any given organisation may assist researchers, employees and organisations alike to proactively intervene in such incidence where compassion fatigue or burnout influenced the ability of the individual counsellor or the productiveness of the organisation.

1.3 INTRODUCTION TO LITERATURE

"Secondary trauma, a relatively recent topic that emerged in the field of social work, includes the emotional and psychological effects that working with traumatised clients has on therapists." (Hesse, 2002:293.) If this is the case, what are the responsibilities of the individual counsellor and the organisation, respectively in addressing this phenomenon? What actions or processes are organisations engaging in to limit these experiences by employees?

Considering the quote form Hesse (2002), she explains that a traumatic event is characterized by a situation that involves the actual or threatened death or injury to one's self or others. Specific situations such as these are accompanied by feelings of fear, helplessness or horror. Considering the direct experiences of individuals subjected to trauma Figley (1999), states that individuals exposed to a traumatised person, may experience emotional upset and may become a victim, indirectly of the traumatic event. This may cause traumatic stress. Secondary Traumatic Stress (STS) emerges suddenly and without warning. The sufferer of STS often experience feelings of confusion and helplessness.

The relationship between STS and compassion fatigue may be explained as follow:
The term compassion fatigue first appeared in studies of job burnout in the helping professions to describe a decline in compassionate feelings toward patients or clients in need. In recent years, however, the term has been used outside the occupational context,

in the broader social community (Kinnick, Krugman & Cameron, 1996). A model derived from Figley (1999), indicates empathic feelings, efficient concern and exposure to traumatised individuals causes one to provide the correct compassionate, empathic responses needed. This model also suggests occurrence of compassion fatigue when the existence of residual stress from compassionate and empathic experiences, are not addressed. It is important to note that STS and compassion fatigue are equivalents of each other.

Theories explored to comprehend trauma and related issues are the constructivist self development theory, five personality traits, biological theory, psychoanalytic theory, and social theory.

The c*onstructivist self development theory*, which is interactive, focuses on the complex interaction between the individual and the environment. The constructivist self development theory is based on constructivism, the self, traumatic memories and the adaptation to trauma. According to these aspects, individuals construct their own realities. The self is the seat of the individual's identity and inner life, which encompasses four interrelated aspects: self-esteem, ego resources, psychological needs and cognitive schemas. Traumatic experiences are encoded in the verbal and imagery systems of the memory. Adaptation to trauma reflects an interaction between life experiences and the self (McCann & Pearlman, 1990). According to Pearlman and Saakvitne (1995), individual differences, interpersonal context and familial and socio-cultural contexts are very important and should be discussed in conjunction with the basic

assumptions of the theory. In relation to that, this study investigates the time spend with family and friends in conjunction with the compassion fatigue and burnout experienced.

According to Cherniss (1980), individual responses to stress are guided by the *five personality traits*: Neurotic anxiety, Type A syndrome, locus of control, flexibility, and introversion. Previous research indicates that specific personality traits, career goals, and previous experiences may influence an individual's susceptibility to stress. Social support and the load of stress on the individual will have a great influence on the coping strategy of an individual and the success thereof. In addition to this, the study investigates the supervision allocated to each individual, and the climate in which this supervision is executed.

The *biological theory* indicates, according to Van der Kolk and Saporta (1993), that fixation on trauma is biologically based. Posttraumatic stress (PTSD) disorder is associated with complex abnormalities in several biological systems. PTSD patients indicate distinct physiological, neuropharmalogical and neuroendocronicalogical alterations (Friedman, 1993). This may indicate the possible reason why individuals suffering from compassion fatigue and burnout have feelings of exhaustion and fatigue.

The last theory, the *psychoanalytical theory*, focuses on the intrapsychic processes and infantile conflict (Brett, 1993). According to Meyer, Moore and Viljoen (1997), three basic assumptions are the core of the psychoanalytic theory. Firstly, psychosocial conflict indicates that the individual is in constant conflict regarding their needs and the

prescriptions of society. Secondly, biological and psychological determinants are separate functions and have separate locations in the psyche. The biological determinants, or needs of individuals, are situated in the body, but the psychological determinants are situated in the psyche. Lastly, the mechanistic assumption is based on natural sciences and indicates that an individual functions like a mechanism with energy and accompanied functions thereof. Social interaction with family and members of society plays a crucial role in facilitating mental well-being and coping with trauma. According to Harel, B. Kahana and E. Kahana (1993), social resources, in particular, social networks and social interaction are very important in any trauma survivor's recovery and coping with new situations. Individuals in every domain are at risk of developing compassion fatigue, including correctional officers, counsellors, psychologists, social workers, emergency response personnel, and medical staff. This state of mind was first identified in emergency response, public safety, criminal justice and medical staff personnel who have intense negative experiences in the course of their work (Janik, 1995).

In all mentioned theories, correlations can be drawn between the importance of family and social support in combating trauma.

Numerous researchers indicated the importance of distinguishing between compassion fatigue and burnout. Figley (1999), states that a general assumption regarding burnout is observed as a common problem of individuals with stressful work. An explanation was given by Figley indicating burnout as a result of emotional exhaustion and emerges

gradually. Compassion fatigue can emerge suddenly and is associated with feelings of hopelessness and confusion, although the recovery rate is faster than that of burnout. According to Maslach (1982), burnout is a viewed as a syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishments. This may occur in professionals which work extensively with others in need.

According to Spence Laschinger, Shamian and Thomson (2001), burnout is a logical outcome of lower levels of autonomy, control over practice, collaborative working relationships, and organisational trust. Burnout has been associated with work conditions in the helping professions and viewed a type of work stress. Given that, this research attempts to find the relationship and explain the influences of organisational actions on job stress, in particular symptoms of trauma such as compassion fatigue and burnout.

According to Maslach (1982), the sources of burnout are characterised by involvement with others, job-settings and personal characteristics. By identifying the sources of stress, the organisational responses may initiate prevention tactics. Prevention of compassion fatigue and burnout has been researched for a number of years, yet the focus always lies with the individual. Very little research has been done on the organisational involvement and commitment necessary to address these phenomena in employed trauma therapists (Bell, Kulkarni &Dalton, 2003).

Organisational responses to trauma counsellors that may confront symptoms of compassion fatigue and burnout are the following: Reduce the number of caseloads each

trauma counsellor are responsible for, and provide supervision and group support programmes to assist employees in rendering these effects. On a very simplistic level, organisations should provide safe and comfortable organisational settings to perform their duties. Organisations should ensure adequate benefits, staff development opportunities, regular leave, informed consent as a standard organisational policy to inform new counsellors of the risks involved in trauma counselling and expressive staff meetings (Hesse, A.M. 2002).

According to Bell, Kulkarni and Dalton (2003), organisational responses to secondary trauma could also involve the following:

Workload, in the form of caseload, must be more diverse in the attempt to prevent compassion fatigue and burnout among their employees. Work environment; setting, location, safety and privacy influences the experiences of the trauma counsellor and the client. These work environment characteristics may contribute to the effects of compassion fatigue and burnout.

Furthermore, education reduces the likelihood in onset of the specific phenomenon in that it empowers the employee. Group support within the organisation plays a vital role in managing the onset of symptoms related to secondary trauma. By using informal debriefing, peer support groups or group support the prevalence of secondary trauma may be reduced.

Additionally, supervision may be one of the most imperative managing tools in preventing secondary trauma. Supervision and evaluation should be separate from one-another and the importance of and intention with supervision should be explained to the employees. Resources for self-care should be established by the organisation and adequate time should be allowed if an employee requires the engagement in personal therapy sessions. Lastly, teamwork is highly desirable, offering mutual support, sharing and reflection (Sexton, 1999).

Suffering therapists may have a detrimental effect on the organisations within which they are appointed. The quality and effectiveness of the organisation's work may be compromised in that productivity of the counsellor decreases and an increase in absence from work may occur. Therapists who do not adequately deal with compassion fatigue and burnout are likely to experience more disruption of their empathic abilities, resulting in therapeutic impasses and more frequent incomplete therapies (Waldrop, 2003).

To indicate the respective responsibilities of organisation and trauma counsellor clearly, added research regarding these responsibilities are necessary.

1.4 CHAPTER DIVISION

The chapter division was performed as follow:

Chapter 1: Introduction

Chapter 2: Compassion fatigue and burnout

Chapter 3: Organisational responses

Chapter 4: Methodology

Chapter 5: Analysis

Chapter 6: Discussion and Conclusion

Chapter 7: Limitations and recommendations

CHAPTER 2: COMPASSION FATIGUE AND BURRNOUT

2.1 INTRODUCTION

Hesse (2002) specifies that secondary trauma includes the emotional and psychological effects on therapists working with traumatised clients. If this is the case, what are the responsibilities of the individual counsellor and the organisation, respectively in addressing this phenomenon? What actions or processes are organisations engaging in to limit these experiences by employees? The quote and related questions from the introduction proves to be typical questions to be answered by the literature provided in the following two chapters regarding compassion fatigue and burnout and also organisational responses towards these issues.

Chapter 2 consists of the origin of compassion fatigue and burnout, definitions of relevant terms found in literature which is used to refer to different phenomena. In addition related theories are investigated. Compassion fatigue models will assist the reader in grasping the meaning of compassion fatigue comprehensively in conjunction with the theory presented. The relationship and relevance of compassion fatigue and burnout in counsellors is also addressed with prevention methods provided briefly.

2.2 THE ORIGIN OF COMPASSION FATIGUE AND BURNOUT

Compassion fatigue first appeared in studies relating to job burnout in the helping professions in description of a decline in compassionate feelings toward patients or clients in need. The term has been used outside the occupational context and became known in the broader social community (Kinnick, Krugman & Cameron, 1996). A model derived from Figley (1999), indicates empathic feelings, efficient concern and exposure to traumatised individuals causes one to provide the correct compassionate, empathic responses needed. This model also suggests occurrence of compassion fatigue when the existence of residual stress from compassionate and empathic experiences, are not addressed.

2.3 DEFINITION OF TERMS

In order to grasp the often confusing terminology of trauma and trauma related phenomena, one should firstly understand the meaning of a traumatic event. According to Hesse (2002), a traumatic event is characterized by a situation that involves the actual or threatened death or injury to one's self or others.

When considering the implications of a traumatic event, confrontation with such an event may cause posttraumatic stress disorder. According to DSM-IV-TR (2000), the essential features of posttraumatic stress disorder (PTSD) is the development of characteristic symptoms followed by exposure to an extreme traumatic stressor experienced by the

individual or a close family member. These characteristic symptoms may derive from exposure of events that include actual or threatened death or serious injury. The characteristic symptoms may include intense fear, helplessness, or horror. Re-experiencing of the traumatic event in the form of dreams, and avoidance of associated stimuli with the traumatic event may be present.

Figley (1995) argues the symptoms described by DSM-IV indicate that the mere thought of a loved one in danger could be traumatic. Therefore, an individual experiencing the event secondary or indirectly are just as vulnerable as the person experiencing the traumatic event directly. Figley (1999), furthermore states individuals exposed to a traumatised person, may experience emotional upset and may become a victim, indirectly, of the traumatic event. This may cause traumatic stress, although secondary. According to his findings, it may be evident that individuals such as therapists experiencing stress due to their job or profession are as vulnerable as those treated by these professionals. A situation as this may cause the professional to experience what is known as secondary traumatic stress.

Secondary traumatic stress (STS) may be defined as natural consequent behaviours and emotions resulting from the knowledge regarding a traumatic experience by a significant other. It may also persevere in the stress resulting from helping a traumatised individual. The individual experiencing symptoms related to secondary traumatic stress, hereafter referred to as STS, and may indicate a sudden emergence without warning. As previously mentioned, sufferers of STS often experience feelings of confusion and

helplessness. Figley (1995) states that compassion fatigue is used as an alternative term for secondary traumatic stress and compassion fatigue is the equivalent of posttraumatic stress disorder, hereafter referred to as PTSD.

Secondary traumatic stress (STS), as described, must not be confused with burnout. According to Cherniss (1980), burnout is a reaction to a stressful work situation and appears to consist of three stages. The first stage involves an imbalance between resources and demand. The second stage is the immediate and short-term reaction to the imbalance. Accompanied feelings with the second stage may include anxiety, tension, fatigue and exhaustion. The last stage consists of changes in attitude and behaviour. These changes include detached and mechanical involvement in clients. A transactional process could describe burnout due to the factors like job stress, work strain and psychological accommodation. Maslach stated that burnout may be identified as "a syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment" in individuals in the helping profession (1982; 3). Burnout more often than not occurs in the extensive work with individuals that may be traumatised. Many considers it job stress but uniquely derived from social interaction between the therapist and the client.

It is therefore possible that any trauma counsellor or counselling professional may suffer from compassion fatigue, burnout or both.

2.3.1 Distinction between compassion fatigue and burnout

A clear distinction is provided below in order to ensure optimum understanding that compassion fatigue and burnout may occur simultaneously within one individual.

Many researchers indicate the importance of distinguishing between compassion fatigue and burnout. Figley (1999), states that a general assumption regarding burnout is observed as a common problem of individuals with stressful work. An explanation was given by Figley, indicating burnout as a result of emotional exhaustion and emerges gradually. Compassion fatigue can emerge suddenly and is associated with feelings of hopelessness and confusion, but may have a faster recovery rate than that of burnout.

2.3.2 Categories of Secondary Traumatic Stress

The term secondary traumatic stress is used to describe the categories; therefore acknowledgment must be made in that compassion fatigue is an alternative term for secondary traumatic stress.

According to Dutton and Rubinstein (1995), STS may be categorised according to three descriptive areas: Indicators of psychological distress, changes in cognitive schema, and relational disturbances.

2.3.2.1 Indicators of psychological distress

Indicators may include distressing emotions including sadness, depression or grief. Intrusive imagery of the client's traumatic material such as nightmares, numbing or avoidance to work with traumatic material and traumatised clients may be experienced. Somatic complaints such as loss of sleep, headaches and heart palpitation, addictive or compulsive behaviour such as compulsive eating and even substance abuse, physiological arousal, daily functional impairments in social and personal roles are final key indicators of secondary trauma (Dutton & Rubinstein 1993).

2.3.2.2 Changes in cognitive schema

Changes in cognitive shifts in beliefs, expectations and assumptions held by trauma workers and therapists due to exposure to trauma material may be evident. According to McCann and Pearlman, as sited in Dutton and Rubinstein (1995), cognitive shifts may occur alongside dimensions such as dependency, safety, power (or loss thereof), esteem, intimacy, and frames of reference.

2.3.2.3 Relational disturbances

Radical influences on personal and professional relationships may occur. Not only lack of trust and dysfunctional relations in personal life with spouse or children, but also to the community. The therapist may withdraw professionally from clients, which may cause labelling and pathologising the traumatic reaction (Dutton & Rubinstein, 1995).

Considering the categories of STS, it may be postulated that these emotions, change in behaviour and disturbances in relation may not only have an influence on the individual in his or her occupational setting, but also in their private surroundings.

2.4 THEORIES

The following theories are discussed in relations to the applicability to trauma: Constructivist self development theory, the biological theory, five personality traits, psychoanalytic theory, and the social theory. Also, applicability to compassion fatigue and burnout is discussed. Each theory provides unique views to comprehend trauma and the effect it has on an individual, but nevertheless, these theories provide insight to a magnitude of relevant aspects when considering trauma and the individual.

2.4.1 Constructivist self development theory

The constructivist self development theory (CSDT), which is interactive, focuses on the complex interaction between the individual and the environment. In addition, the theory provides an explanation of the basis for understanding the psychological, interpersonal and transpersonal impact on the traumatised individual.

According to Pearlman and Saakvitne (1995), the constructivist self-development theory integrates psychoanalytic theory and cognitive theories and may be described as a synthesis of developmental theory, self-psychology, social learning theory and other

cognitive theories. As other interactive theories, the constructivist self development theory, hereafter referred to as CSDT, has yet to articulate the means in which specific aspects and situations elicit particular schemas, feelings and needs of different individuals.

According to the CSDT, individuals construct their own realities. The self is the seat of the individual's identity and inner life, which encompasses four interrelated aspects: self-esteem, ego resources, psychological needs and cognitive schemas. Traumatic experiences are encoded in the verbal and imagery systems of the memory. Adaptation to trauma reflects an interaction between life experiences and the self (McCann & Pearlman, 1990).

Individual's experiencing secondary trauma elicit the same dynamics as the individual with posttraumatic stress. The argument stated by Figley (1999) that an individual experiencing trauma second-hand experiences the same shifts in relationships and the self as that of a primary affected individual may provide workable explanations to questions such as why traumatised individuals behave differently.

2.4.1.1 Constructivism

As already mentioned, the constructivist assumption indicates that individuals construct their own realities by new information and experiences incorporated into their beliefs and systems of meaning. Not one individual will experience a traumatic event in a similar

way to another individual (Pearlman & Saakvitne, 1995). Individuals construct their own reality to evaluate experiences perceived as reality (McCann & Pearlman, 1990).

2.4.1.2 The self

The self is a hypothetical construct to describe the psychological foundation of the individual. The self comprises of basic capacities that regulates the inner sense of identity. Also, positive self-esteem, ego resources, which regulates the interaction with the world are imbedded in the self. Lastly, psychological needs which motivate behaviour and cognitive schemas such as beliefs, assumptions and expectations are formulated in the self (McCann & Pearlman, 1990).

a) Self capacities

McCann and Pearlman (1990), identifies four self-capacities associated with trauma survivors. Firstly, the ability to tolerate strong affects without acting out. This indicates the ability of experiencing deep emotions without the existence of psychological instability. This is evident in individuals experiencing secondary traumatic stress, as seen in counsellors being able to function relatively within their professional psychological boundaries. Secondly, a positive feeling should be associated with the ability of being alone without feeling lonely. Thirdly, an individual should have the ability to recover from emotional distress without extensive external support. Lastly, the ability to face criticism without permanent damage to one's self-worth must be present.

b) Ego resources

Two groups of ego resources exist: the first group includes ego resources used in the therapeutic relationship, and the second group of ego resources incorporates protection from future trauma.

The first group includes intelligence, ability to introspect, willpower, initiative, strive for personal growth, awareness of own psychological needs, empathy, and the ability to have multiple viewpoints of oneself and others. The second group includes the ability to foresee consequences, mature relationship establishment, to establish personal and interpersonal boundaries, and the ability to formulate self-protective judgments (McCann & Pearlman, 1990). It is evident in individuals who experienced secondary traumatic stress to find it difficult to function optimally in regards to both the first and the second group of ego resources.

c) Psychological needs

Psychological needs motivate one's behaviour and has a direct influence on the interaction with others. Some basic needs that are universal to traumatised individuals and formulate the basis of the CSDT:

Frame of reference indicates the need to be able to develop stable and coherent frameworks for understanding one's experience. The need to feel safe, trusting in other's promises and expectations of others, the need to be valued by others as esteem-need, the need to control one's own behaviour and rewards, the need to exert control over self and

others, and the need to feel connected to others in individual relationships as intimacy needs (McCann & Pearlman, 1990).

d) Cognitive schemas

According to McCann and Pearlman (1990), schemas may be described as personal constructs of organising reality. Under normal circumstances, these schemas represent reality and realistic expectations regarding one's environment. Evidently, in traumatised individuals these schemas may portray disruption and distortion of reality.

2.4.1.3 Memory

Pearlman and Saakvitne (1995), indicate that memory is descriptive according to CSDT. Five different aspects of perception and thus, traumatic memory are identified:

a) Verbal memory

The verbal memory explains the cognitive narrative of events. Verbal memory and the cognitive sequence are based on the cognitive theory, which underlines the CSDT. Therefore, one must be aware of the possibility of verbal memory not functioning adequately and in that providing altered information regarding events.

b) Imagery

Imagery stipulates visions, symbols and images associated with the events.

c) Affect

An emotion experienced during, prior to and subsequent to the traumatic event is specified.

d) Somatic memory

Any physical experiences, represented by the traumatic event, must be described and constitutes this memory.

e) Interpersonal memory

Any interpersonal sequences associated with the traumatic event that is identifiable in current interpersonal relationships.

2.4.1.4 Additional constructs

According to Pearlman and Saakvitne (1995), individual differences, interpersonal context and familial and socio-cultural contexts are very important and should be discussed in conjunction with the basic assumptions of the theory.

a) Individual differences

Individual differences play a crucial role in life experiences, personality development and, adaptation to the traumatic event or events. In conjunction with the therapist, the traumatised individual will investigate their own differences from others and how these differences stipulate their experiences and adaptation processes.

b) Interpersonal context

When considering the interpersonal context of the traumatic events, it is very important to portray that interpersonal context in therapy in that, an individual is experiencing trauma due to their work with traumatised individuals, that stipulates an interpersonal relationship and therefore therapy should also be interpersonal and not a solo experience.

c) Familial and socio-cultural context

The context in which the trauma occurs is very important. Traumatised therapists may also experience additional secondary trauma in a familial or socio-cultural context. The secondary trauma experienced is not obsolete from the work environment, the colleagues or the managers. Therefore, the broader familial and socio-cultural context should be included in therapy.

All above mentioned aspects may be visible in the behaviour and actions of a traumatised individual, primary or secondary.

2.4.2 Five Personality Traits

To comprehend the trauma experienced by any individual, aspects to personality must be investigated.

According to Cherniss (1980), individual responses to stress are guided by the five personality traits: Neurotic anxiety, type A syndrome, locus of control, flexibility, and

introversion. Previous research indicates that specific personality traits, career goals, and previous experiences may influence an individual's susceptibility to stress. Social support and the load of stress on the individual will have a great influence on the coping strategy of an individual and the success thereof. Individuals that experienced secondary traumatic stress may find it difficult to cope with additional stress in their working or personal environment. Due to the different coping strategies of individuals, it may become evident that some individuals do not suffer from additional stress or that these additional stresses are well accounted for.

2.4.3 Biological Theory

According to Van der Kolk and Saporta (1993), Freud suggested that fixation on trauma is biologically based. Posttraumatic stress disorder is associated with complex abnormalities in several biological systems. PTSD patients indicate distinct physiological, neuropharmalogical and neuroendocronicalogical alterations (Friedman, 1993). Furthermore, Van der Kolk and Saporta (1993) pointed out that the relationship between trauma and the limbic systems do exist. The limbic system influences and stimulates behaviour like self-preservation and survival. When trauma affects the physiological aspects of the individual it is a definite possibility that the limbic system may not function to its optimum.

Van der Kolk and Saporta (1993) specify some stress responses regarding the effects of trauma and secondary trauma:

- The body's stress responses consist of the secretion of specific hormones to assist the body in mobilising the energy necessary to deal with particular stressors. This brings about arousal.
- Numbing effects may result from the memories of the traumatic event. This is not apparent to all individuals affected by trauma or secondary trauma, but some numbing regarding particular stimuli may also be apparent.

From the biological theory it is evident that human beings experience a close relationship between the psychological and the biological alteration.

2.4.4 The Psychoanalytic Theory

The Psychoanalytical theory focuses on the intrapsychic processes and infantile conflict (Brett, 1993). According to Meyer, Moore and Viljoen (1997), three basic assumptions are the core of the psychoanalytic theory. These are: psychosocial conflict indicating that the individual is in constant conflict regarding their needs and the prescriptions of society. Furthermore, biological and psychological determinants are separate functions and have separate locations in the psyche. Also, the mechanistic assumption which is based on natural sciences indicates that an individual functions like a mechanism with energy and accompanied functions thereof.

2.4.4.1 Traditional psychoanalytic symptom formation

Symptoms of trauma form when current conflict revives earlier conflict. Under the impact of the later frustration, a regression occurs to the point of fixation of the previous conflict. Some problems as identified by Brett (1993), are that this model has only a limited focus on the severity of the stressor, the regression following the present stressor is important to understand the reason for fixation regarding the initial conflict, but this may only be possible under severe situations.

2.4.4.2 Definition of trauma

Freud's definition of trauma, as sited in Brett (1993), states that trauma occurs when the intensity of the stimuli became so great that the stimuli barriers are overwhelmed. According to Brett, this definition is useful due to emphasis on the intensity of the stressors. Although this is helpful, no reference to adult or child trauma is given.

2.4.4.3 Repetition and defence

This model, based on Freud's model of repetition compulsion, specifies the return of traumatic material in the form of nightmares or dreams. Although this could no account for the distinctive posttraumatic symptoms, Freud adapted the model. When an individual suffers extreme stressors and the defence barriers cannot withstand that stressor, regression occur leading to the use of an early defence, the repetition compulsion. Although these may be somewhat severe explanations of a traumatised individual's behaviour and action, some may be applicable to posttraumatic stress and secondary traumatic stress.

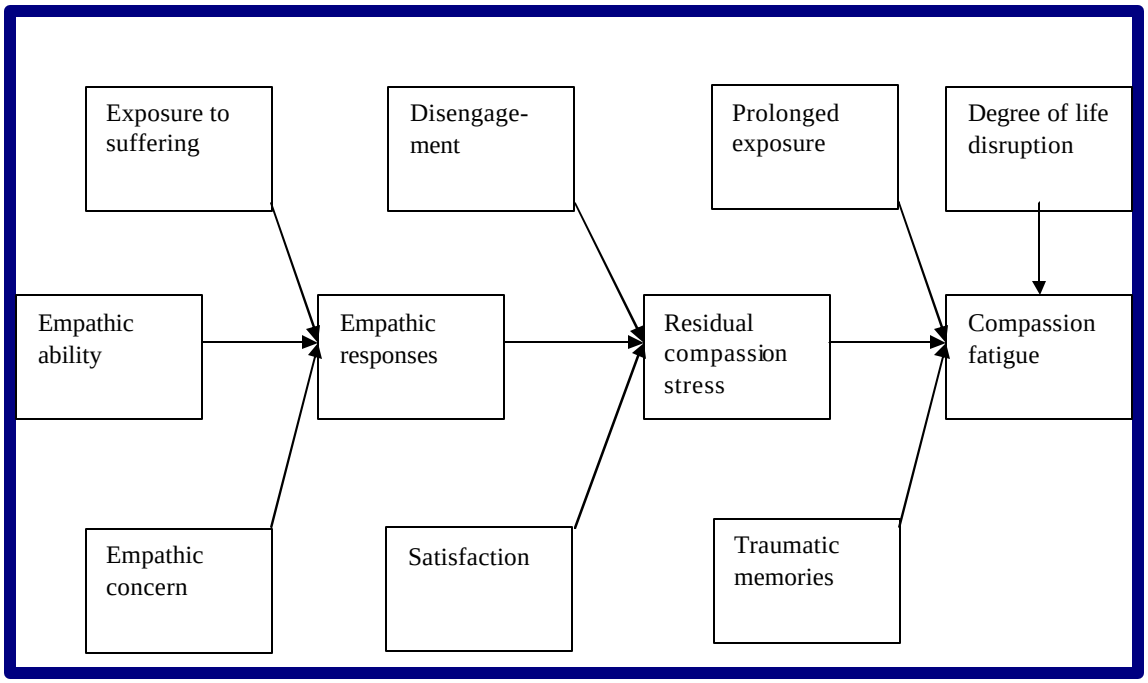
2.4.5 Social Theory

Social interaction with family and members of society plays a crucial role in facilitating mental well-being and coping with trauma. According to Harel, B. Kahana and E. Kahana (1993), social resources, in particular, social networks and social interaction are very important in any trauma survivor's recovery and coping with new situations.

Burnout has been associated with work conditions in the helping professions and viewed a type of work stress, but the social interaction with others may enhance or hinder the coping of the individual (Maslach, 1982). Therefore, investigation must be executed by the therapists or the EAP organisation to comprehend what type and to what extent of social interaction and social support exists for each individual.

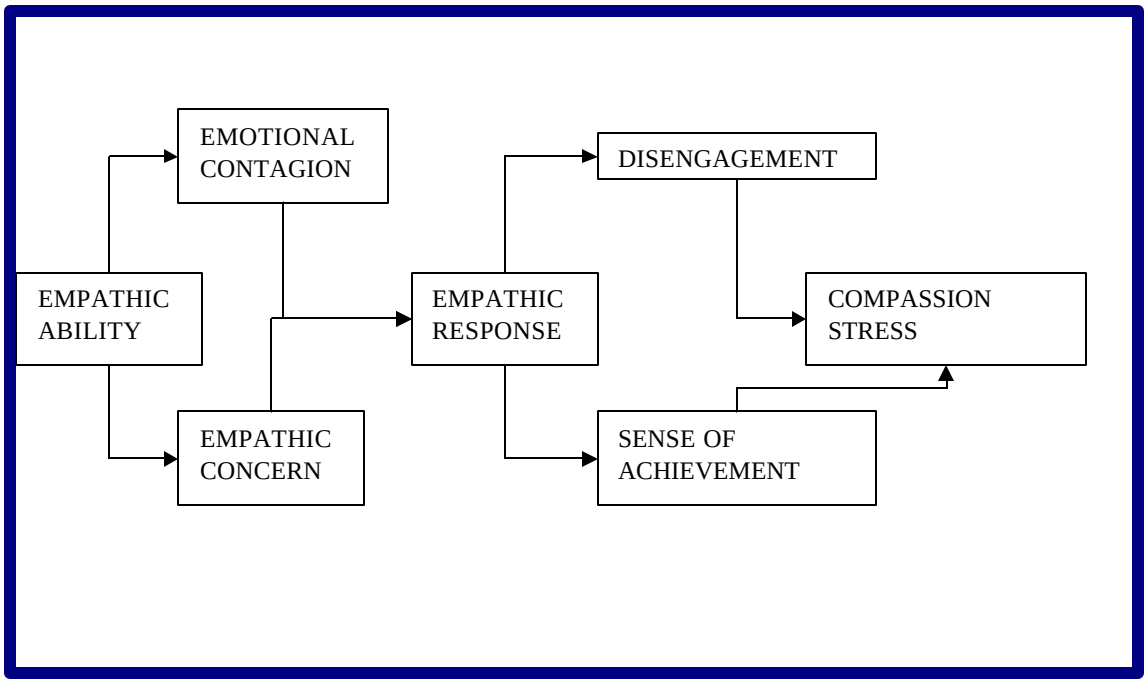
2.4.6 Compassion stress models

The compassion stress models were derived from various sources in order to clarify additional issues regarding compassion fatigue or secondary trauma in traumatised individuals.



[1] **Figure 1: Compassion stress and fatigue model**.

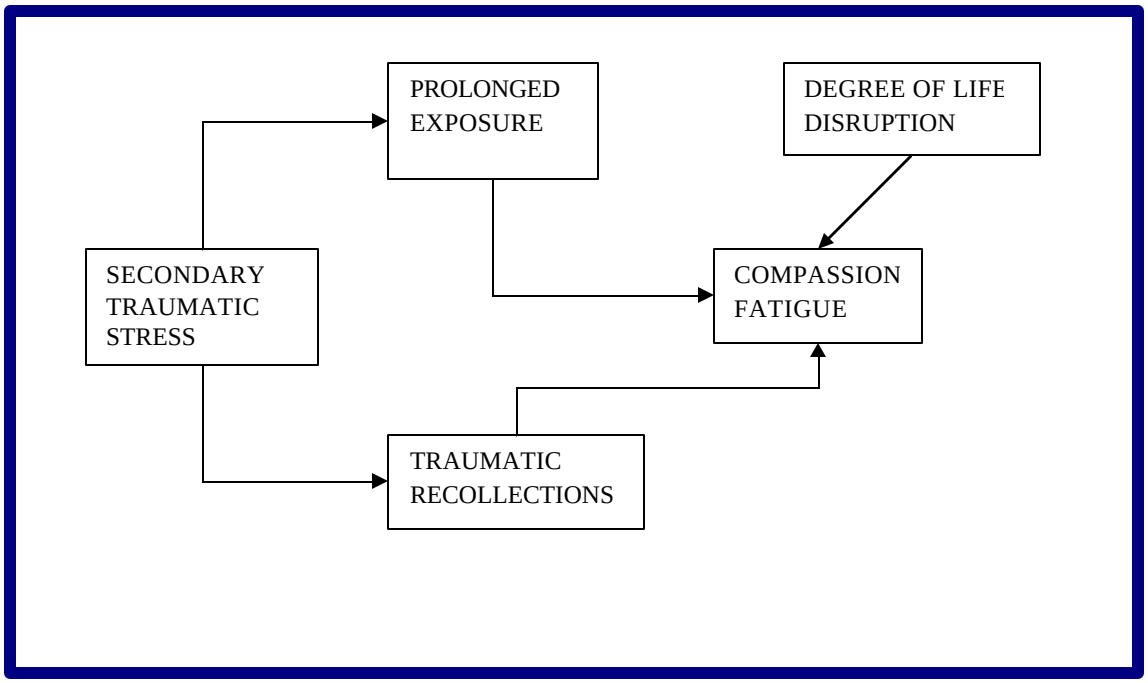
[1] From "Police compassion fatigue (PCF): Theory, research, assessment, treatment, and prevention. In J.M. Violanti, D. Paton (Eds.)," by C.R. Figley, 1999, Police trauma , p. 45. Adapted with permission of the author.



[2]**Figure 2: Compassion stress model**

From figure 1 and 2 it seems the empathic ability and empathic concern may ultimately lead to compassion stress or fatigue. As previously mentioned, the empathic responses in relation to residual compassion stress may not be adapted properly and may result in compassion stress or fatigue.

[2] From "Epilogue: The transmission of trauma. In C.R. Figley (Eds.)," by C.R. Figley, 1995, Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatised, p. 248-254. Adapted with permission of the author.



[3]**Figure 3: Compassion fatigue model**

2.5 COMPASSION FATIGUE AND THE TRAUMA COUNSELLOR

Numerous studies appeared on the relevance of compassion fatigue to a trauma counsellor or any other professional that is in direct contact with a traumatised individual. The following issues came to the fore: which individuals are susceptible to compassion fatigue and why, but also, what factors may contribute to the development of compassion fatigue?

[3] From "Epilogue: The transmission of trauma. In C.R. Figley (Eds.)," by C.R. Figley, 1995, Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatised, p. 248-254. Adapted with permission of the author.

2.5.1 Susceptibility to compassion fatigue

Much debate on who is susceptible to compassion fatigue arises from literature. Figley (1995) indicates that the vulnerability is not limited to trauma workers or therapists, but nevertheless these individuals are more susceptible. Professionals that may suffer from compassion fatigue, other than trauma workers and therapists are medical staff, in particular, nurses, paramedics and psychiatric personnel. The vulnerability to compassion fatigue is attributed to the fact that therapists and trauma workers are constantly surrounded by traumatised individuals and trauma-inducing factors. The following reasons are specified by Figley:

- *Empathy is a one of the major resources for trauma workers to help clients:*

  According to research done by Figley, it is clear that empathy is a key factor in the transference of traumatic material from the primary (client) to the secondary (trauma worker or therapist) victim.

- *Most trauma workers experienced a traumatic event in their lives:*

  Trauma workers and therapists work with vast spectrum of trauma related incidents. It is obvious that one client may have a similar experience than those of the trauma worker and therefore generalisation may be a central problem. The trauma worker or therapist may over promote their own coping skills and create inappropriateness or ineffectiveness regarding the coping process of the client.

- *Unresolved traumatic experiences may be activated by similar experiences of clients:*

  Trauma workers and therapists should be aware of the possibility of reoccurrence of traumatic material, if unresolved. Not only could the therapeutic relationship be contaminated but the personal well-being of the therapist or trauma worker may be jeopardised.

2.5.2 Factors contributing to compassion fatigue

According to Beaton and Murphy (1995), factors that may contribute to the onset of compassion fatigue are divided into individual, organisational, societal, and community contexts.

2.5.2.1 Individual context

A history of psychiatric symptoms diagnosed with a crisis worker or trauma worker may amplify the probability for developing secondary traumatic stress symptoms.

Demographic characteristics, according to studies conducted by Beaton and Murphy (1995), indicated no significant relationship between ethnicity and secondary stress symptoms. Most crisis workers in America are white males, and female representation was limited to conduct a thorough study. Age did not provide any significant information either and therefore the author will not reach any conclusions regarding these phenomena subsequent to statistical information.

2.5.2.2 Organisational context

Beaton and Murphy (1995) specify the following influences:

- Authority and chain of command
- Organisational size
- Role conflicts and ambiguities

Attributing factors are experience, training, and role orientation.

2.5.2.3 Social context

The social context not only includes the support systems adhering to personal environments, but also the support from colleagues. Support provided by colleagues, might be appraisal regarding work, emotional support in conflict situations and friendship or companionship regarding high caseloads (Beaton & Murphy, 1995).

2.5.2.4 Community context

The community context includes the educational, religious, political and economic environment. Communities have to provide support to each other when one individual suffers from a traumatic experience. It may also be possible that the community support is limited to each community and the members of those communities.

2.6 BURNOUT AND THE TRAUMACOUNSELLOR

According to Cherniss (1980), burnout as a process, initiates when a helper experiences stress and strain that cannot be relieved through problem solving. Mechanisms used by

burned-out professional helpers could be specified as follows: Loss of idealism and increasing apathy, and blame of the system and clientele. These detachment mechanisms are used due to extreme psychologically demanding situations as a defence mechanism. Empathy towards clients demand psychological and emotional commitment, therefore, a burned-out helper could experience lack of empathy due to the high psychological load. These effects may influence the helper in two ways; strain may influence the helping relationship from the beginning as a result of tension, and also, loss of motivation and negative feelings toward clients may reduce effectiveness.

2.7 SOURCES OF BURNOUT

The primary source applicable to the current research is organisational sources, and only that will be discussed.

2.7.1 Organisational sources

According to Cherniss (1980), differences in jobs and organisations are more likely sources of burnout than individual differences. Changing problematic and interfering social settings and personal differences may be more challenging than changing the work environment and job characteristics and therefore change in problematic organisational settings are more apparent. Individuals tend to adjust more readily to changing work settings and job characteristics than changing their own beliefs, values and personality characteristics.

Some specific work settings and job characteristics may induce job stress and strain that could lead to burnout. Cherniss (1980) specifies the following:

- *Problematic and demanding clients*: Some helpers may lack in previous experience within the domain they currently work in and may feel that training and education obtained is not used to its full potential. Some helpers also specify a feeling of "crisis management" summarising their daily activities. No sense of personal satisfaction, triumph or rehabilitation was experienced.
- *Very high caseload*: High caseloads could impose feelings of inappropriate helping strategies and hastened strategies due to inadequate time.
- *Organisational conflict and lack of support from the organisation*: Competition, rivalry and decremented professional relationships may be present. When the work environment is strained, strain is transferred to individuals in that setting.
- *Supervision*: When supervisory roles are not adequately specified and defined conflicting messages may be provided to the supervised which may create additional conflict and possibly evolve in strain.
- *Organisational design*: The organisational design may be discussed according to the role structure, power structure and normative structure of the organisation.
    - Role structure: Role structure in this sense is the way in which tasks are allocated according to specific roles in the organisation. Role conflict and ambiguity are the two problematic phenomena in role structures. Firstly, role conflict in the way of role overload is most often experienced. Research indicated a strong

correlation between role overload and burnout. Person-role conflict may create additional strain to the role structure.

Secondly, role ambiguity occurs when the employee lacks the information required to perform the role adequately.

- Power structure: Autonomy, centralisation and formalisation are three major factors influencing the power structure and ultimately creating strain and burnout. Autonomy refers to the extent in which individuals may work independently and create their own space in the organisation. Centralisation refers to the degree of participative decision making of lower level employees. Formalisation refers to the standardisation of tasks and the control in which deviations from the standardised tasks are allowed.
- Normative structure: The normative structure includes the values goals and ideologies of the helping professions. These may include addition to knowledge in the organisatio n as a goal. Organisational health policies and employee needs may serve as values and embedded goals.

2.8 PREVENTION OF COMPASSION FATIGUE AND BURNOUT

According to Dutton and Rubinstein (1995), effective prevention of STS results from effective prevention of the traumatic events that lead to secondary stress reactions. Although some traumatic events such as nature disasters are not preventable, most traumatic events are. Not to argue that primary intervention (actions such as protective thinking, responsible actions and keeping oneself safe) are very important, but secondary

prevention should be addressed in most cases. Secondary prevention may include training of trauma workers to identify and cope with these traumatic experiences.

2.8.1 Survival strategies

The following section comprises of survival strategies each discussed in relation to adaptive and maladaptive coping. According to Valent (1995) the following are survival strategies:

2.8.1.1 Care

This is a very common survival strategy in those that care for the traumatised, such as caseworkers and social workers. Caring, nurturing and protecting are characteristic of all humans. This survivor strategy has a connection to the limbic system; therefore, the biological theory is an appropriate framework.

- The *adaptive* mode of this survivor strategy is associated with feelings such as caring, empathy, devotion, and responsibility.
- The *failed* survivor strategy brings about feelings of quilt and shame for not being able to safe another. These emotions may also be avoided or relived in traumatic stress symptoms

2.8.1.2 Attaching

Attaching, as a survivor strategy, evokes when the perception that others are needed to effect one's own survival by providing protection to them and satisfy their needs.

- In *adaptive* attaching the reaching out to the other individual leads to satisfaction of needs.
- Abandonment and aloneness describes maladaptive attachment.

2.8.1.3 Assertiveness

One must achieve specific goals to survive and this survivor strategy explains those behaviours. Valent (1995) makes use of the hunting example, he states that: hunting was one of the key behaviours of our existence and due to the evolutionary changes; hunting directs the evolution of the human individual in today's technology, and society. Hunting in the job context, will ensure shelter and food.

- *Adaptive* assertiveness and goal achievement bring about feelings of strength, high morale and control.
- *Failure* is associated with feelings such as a sense of loss of control, powerlessness and frustration. It is evident that some symptoms of compassion fatigue and burnout is visible in maladaptive goal achievement.

2.8.1.4 Adaptation

New goals are stepping to the foreground in the liberty of old goals. Acceptance of loss and developing new goals indicate adaptation as a survival strategy.

- Some helpers may experience the same loss as their clients, but helpers must accept losses and conceptualise that they do have vulnerabilities and limits. The acceptance of losses, grieving, and focussing on new goals are adequate adaptation by the helper.

- *Maladaptation* occurs when the helper is unable to grieve the losses and internal dialogue "do not cry" hinders the adaptation.

2.8.1.5 Defending

Defence is a reflex to attack present in most human behaviour. When a helper perceives a client as potentially threatening, the helper may induce a survivor strategy in this case defending, to indicate to the client that the helper will not stand down and will not be threatened.

- *Adaptive* defending is merely not standing down to attack.
- *Maladaptive* defending may result in extensive hurting of or destructive behaviour towards the other individual

2.8.1.6 Fleeing

When a situation is becoming a dangerous and hurtful experience, the helper may result to the survivor strategy of fleeing.

- *Adaptive* fleeing is associated with feelings of fear and terror, which turn into relief once fled.
- Premature fleeing may result in emotions such as inadequate skills and a feeling of lack of competence.

2.8.1.7 Competing

- Helpers may become a competitor and may use their status and influence to obtain better resources, in this case, clients.
- Helpers may also compete among their own colleagues. When this competition is not balanced, the clients may become a resource so highly sought after by the helper that the helping relationship is affected.

2.8.1.8 Cooperating

Cooperating as a survivor strategy becomes apparent when a helper becomes a trusting partner to create mutual essentials in the helping relationship.

- *Adaptive* cooperation is associated with feelings such as trust, sharing, commitment and generosity.

- When cooperation is *maladaptive*, emergence of feelings such as betrayal and loss of creativity may result.

According to Valent (1995), helpers may develop secondary traumatic stress disorder when survival strategies are not adaptive. Commonly used strategies for helpers are those specified as caring and asserting. Possible means to remedy the likelihood of developing STSD is to build the strategies into debriefing sessions or in training.

2.8.2 Characteristics of survival strategies

Valent (1995) stipulated the following characteristics of survival strategies:

2.8.2.1 Evolutionary adaptation

Adapted models in individuals that enhances endurance and maintenance in stressful situations are evolutionary.

2.8.2.2 Level of operation

Humans have different levels of operations for each survivor strategy, according to the midbrain, limbic system and primitive cortex, which are used to persevere in stressful situations. Again, the biological theory indicates the importance of the relationship between the psychological and physiological.

2.8.2.3 Bio-psychosocial

Each survival strategy has biological, psychological, and social aspects that are functional to that specific strategy.

2.8.2.4 Small number of survivor strategies with a mass of combinations

Only a small number of survivor strategies exist, but in the vast amount of combinations available, one has infinite possibilities for each stressful and traumatic situation.

2.8.2.5 Adaptive vs. maladaptive strategies

An adaptive strategy will be beneficial to the individual in any situation although caution is advised for possible maladaptation of the strategy when specifics in the situation changes. When a survivor strategy becomes maladaptive in specific situations, the influence on the individual may be problematic. Specifics like disorders, suppressed feelings and illness may result.

2.8.2.6 Interpersonal effects

Survival strategies may be identified with in others and influence the strategies of any individual.

2.8.2.7 Modulation of survival strategies

When a particular survival strategy becomes maladaptive, others may induce moral judgements on the individual that will bring about alteration of the survival strategy.

2.8.2.8 Higher level of symbolisation

When an individual, removed from the situation, is faced with memories and feedback from the situation, some symbolisation may occur. This indicates that the individual may result back to the survivor strategy once used in the original situation.

2.9 CHAPTER CONCLUSION

Individuals in every domain are at risk of developing compassion fatigue, including correctional officers, counsellors, psychologists, social workers, emergency response personnel, and medical staff. It is evident from the literature that not only is compassion fatigue and burnout serious emotional altering states, but also astonishing changes could manifest in personal and societal relationships. Although these phenomena may influence a professional care worker very negatively, it is not irreversible. Through the correct strategies and early intervention, care could be optimised and prove very successful.

Chapter 3 will focus attention on organisational responses to compassion fatigue and burnout.

CHAPTER 3: ORGANISATIONAL RESPONSES

3.1 INTRODUCTION

Considering literature provided in Chapter 2 one may reach the assumption that organisations play a crucial role in the onset and manifestation of secondary traumatic stress and burnout.

Chapter 3 focuses on the various responsibilities of organisations in identifying and preventing secondary traumatic stress and burnout in the workforce. Many authors indicated that organisations play a crucial role in the identification of traumatic incidences and the prevention thereof, but many organisations lack the commitment to their workforce to successfully identify and render these situations.

In order to ensure optimum understanding regarding the organisational responses of organisations to secondary traumatic stress or compassion fatigue and burnout it is necessary to provid e definitions of terms used.

3.2 DEFINITION OF TERMS

Organisational responses are defined as the responsibilities of organisations to identify and prevent traumatic incidences in the workplace. No formal definition is available, but through the extensive literature it is evident that organisational responses are described as

those activities implemented by organisations in relation with individual employees to render possible problematic situations.

The organisational responses are divided into primary, secondary and tertiary interventions

Primary intervention may be defined as the initiation actions and responsibility taken by organisations to ease the emotional load of employees in different departments. These interventions take place before any identified problems emerged. This is the primary goal of organisational health and safety and may also include organisational policies and procedures (Williams, 1993).

Secondary intervention may be described as the management of identified problems. Organisations have already identified the problem areas and have actions to control these problems. It is also those measures employed to prevent the development of permanent psychological detriments (Williams, 1993).

Tertiary intervention is indicated by the failure of the organisation to identify the problem initially and care or crisis management needs to be done. Tertiary intervention is to provide resources to individuals after the emergence of specific symptoms related to trauma (Williams, 1993).

3.3 ORGANISATIONAL RESPONSES

Organisational responses to trauma counsellors that may endure symptoms of compassion fatigue and burnout, or the foreseeing event of these symptoms occurring, could engage in the following to assist employees:

- Reduce the number of caseloads each trauma counsellor is responsible for.
- Provide supervision and group support programmes to assist employees in rendering these effects.
- On a very simplistic level, organisations should provide safe and comfortable organisational settings to perform their duties.
- Organisations should ensure adequate benefits, staff development opportunities, regular leave, informed consent as a standard organisational policy to inform new counsellors of the risks involved in trauma counselling and expressive staff meetings (Hesse, 2002; Yassen, 1995).

These organisational responses correlate with those already mentioned in chapter 2 regarding sources of burnout.

In addition Bell, Kulkarni and Dalton (2003), specify the following organisational responses to secondary trauma:

- Workload, in the form of caseload, must be more diverse in the attempt to prevent compassion fatigue and burnout among their employees.

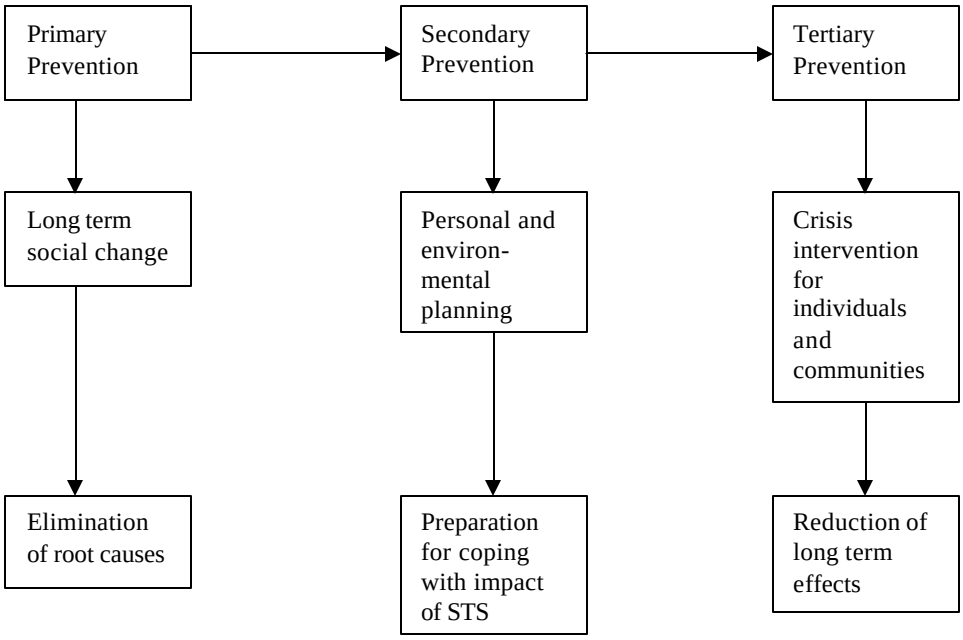
- Work environment; setting, location, safety and privacy influences the experiences of the trauma counsellor and the client. The work environment may contribute to the effects of compassion fatigue and burnout.
- Education reduces the likelihood in onset of the specific phenomenon. Education starts at the interview in that the organisation educates the new counsellor on the possibility and symptoms of secondary trauma. Education could also take the form of workshops and courses.
- Group support within the organisation plays a vital role in managing the onset of symptoms related to secondary trauma. By using informal debriefing, peer support groups or group support may reduce the prevalence of secondary trauma.
- Supervision, when effective, may be one of the most vital managing tools in preventing secondary trauma. Supervision and evaluation should be separate from one-another and the importance of and intention with supervision should be explained to the employees.
- Resources to self-care should be established by the organisation. Adequate time should be allowed if an employee wishes to engage in personal therapy sessions.
- Teamwork is highly desirable, offering mutual support, sharing and reflection (Sexton 1999).

3.4 PREVENTION METHODS

The familiarisation of organisational responses towards compassion fatigue and burnout brings forth prevention models to be explored. Of those preventative models the ecological approach and the environmental model will be explained.

3.4.1 The ecological approach

The ecological approach specifies primary, secondary and tertiary prevention in a multi-dimensional approach.



[4]**Figure 4: Multidimensional framework**

The primary, secondary and tertiary prevention paradigm used in figure 4 specifies the following interventions (Yassen, 1995):

- Primary prevention: Workshops, antiviolence campaigns, community involvement through education of specific problem areas.
- Secondary prevention: Debriefing methods, support groups.
- Tertiary prevention: Crisis intervention and identification and referral of individuals to related professionals for further assistance.

[4] From "Preventing secondary traumatic stress disorder. In C.R. Figley (Eds.)," by J. Yassen, 1995, Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatised, p. 178-208. Adapted with permission of the author.

3.4.2 Environmental prevention

As already mentioned, individual responsibilities towards prevention is one part of STS prevention. According to Yassen (1995), prevention of environmental STS rests on secondary and tertiary intervention due to the need of planning and preparation. Social and work settings are investigated further.

3.4.2.1 Social setting

Interventions in this sphere include: Educational interventions, coalition building, legislative reform, social activism, and mass media education and global communications (Yassen, 1995).

3.4.2.2 Work setting

Industries or organisations should take note of the following in order to assist employees in attending to their personal health and well-being: Value systems, tasks such as job description, job security, job overload, managerial functions such as line of authority, and interpersonal influences such as respect for differences, trust among staff.

3.5 CHAPTER CONCLUSION

As indicated from literature, common themes can be pointed out considering organisational responses. These are: adequate training, supervision, adequate work

environments, case load, benefits and communicative meetings. The methodology will be discussed in chapter 4.

CHAPTER 4: RESEARCH METHODOLOGY

The empirical study, as the following step in the research process entails a number of steps that includes the selection of a study population, determining the appropriate measuring instruments and data analysis.

This chapter describes the process by which the study population was selected, descriptions of the measuring instruments and the procedures used to administer and score the measuring instruments are provided. The introduction to the research questions is also provided. Also, statistical analysis used is discussed.

4.1 RESEARCH QUESTIONS

1. What are the key organisational responses to compassion fatigue and burnout in trauma counsellors?
2. What are the differences in the organisations in their responses to compassion fatigue and burnout?
3. Do any of the organisational responses predict compassion fatigue and burnout experienced by the trauma counsellors?
4. Is the predictive power of the organisational responses evident when individual variables are accounted for?

4.2 RESEARCH DESIGN

Although a quantitative approach is employed to reach the research objectives, the study may be described as a multi-method study due to quantitative and qualitative characteristics.

4.3 STUDY POPULATION

4.3.1 Population

The target population for the study includes counsellors working with trauma survivors. Five different organisations have been approached regarding their possible interest in the study. All five organisations are based in Gauteng except one, which is based in Northern Free State.

4.3.2 Sampling

Purposive sampling was used in that this enables the researcher to ensure that the study population is representative of the universal population (Kerlinger & Lee, 2000). To be able to generalise the findings to the broader population, it is necessary that the sample consist of trauma counsellors from a broad spectrum of organisations. The trauma counsellors all have some formal training regarding specific trauma counselling. This may also include a formal educational background. No volunteer counsellors were used

for the reason that different responses may be associated with volunteer counsellors beyond the scope of this study. The sample comprised of 25 (*N*) trauma counsellors.

Organisation 1 and Organisation 2 provide services such as counselling, debriefing and support to their communities regarding problematic issues involving children and families. Organisation 3 provides services such as counselling and support groups to any individual that requires assistance regarding personal psychological wellbeing or that of family members. Organisation 4 and 5 are consultation organisations specialising in counselling and debriefing employees of different client organisations. The counsellors are specialised individuals that have formal training in relevant trauma counselling ranging from registered counsellors to registered clinical psychologists.

These organisations were selected for the purpose to explore the psychological impact on individuals working closely with traumatised individuals. All the counsellors at these organisations are caseworkers in trauma.

Of the 25 counsellors participating in the study, 19 were female and five (5) were male, with one response missing. The mean age ranged between 25 and 45. The educational level of all participants ranged from two having a Matric to one having a Doctorate degree. Number of years experience with trauma survivors ranged from one having less than six months experience to 14 having three to five years experience with the mean between two and three years experience. The number of years in the current organisation ranged from five working less than six months in the organisation to six working between

three and five years in the organisation with the mean between one and two years working in the current organisation.

4.4 PROCEDURE

All managers or office heads were contacted by the researcher and a copy of the research proposal was provided. Once approval and consent was given by all organisations to pursue in the study, meetings were arranged. The meetings served the purpose of the researcher explaining the study to all counsellors. After all counsellors were informed the researcher explained the procedure of the questionnaires to be completed. Envelopes in conjunction with the questionnaires were provided and completed questionnaires were deposited into a sealed box which was cleared at regular intervals. Confidentiality assurance was established with this procedure. Secondary information was obtained via organisational documents, such as management meeting minutes, office memos and internal notices. Organisational documents assisted in obtaining an objective framework to support the data gathered via the individual assessments. Although no copies of the secondary information were allowed to be made, organisations indicated that their policies and procedures were in place. The organisational policies were viewed.

4.5 MEASURING BATTERY

The method of data collection was by means of structured questionnaires. The measuring battery will be discussed according to the development, description, administration, scoring and interpretation. The reliability of the measuring instruments will also be provided.

4.5.1 Compassion fatigue and Burnout

Compassion fatigue and burnout was measured through the Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales – Revision III (ProQol – RIII). (Appendix 1)

4.5.1.1 The Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales – Revision III (ProQol – R III)

- Development

The ProQol – R III was developed by Dr. Beth Hudnall Stamm, Ph.D., Dr. Debra Larsen, Ph.D., and Ms. Kelly Davis-Griffel from the Institute of Rural Health, Idaho State University.

The items of the scale were compared to the DSM-IV-TR definition of trauma and therefore this scale are valuable to the study due to the phenomena compassion fatigue

and burnout addressed as symptoms of trauma and specifically secondary traumatic stress (Stamm et al., 2003).

- Description

The ProQol – R III consists of 30 items. The response format comprises of a six-point scale ranging from 0 = never to 5 = Very often. It consists of three subscales, namely Compassion Satisfaction, Burnout and Compassion Fatigue with 10 items each (Stamm et al., 2003).

- Administration

The ProQol – R III is a self assessment measure. Instructions to the questionnaire introduce the purpose of the items and explain its relevance to experiences, positive and negative, in the last 30 days. Respondents are requested to record their responses to the set of statements on the six-point scale reflecting their current situation. No time limit is imposed, but the respondents are requested to respond to items with their initial reactions or impressions (Stamm et al., 2003).

- Scoring

Scoring directions are stipulated as self-scoring, but for the purpose of the research the scoring was done by the researcher. Five items needed to be reversed according to the response scale 0 = 5, 1 = 4, 2 = 3, 3 = 2, 4 = 1, 5 = 0. The items needed to be reversed are 1, 4, 15, 17, 29.

Although instructions to scoring were clear, the decision was made to alter the reverse scoring procedure due to the following reasons:

A six point Likert-scale was used and the reverse scoring was advised as follow: 0=0; 1=5; 2=4; 3=3; 4=2; 5=1 (Stamm, et al, 2002). The researcher decided to change the reverse scoring due to the fact that 0 = never and should be included in the reverse scoring as an answer. If however, 0 = not applicable, the reverse scoring would have been accepted. By engaging in this change, some items had positive correlations where negative correlations were indicated at first, and also the reliability was influenced positively.

- Interpretation

The explanations provided for each of the subscales are as follow:

a.) Compassion Satisfaction

Compassion Satisfaction is considered the pleasure one derives from performing your job well. These feelings are extended to the relationships with clients, colleagues and also the possibility of contributing to the society. High scores indicate a greater satisfaction related to your occupation.

According to Stamm, et al. (2003), the average score is 37 with approximately 25% of individuals scoring higher than 41 and approximately 25% scoring below 32. When an individual scored in the higher range, it is possible that that they derive a substantial amount of professional satisfaction from their

position. Scoring in the lower range could indicate a problem with their job or simply that the individual derive satisfaction from sources other than their job.

b.) Burnout

Burnout is considered as feelings associated with helplessness and difficulty in dealing with particular aspects of work. These feelings have a gradual onset and are associated with high workload or an unsupportive work environment.

According to Stamm et al. (2002), the average score is 23 with approximately 25% of individuals scoring higher than 28 and approximately 25% scoring below 19. When an individual scored in the higher range, it is possible that that they should consider the reasons for the associated feelings and address these as soon as possible. Scoring in the lower range could indicate a positive feeling regarding aspects at work and feelings of effectiveness may be experienced.

c.) Compassion Fatigue

Compassion fatigue is also called secondary trauma and is related to vicarious trauma (Stamm et al., 2002), is related to exposure to extremely stressful events at work. The symptoms are usually rapid in onset and associated with particular events.

According to Stamm et al. (2002) the average score is 13 with approximately 25% of individuals scoring higher than 17 and approximately 25% scoring below 8. When an individual scored in the higher range, the individual should consider what may be frightening or causing secondary traumatic symptoms.

The scale had applicable subscales relevant to the study and therefore was used to gather the data. The scale has some negative attributes such as the initial problematic reverse scoring which was altered and the continual research being done on the questionnaire. Per se the ongoing research may not create problems for the current study, but could be an issue when a duplicate study should be attempted (Stamm et al., 2002).

4.5.1.2 Reliability of the ProQol – R III

The reliability scores obtained by the researcher indicated the following: The subscale compassion satisfaction is very reliable in that it has an alpha of .92. Subscales burnout and compassion fatigue had lower alphas of .62 and .66 respectively. This may be due to problematic items found in the scale which could derive from the odd reverse scoring instructions given by the authors of the scale. One item was deleted due to the confusing nature it may have had for respondents. The item deleted is question one of the burnout sub-scale. Below are the alpha scores after reverse scoring was corrected.

Table 1: Alpha coefficient

COMPONENT	a
Compassion Satisfaction alpha	.92
Burnout alpha	.67
Compassion Fatigue alpha	.66

The questionnaire was used in the altered format due to higher reliability.

4.5.2 Organisational Responses

Organisational responses to compassion fatigue and burnout of each organisation was measured through the Organisational Response Questionnaire developed by the researcher.

4.5.2.1 Organisational Responses Questionnaire

An organisational response questionnaire was developed by the researcher according to vast amount of literature on organisational responses identified towards employees in the health professions as mentioned in chapter 2 and 3. The questionnaire has two subsections, the first considering the individual differences employees may experience with seven items, and the second section considering organisational questions, with 19 items, regarding the research ideas. The second subsection composed of organisational issues has three different sections namely; primary, with eight items, secondary, with

eight items, and tertiary interventions, with three items. The information gathered from this questionnaire serves as primary information to the information gathered from organisation policies and procedures.

4.6 STATISTICAL ANALYSIS

All statistical analysis will be carried out with the assistance of the SAS Programme (SAS Institute, 2000). Descriptive statistics, i.e. maximum values, minimum values, means, and standard deviations were used to analyse the data of the different organisations. Cronbach's alpha coefficient was used to assess the internal consistency reliability of the measuring instrument (Kerlinger & Lee, 2000).

Content analysis will be used to describe each organisation and organisational responses to compassion fatigue and burnout. A profile of the organisational responses to possible compassion fatigue and burnout was developed for each organisation. Organisations with different profiles were compared on their compassion fatigue and burnout score as a means to establishing relationships between organisational responses and the respective dependant variables. Although extreme detail was obtained from the analysis, profiles were only compared according to information that does not disclose any identifying information as to protect organisational and employee confidentiality.

In order to provide relevant answers to questions one and two, descriptive statistics was used. T-tests were used to answer questions three and four respectively.

4.7 ETHICAL CONSIDERATIONS

Consent has been given by the organisations in that permission letters were obtained from the various research settings and a subject information letters was provided in conjunction with the questionnaires. As stated in the subject information letter, no information that could identify any individual, such as names and identification numbers were requested. The respondents needed to complete the questionnaires, insert in the envelope provided and deposit the documents to the sealed box. Completed questionnaires were regarded as consent for participation in the study.

Interviews with managerial staff were preceded with a consent form providing informed participation in the study. Clearly stated information regarding the rights and responsibilities of the interviewee was provided. The interview schedule was on the basis of the organisational questionnaire. Assurance was provided that only the researcher will have access to the data obtained. When confirmation regarding the accuracy of the data was received, all questionnaires and interview recordings was destroyed.

4.8 CHAPTER CONCLUSION

Chapter 4 specified all empirical procedures and ethical considerations. Chapter 5 consists of results and discussions of profiles conducted from the empirical study.

CHAPTER 5: ANALYSIS

This chapter reports the findings of the data obtained in the study. The results will be discussed according to the different profiles of each organisation and seeking comparisons and contradictions between the profiles.

5.1 ORGANISATION PROFILES

Organisational profiles were used to explore the different issues in organisational procedures that may or may not contribute to secondary trauma in trauma counsellors. These profiles consist of information on all the participating organisations, but as mentioned in chapter 4, some information may not be included in order to keep the identity of all organisations confidential.

5.1.1 Organisational background

Organisation 1, 2 and 3 are situated in a town close to Johannesburg and all employees live in and around the particular town or city. All the organisations consist of an office manager, also a trauma counsellor, a receptionist and multiple counsellors. Organisations 4 and 5, consisting of ten or more counsellors, are situated in Johannesburg and are relatively larger than the first three organisations which consist of three to eight counsellors. All organisations were fairly eager to participate in the study.

Six employees in Organisation 1 were introduced to the study and five actually participated, eight employees from Organisation 2 were introduced to the study and four actually participated. The first impression of the organisation was not favourable and the researcher was the witness of organisational conflict. All employees from organisation 3 were introduced to the study and the total organisation actually participated. From the fourth organisation 20 employees were introduced to the study and nine actually participated. Only four participants from Organisation 5 completed questionnaires due to variable working hours of contract counsellors employed by the organisation. When considering the low response rates from all the organisations except one, it may be that employees were either not informed regarding the study beforehand or employees may have felt threatened by the type of study or the reason for investigating organisational responses and/or personal responses regarding secondary trauma. In a small organisation it is easier to fall victim to unfair confrontation in that it may be easier for management to ascertain who did or did not participate in the study. This response from management may not be negative at first, but feedback from results obtained may influence behaviour towards participating individuals. As stated, confidentiality of identities was ensured to all participating individuals and organisations.

5.1.2 Demographic results

The majority of participants were female with male participants from only two organisations. The academic qualifications ranged a great deal in all the organisations, indicating that counsellors have different degrees of knowledge and experience to offer.

It may enable organisations to direct specific cases to different skilled individuals in order to streamline their activities. The employees at Organisation 4 and 5 are very highly qualified in that all employees have at least a Masters Degree in Clinical Psychology, Industrial Psychology, Social Work or Counselling.

5.1.3 Individual responses

The individual responses section of the organisational questionnaire included questions regarding responsibilities of individuals to their own physical and psychological well-being. Previous research indicated that the focus is fixed on individual responsibilities and therefore the individual responses were examined.

The results were:

All participants viewed their lives as generally healthy with some improvement necessary. With regard to exercise, included in the general health category, most participants indicated that exercise was not one of their highest priorities, although employees of Organisation 4 have a generally healthier lifestyle. This may be due to the younger age group found at this organisation. Of the total population, 42% indicated that they spend time with family and friends once a week and 47% indicated that time spent alone once a week is a necessity. 52% participants indicated that personal therapy was never sought before and 42% indicated that the possibility in seeking personal therapy is not an option. This figure concerning personal therapy may indicate that the counsellors did not give the possibility any thought or that the need did not previously arise.

5.1.4 Organisational responses

The organisational responses are divided into three subsections namely; primary, secondary and tertiary responses of organisations to compassion fatigue and burnout. Primary intervention indicates responses organisations commit themselves to before any problematic situations arise or before any signs of compassion fatigue and burnout is visible, as previously mentioned (Williams, 1993). Secondary intervention is those intervention organisations implement to manage possible burnout and compassion fatigue among employees and also includes those responses to ensure that it does not escalate into an unmanageable situation. Tertiary intervention is responses needed to manage the current situation marked by burnout or compassion fatigue, or both.

5.1.4.1 Primary intervention

The primary interventions were characterised by Williams (1993) but supported by Yassen (1995), Hesse (2002) and Bell, Kulkarni and Dutton (2003). It includes change of line of authority, restructuring organisational units, employee decision making, redesigning tasks, restructuring physical work environment, reward systems, and information provided to employees adhering to the Occupational Health and Safety Act. Employees and management were asked which of these primary interventions are present in the organisation.

Management groups of the organisations indicated their responses as follow:

Organisations indicated that they do provide encouragement of employee decision making, redesigning of physical work environment, and provide information on policies and procedures adhering to the Occupational Health and Safety Act. Organisation 1, 2, and 3 indicated that no change of line of authority or restructuring organisational units was implemented as regard to the limited number of employees in the organisation. Each of these organisations only has one office head or manager and only that person is in an authoritative position. Although management of Organisation 1 and 2 indicated the possibility of some subordinates being asked to provide some authority to others from time to time, these situations are limited. Organisations 4 and 5 indicated that changes in the line of authority and restructuring of organisational units are used as interventions in the organisation. Furthermore, only Organisation 1, 4, and 5 indicated that they might have reward systems for encouragement. Formal proof was not obtained from the organisations as regards to respect of confidentiality in their practices.

Table 2 indicates the data obtained from the questions on primary interventions as to employee responses.

Table 2: Primary Intervention Results

Action	%		Org 1		Org 2		Org 3		Org4		Org5	
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
1 Change the line of authority	30	70	2	2	0	4	0	3	3	6	1	3
2 Restructure organisational units to prevent monotony	24	76	0	5	1	3	1	2	2	7	0	4
3 Encouragement of employee decision making	57	43	4	1	4	0	3	0	2	7	1	3
4 Redesigning tasks	48	52	3	2	2	2	3	0	0	9	3	1
5 Redesign physical work environment	57	43	4	1	2	2	3	0	4	5	3	1
6 Establishment of a reward system for encouragement	19	81	0	5	2	2	1	2	1	8	1	3
7 Supportive climate with constructive feedback	52	48	1	4	3	1	3	0	4	5	2	2
8 Policies and procedures adhering to OHS Act	19	81	0	5	2	2	0	3	2	7	2	2

In table 2 it is clear that the respondents of the total population are unanimous regarding organisations not providing responses such as change the line of authority (70%), restructuring organisational units in order to prevent monotony (76%), establishing reward systems for encouragement (81%), and information regarding policies and procedures adhering to the Occupational Health and Safety Act (81%).

Also clear from table 2, employees seem to disagree on provision of the following: Employee decision making, redesigning tasks, redesigning physical work environments, and provision of a supportive climate with constructive feedback.

The organisation profiles independently indicated the following on primary interventions:

Employees from Organisation 1 agree that no provision is made of the following actions: restructuring organisational units to prevent monotony, establishing a reward system to encourage employees, supportive climate with constructive feedback, and policies and information regarding policies and procedures adhering to the Occupational Health and Safety Act. Agreement was reached that management do provide actions such as encouragement of employee decision making and redesigning of the physical work environment. Some uncertainty among employees exists regarding the change of line of authority and redesigning of tasks.

Employees of Organisation 2 are unanimous both in their assertion that the organisation does not encourage employee decision making or change the line of authority in order to prevent monotony. By contrast employees displayed uncertainty regarding redesigning tasks, redesigning physical work environment, reward systems for encouragement, and information on policies and procedures regarding the Occupational Health and Safety Act.

Organisation 3 employees are unanimous regarding all the primary intervention actions in that no provision is made as regards to change the line of authority, restructuring organisational units to prevent monotony, and establishing a reward system for encouragement. Employees agree that the following are provided: encouragement of employee decision making, designing physical work environment, redesigning tasks and have a supportive climate with constructive feedback. Employees have a clear consistent picture of the organisational practices in place.

Employees from Organisation 4 agree that the following organisational actions are not provided: redesigning tasks, change the line of authority, restructure organisational units to prevent monotony, encouragement of employee decision making, establishment of a reward system for encouragement, and provision of information regarding policies and procedures adhering to the Occupational Health and Safety Act. Employees seem to disagree on the provision of redesigning the physical work environment and supportive climate with constructive feedback.

Unanimous agreement was reached by employees from Organisation 5 that management do not restructure organisational units in order to prevent monotony. Most employees agree that the organisation also does not provide change the line of authority, encouragement of employee decision making, and establishment of a reward system for encouragement. Most employees also agree that the organisation does redesign tasks and redesign their physical work environment. A disagreement exists concerning supportive

climate with constructive feedback and information on policies and procedures adhering to the prescription of the Occupational Health and Safety Act.

5.1.4.2 Secondary intervention

The secondary interventions, also characterised by Williams (1993), indicates training and debriefing options as the most relevant interventions to be addressed by organisations. The secondary interventions in this study include training concerning stress management, time management, and conflict management. These interventions also include provision of health promotional activities, supervision, debriefing options concluding difficult cases, and support groups.

All organisation management groups indicated that training, supervision and debriefing is provided to employees. No indication was made in regards to health promotional activities. Again, formal proof was not obtained from the organisations as to the respect confidentiality in their practices.

Table 3: Secondary Intervention Results

Action	%		Org 1		Org 2		Org 3		Org4		Org5	
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
1 Stress management training	48	52	1	4	2	2	3	0	4	5	2	2
2 Time management training	14	86	0	5	2	2	0	3	1	8	1	3
3 Conflict management training	14	86	0	5	1	3	0	3	2	7	1	3
4 Health promotional activities	20	80	0	5	0	4	0	3	5	4	0	4
5 Supervision	62	39	0	5	3	1	3	0	8	2	2	2
6 Debriefing options concluding difficult cases	70	30	1	4	3	1	3	0	9	0	3	1
7 Focus or support groups	25	75	0	5	0	4	2	0	2	7	2	2

In table 3 it is clear that the respondents of the total population are unanimous regarding organisations not providing time management training (86%), conflict management training (86%), focus groups or support groups (80), and health promotional activities (75%). There was also agreement among the respondents that management provide debriefing option concluding difficult cases (70%). In contrast, disagreement among employees exists in relation to the availability to stress management training and supervision.

The organisation profiles independently indicated the following concerning secondary interventions:

Agreement was reached that management do not provide any of the secondary interventions for employees of Organisation 1. Employees from Organisation 2 are in agreement that no conflict management training, health promotional activities or focus and support groups are offered. Most employees agreed that they do have supervision on a regular basis and also have debriefing options concluding difficult cases.
A general disagreement among all employees exists on stress and time management training.

All employees of Organisation 3 agree that the organisation does provide stress management training, supervision, debriefing options concluding difficult cases, and focus or support groups. No time management training, conflict management training, and health promotional activities are provided.

A unanimous agreement was reached by employees of Organisation 4 that management do provide debriefing options concluding difficult cases and a general agreement among participants exist upon supervision being provided on a regular basis. Agreement that the following is not provided was found: time management training, conflict management training and support or focus groups. In contrast disagreement was found about the provision of stress management training and health promotional activities.

Lastly, participants from Organisation 5 mainly agree that the organisation does provide debriefing options concluding difficult cases. Also a unanimous agreement is noted about management not providing time management training, conflict management training and health promotional activities. Stress management training, supervision, and focus or support groups availability provided disagreement among employees of this organisation.

5.1.4.3 Tertiary intervention

Williams (1993) specified tertiary intervention as crisis management with specific referrals to private consultation or therapy for the traumatised employees. The tertiary interventions included in the study are availability to employee assistance programmes, in-house counselling, reference to counselling and attendance of counselling during office hours.

Management indicated that any employee are permitted to attend counselling sessions, but no indication was made regarding the availability of referral to these professionals or whether employees were allowed to attend these sessions during office hours. Only organisation 4 provided their employees with an employment assistance programme due to their nature of consulting to others. Although formal proof was not obtained from the organisations no continuous queries regarding this was made in order to respect confidentiality in their practices.

Table 4: Tertiary Intervention Results

Action	%		Org 1		Org 2		Org 3		Org4		Org5	
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
1 Provision of assistance programmes	33	67	0	5	2	2	1	2	4	5	2	2
2 In-house counselling or referral	24	76	0	5	0	4	1	2	4	5	1	3
3 Attendance of sessions in office hours	44	56	1	3	1	3	3	0	2	7	3	1

In table 4 the results were that the respondents of the total population are unanimous regarding organisations not providing in-house counselling or referrals. Employees disagree on the provision of assistance programmes and attendance of sessions in office hours.

The organisation profiles independently indicated the following concerning secondary interventions:

Table 4 specifies that Organisation 1 has a unanimous agreement regarding no provision of assistance programmes and in-house counselling and referrals, and attendance of sessions during working hours. Employees from Organisation 2 are in agreement that management do not provided any in-house counselling or reference to counselling, and

they are also not provided with the opportunity to attend counselling sessions during office hours. A discrepancy was noted on provision of assistance programmes.

Individuals in Organisation 3 are in total agreement about not receiving assistance groups, in-house counselling or reference to counselling but however, employees are allowed to attend counselling sessions during office hours.

Agreement that management provides opportunities to attend counselling sessions during office hours was indicated in Organisation 4, but disagreement exists regarding provision of in-house counselling and referrals, and provision of assistance programmes.

Individuals from Organisation 5 mainly agree that the organisation do permit attendance of counselling sessions during office hours. There is also an agreement that the organisation do not provide in-house counselling or any referrals to private practitioners. There is however disagreement as regards to the availability of assistance programmes.

5.1.5 Compassion fatigue and burnout

The questionnaire used for measurement of compassion fatigue and burnout has three (3) subscales including compassion satisfaction, compassion fatigue and burnout. Table 5 indicates the expected norm averages including higher and lower ranges of these subsections (Stamm et al., 2003).

Table 5: Subsection scores

	Average	Higher range	Lower range
CS	37	> 41	< 32
CF	13	> 17	< 8
BO	23	> 28	< 19

CS = Compassion Satisfaction

CF = Compassion Fatigue

BO = Burnout

As previously explained these ranges indicate areas of concern and does not necessarily indicate a definite problem.

Table 6: Individuals per Range

	Org 1			Org 2			Org 3			Org 4			Org 5		
	HR	AR	LR	HR	AR	LR	HR	AR	LR	HR	AR	LR	HR	AR	LR
CS	1	2	2	1	0	3	1	1	1	1	7	1	0	4	0
CF	2	2	1	1	2	1	1	1	1	6	2	1	1	3	0
BO	2	2	1	0	3	2	0	0	3	1	1	7	0	0	4

CS = Compassion Satisfaction

CF = Compassion Fatigue

BO = Burnout

In table 6 indication were noted that all organisations have average to low compassion satisfaction scores. All organisations tend to have average to high compassion fatigue and burnout being lower for all organisations except Organisation 1 with a tendency of higher burnout.

Although Organisation 4 indicated a lower range of burnout but a higher score on compassion fatigue the reason may be attributed to personal variables not accounted for in this study. An additional reason may be that burnout, which has a slower onset than compassion fatigue, did not yet manifest at the time of the study.

5.2 RELATIONSHIP BETWEEN COMPASSION FATIGUE, BURNOUT AND ORGANISATIONAL RESPONSES

Firstly, descriptive statistics is provided in order to explain the normal distribution of compassion satisfaction, compassion fatigue and burnout. A histogram of the subscales of the ProQol – RIII was provided to determine if the scale is sufficiently close to a normal distribution.

Price (2000) indicates that when hypotheses about population parameters are tested, assume that the population distribution of the variable being measured is normal in form. Abundant tests assume the normal distribution and equal variances in multiple condition designs and these assumptions received great attention from statisticians in the past. A current opinion is that, in general, no concern should be experienced regarding normality

and equal variance in that, research indicates that most parametric inference procedures are fairly refined in the face of moderate departures from both normality and equality of variance.

In relation to the above mentioned, the normal distributions of compassion satisfaction, burnout and compassion fatigue are as follow:

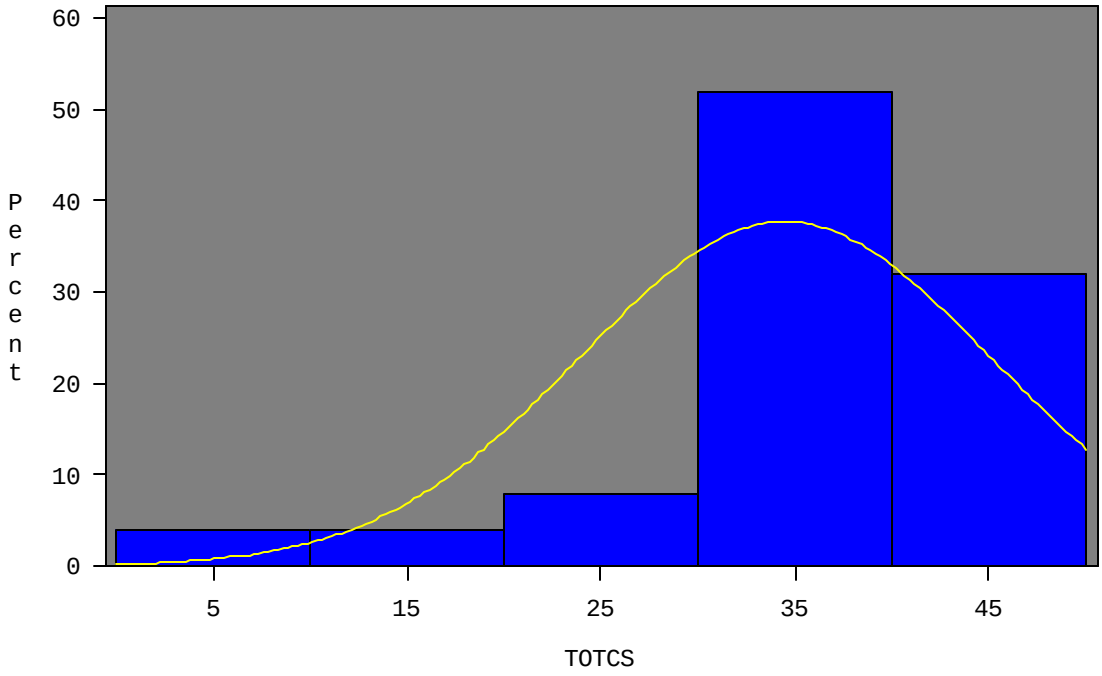


Figure 5: Histogram of compassion satisfaction

Compassion satisfaction with N = 25, has a mean of 34.5, standard deviation of 10.57, skewness of -2.01 and the kurtosis is 4.39. According to Price (2000), deviations from a normal distribution should not be alarming in that most parametric inference procedures are fairly refined in the face of moderate departures from both normality and equality of variance.

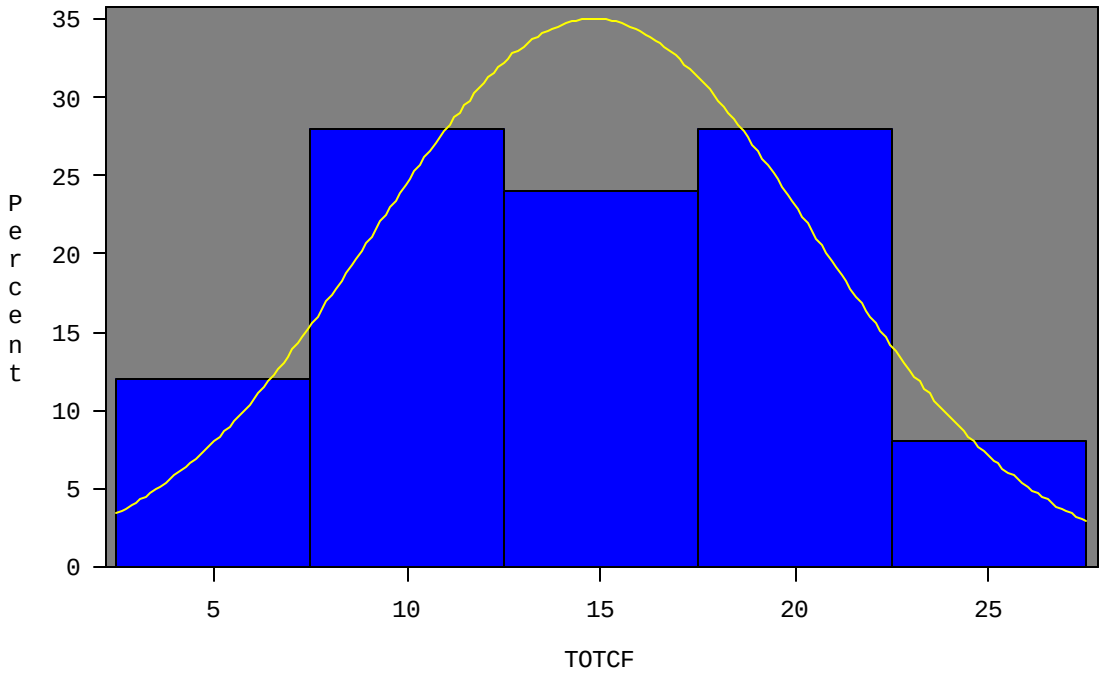


Figure 6: Histogram of compassion fatigue

Compassion fatigue with the N = 25, has a mean of 14.8, standard deviation of 5.7, skewness of -0.004 and the kurtosis is -0.8. Again, no concern is raised based on the opinion of Price (2000).

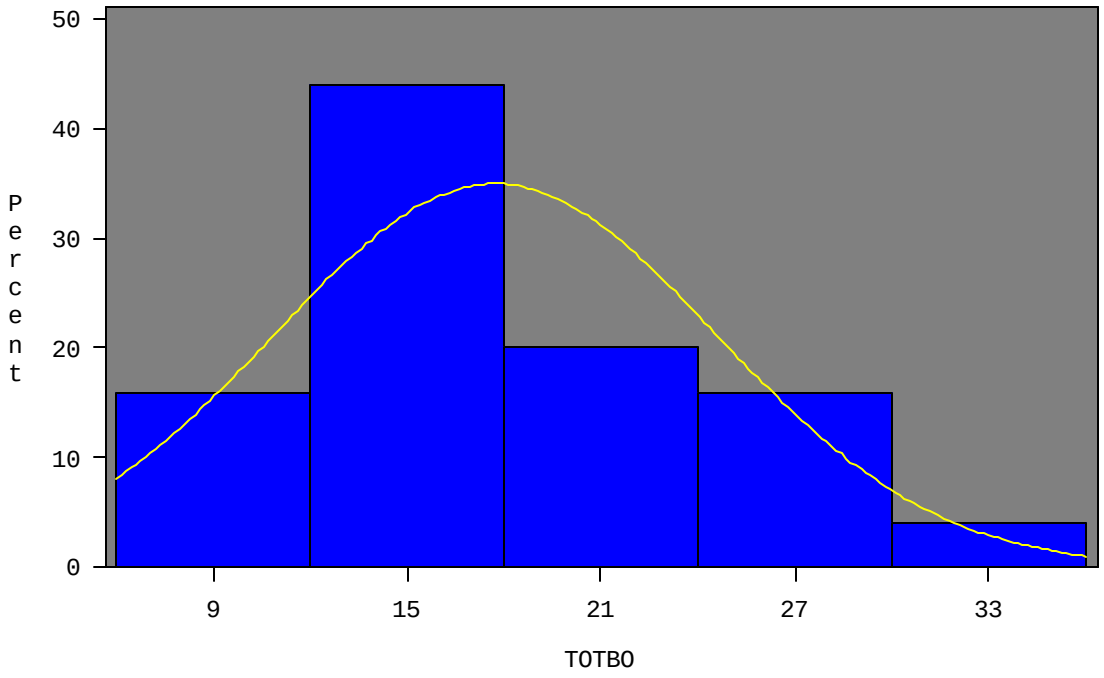


Figure 7: Histogram of burnout

Burnout with the *N* = 25, has a mean of 17.7, standard deviation of 6.8, skewness of 0.6 and the kurtosis is 0.4. According to the opinion of Price (2000), no concern is raised regarding the distribution curve of burnout.

5.2.1 T-test results

T-tests, a parametric approach, were used to examine two different group means to determine any significant differences between the groups. T-tests are used when the total observations are less than 30. Furthermore, we set significant difference at a value smaller than 0.05 (De Wet, de K Monteith, Steyn & Venter, 1981).

T-tests were used to examine the possibility of any statistical significant differences occurring between the group that were subjected to the primary, secondary, and tertiary interventions and the group that was not. Table 7 below indicate the difference in means from the group that was subjected to the intervention and the group that was not. In reference to the table, the following apply:

CS1	=	Mean of group that was subjected to intervention (group 1)
CS2	=	Mean of group that was not subjected to intervention (group 2)
BO1	=	Mean of group that was subjected to intervention (group 1)
BO2	=	Mean of group that was not subjected to intervention (group 2)
CF1	=	Mean of group that was subjected to intervention (group 1)
CF2	=	Mean of group that was not subjected to intervention (group 2)

Table 7: T-test results

Org variables	CS1 Prob>t	CS2 Prob>t	BO1 Prob>t	BO2 Prob>t	CF1 Prob>t	CF2 Prob>t
Primary interventions						
Change the line of authority						
Restructure organisational units						
Employee decision making						
Redesigning tasks						
Redesign physical work environment						
Reward systems						
Supportive climate						
Information on OSH Act						
Secondary interventions						
Stress management training						
Time management training						
Conflict management training						
Health promotional activities						
Supervision						
Debriefing options						
Focus or support groups						
Tertiary interventions						
Assistance programmes						
In-house counselling or referrals						

* Statistical significant means

It was necessary, firstly, to examine whether the compassion satisfaction mean of the group subjected to the primary, secondary and tertiary interventions differed significantly from the mean of the group that was not subjected to these interventions. Secondly, whether the mean burnout score of the two groups differ significantly concerning the primary, secondary and tertiary interventions, and lastly, whether the mean compassion

fatigue scores of the two groups differ significantly regarding the three intervention subsections.

5.2.1.1 Compassion satisfaction

No significant differences were observed between the group that was subjected to either the primary, secondary, or tertiary interventions and the group that was not subjected to these interventions. This implies that the group that was subjected to these interventions did not indicate a higher level of compassion satisfaction than the group not subjected.

5.2.1.2 Burnout

As indicated in table 7, statistically significant difference exists between the group that was subjected to the primary intervention; redesigning of physical work environment, and the group that was not subjected to this primary intervention. In particular, the group subjected to the intervention with *mean* = 15.06 and the group not subjected with *mean* = 21.7 indicating that the mean burnout score for group 1 is lower than the mean burnout score for group 2, therefore redesigning of physical work environment had a positive influence on the burnout of those individuals that were subjected to the intervention.

Regarding the other primary interventions no statistical significant differences were observed. This includes: change of line of authority, restructuring organisational units,

employee decision making, redesign tasks, reward systems, and information provided to employees about the Occupational Health and Safety Act.

Furthermore, statistical significant difference existing between the group that did have the secondary intervention namely stress management training and the group that did not have stress management training. In particular, the group subjected to the intervention with *mean* = 13.9 and the group not subjected with *mean* = 21.2, indicating that the mean for group 1 is lower than the mean burnout score for group 2, therefore stress management training had a positive influence on the burnout of those individuals that were subjected to the intervention.

In addition, a statistically significant difference exists between the group that was subjected to the secondary interve ntion, support or focus groups, and the group that was not subjected to the intervention. In particular, group 1 with *mean* = 16.2 and group 2 with mea*n* = 22.5, thus indicating that the mean for group 1 is lower than that of group 2, therefore support and focus groups had a positive influence on the burnout of those individuals subjected to the intervention.

No statistical significant differences were observed regarding the other secondary interventions including: training concerning stress, time, and conflict management, provision of health promotional activities, supervision, and debriefing options concluding difficult cases. In addition no statistical significant differences were observed regarding the tertiary interventions.

5.2.1.3 Compassion fatigue

From table 7 it is clear that a significant difference exists between the group that were encouraged to exert employee decision making, a primary intervention, and the group that were not permitted. In particular, the group subjected to the intervention with *mean* = 12.2 and the group not subjected with *mean* = 17.5, indicating that the mean burnout score for group 1 is lower than the mean burnout score for group 2, therefore employee decision making has a positive influence on the compassion fatigue of those individuals that were subjected to the intervention.

The other primary interventions, however, indicated no statistical significant differences regarding change of line of authority, restructuring organisational units, redesigning of physical work environment, redesigning tasks, reward systems, and information provided to employees about the Occupational Health and Safety Act. In addition, no statistical significance was observed regarding the secondary or tertiary interventions.

In comparison to the amount of t-tests performed, a relative low number of statistically significant differences were found and could be indicative of the fact that the results were derived from a group of individuals that may have had other difficulties despite their work environment. As indicated earlier in the chapter none of the organisations had all interventions in that all management groups indicated some absence of the interventions questioned.

Finally, as regards to not finding phenomenal significant relationships between the organisation profiles and compassion fatigue and burnout when research question 3 was addressed research question 4 becomes irrelevant.

5.3 CHAPTER CONCLUSION

Organisations faced with issues such as compassion fatigue and burnout may be able to provide their employees options to combat these. From the results it became evident that most of the organisations face the probability of their employees suffering from compassion fatigue especially Organisation 1 and 4. Although the organisations have some interventions in place, room for improvement always exist.

Chapter 6 aims to conclude the most prominent results found in the study.

CHAPTER 6: DISCUSSION AND CONCLUSION

Chapter 6 discusses the most prominent results found in the study to conclude on the responses of the participating organisations to secondary traumatic stress, in particular compassion fatigue and burnout experienced by trauma counsellors.

6.1 DISCUSSION

To comprehensively postulate as regards to the findings in this study, universal assumptions are presented followed by the most prominent results discussed in relation to theory presented.

Respondents were unanimous regarding organisations not providing primary interventions such as change of line of authority, restructuring of organisational units in order to prevent monotony, establishment of reward systems, and information regarding issues concerning the Occupational Health and Safety Act. In contrast disagreement among employees were noted regarding organisations providing primary interventions such as employee decision making, redesigning tasks, redesigning physical work environments, and provision of a supportive climate and feedback.

In response to the primary intervention results given, the following may be postulated:

Organisation 1, 2 and 3 are smaller organisations compared to Organisation 4 and 5 in that the employee numbers are lower. From this it may be possible why interventions such as change of line of authority and restructuring of organisational units to prevent monotony are not implemented in the smaller organisations and would probably not be feasible if implemented. Considering the larger organisations, flexibility exists in that more organisational units are available for restructuring. Nevertheless, employees from Organisation 4 and 5 both indicated absence of these interventions. A possible reason may be that these interventions are not being implemented in Organisation 4 and 5, or has not been implemented. Another reason may be that employees were not subjected to these changes since being employed by the organisations.

Provision of information adhering to the Occupational Health and Safety Act was denied by all employees, although management indicated otherwise. The discrepancy between management and employees may be a result of organisations not wanting to implicate themselves if the information is not provided, or possibly, employees may not recognise the information provided in an alternative form such as training. Management indicated some uncertainty concerning establishment of reward systems for encouragement, and in addition employee indicated no reward systems were in place. It may be possible that this is actually not implemented and management did not want to provide faulty information with reference to the reward systems. Yassen (1995) and Hesse (2002), stipulated benefits such as reward systems as one of the organisational responses that

may have a detrimental effect on systems of compassion fatigue. From the results it is evident that this primary intervention had no significant influence on either the burnout or the compassion fatigue of employees. Although benefits may have a positive effect on the decrease of symptoms, this response should not be presented in isolation.

A possible lack in communication may propose the discrepancies between employees and management on encouragement of employee decision making, redesigning tasks, redesigning physical work environment, and a supportive climate with constructive feedback. In relation to the contributing factors to compassion fatigue, work environments are stipulated as crucial by Ball, Kulkarni and Datton (2003). When the work environment provides privacy to the counsellor employed or the possibility of being redesigned as to satisfy the needs of the counsellor, the organisation may be able to assist in combating the onset of compassion fatigue.

Respondents supplementary agree that organisations do not provide the following secondary interventions: time management training, conflict management training, focus groups or support groups, health promotional activities, and debriefing options concluding difficult cases. In contrast, disagreement concerning stress management training and supervision exist among employees.

In relation to the prominent secondary intervention results, it may be assumed that although management indicated training and debriefing concluding difficult cases as being available to employees, employees are either not informed in this regard or these interventions are only available on request. The discrepancy between management and

employees concerning training and the additional fact that employees themselves are not in agreement on stress management training, may indicate that management do indeed provide these interventions and employees are not knowledgeable on this or training is available only on request. Although supervision exerted disagreement among employees, Organisation 2, 3, and 4 indicated supervision as an intervention. The lack of supervision from the other organisations may implicate defective organisational relationships or ineffective management. In importance to this, Yassen (1995), specified and was supported by Hesse (2002) that in providing supervision and support groups to employees, the onset of compassion fatigue or burnout may be rendered. Also, Bell, Kulkarni and Dalton (2003) expressed the importance of supervision as a vital managing tool in preventing compassion fatigue. However, the interventions should not be implemented in isolation. All possible interventions should be implemented and current interventions maintained. Health promotional activities may not be offered by management, possibly that management do not feel obligated in providing activities that individuals are personally responsible for. As already indicated, previous research emphasised the personal responsibility of the employee above the responsibility of the organisation.

In addition unanimous agreement on the matter of organisations not providing tertiary interventions such as in-house counselling or referrals was indicated. Employees seem to disagree in relation to the provision of assistance programmes and attendance of counselling sessions during office hours. Management of Organisation 4 specify the availability of assistance programmes for employees, but no other organisation indicated

the same. The disagreement between employees of Organisation 4 regarding this may be as a result of employees not requesting availability to assistance programmes or lack of communication in relation to the policy. Bell, Kulkarni, and Dalton (2003) indicated that resources of self-care should be made available to employees who wish to attend counselling sessions, in that, emphasise on counselling being offered and attendance during working hours made possible. Furthermore, the discrepancy between management and employees concerning attendance of counselling sessions during office hours may be as a result of not many employees wanting to attend counselling sessions, or again, this is only provided on request. As indicated by Bell, Kulkarni, and Dalton (2003), resources to self-care are important, but not only that, the organisation also have a legal responsibility toward employees requesting issues related to health and safety in the workplace.

Finally, all organisations have average to low compassion satisfaction. In result to this, assuming that compassion satisfaction is only related to the work environment may be faulty. It may also be possible that employees render satisfaction from sources other than work such as relations to family and friend or extramural activities.

All employees tend to have average compassion fatigue with the exception of Organisation 4. According to Beaton and Murphy (1995), factors that may contribute to the onset of compassion fatigue include the organisational context and in particular, organisational size. When organisations are bigger employees tend to lack affiliation to colleagues and have a lesser community bonding within the organisation. In result to this

it may be speculated that employees in a larger organisation, such as Organisation 4, are more vulnerable to compassion fatigue as a result of organisation size. In addition, the social context, also specified by Beaton and Murphy (1995), may have an influence on the onset of compassion fatigue in that Organisation 4 is situated in a city with possible lesser social support from the community as to Organisation 1, 2, and 3 being situated in towns with a possible closer community and thus, more social support. Within Organisation 4, employees may also indicate higher compassion fatigue relating to the fact that compassion fatigue has a rapid onset and burnout develops gradually (Figley, 1995).

Results of burnout are lower for all organisations except Organisation 1. According to Cherniss (1980) differences in occupation and organisation are more likely sources of burnout than individual differences such as low tolerance to stress. Specific organisational differences may be high case load, problematic and demanding clients, organisational conflict and lack of supervision. Although these issues, except lack of supervision, were not indicated by management or employees it may be postulated that some of these concerns may be present in one or more participating organisation. The fact that burnout of employees of Organisation 1 is higher may indicate individual differences not accounted for.

A multi-dimensional framework based on the ecological model of Yassen (1995) indicates primary, secondary and tertiary intervention to be implemented by organisations to comprehensively address compassion fatigue and burnout in trauma counsellors

employed. In relation to this the ecological approach indicates primary interventions to have a long term social change when implemented resulting in elimination of the root causes. Secondary interventions consist of environmental and personal planning for the preparation in coping with the impact of STS. Tertiary interventions are crisis interventions for individuals and their communities in order to reduce the long term effect of STS (Yassen, 1995). In addition to this explanation, it is evident that organisations may consider not only implementing as many interventions as possible, but also maintaining them as well as possible.

6.2 CONCLUSION

The first key conclusion is that there are a small number of significant relationships between organisational practices and health outcomes. It is evident in Organisation 4 which has the highest level of compassion fatigue but also one of the promising records regarding particular practices. The reason may be that these practices are irrelevant or they are overwhelmed by other organisational differences. Secondly, an immense number of inconsistencies concerning employee responses regarding organisational interventions may indicate that employees were either not informed on organisational interventions, or employees did not make use of these interventions to their availability. As the last key conclusion, a discrepancy exists between information provided by management and employees. A possible reason may be that effective communication is deficient between management and employees, or that management did not provide the interventions as indicated. Possibly, management did not formally implement some of

the interventions and therefore, disagreement exists among employees on various interventions.

6.3 CHAPTER CONCLUSION

Chapter 6 provided a conclusion regarding the five organisational profiles resulting from the information gathered in the study. Chapter 7 will indicate research limitations and recommendations.

CHAPTER 7: LIMITATIONS AND RECOMMENDATIONS

In conclusion to this study, limitations of the research conducted are discussed. Additionally, possible ways in which similar research could be improved are explored.

7.1 LIMITATIONS

A discussion of the research limitations of the present study enables one to consider particular characteristics that may be replicated or avoided, in future studies. The research limitations is divided into limitations related to quantitative research, correlation studies, information recorded, representation and the measuring instruments used.

7.1.1 Limitations related to Quantitative Research

According to Kerlinger and Lee (2000) the multi-method approach can be time and cost consuming. Although this may be the case, some theorists indicated that this may be the best method to obtain a correct image of the study. Quantitative research may indicate the relation between different groups but are not very flexible. Exertion of information from statistics, using this method, may not necessarily be descriptive or explanatory answers to the research questions as will be provided by a qualitative method.

7.1.2 Limitations to a correlation study

According to Huysamen (1993), a correlation design can be used to assess interrelationships among variables at one point in time. Therefore, the interventions may have been in process but not yet implemented at the time of the study thus influencing the results more negatively. The results obtained in this study have only relation to the organisations and their interventions at that specific time.

7.1.3 Limitations regarding information recorded

The organisational policies and procedures were presented by each organisation, but no notes were allowed to be made and no copies were issued. Also, no information such as intervention periods and frequencies of interventions were specified. This made it very difficult to examine the actual influence of each organisation intervention. Organisations may not have provided this information due to not being able to or not wanting to imply that some of these interventions were not implemented at all. Although the policies and procedure were provided to read, it may also be possible that these interventions are not in actual motion in the organisations. Policies may be in writing, but not implemented.

When considering the variance of the organisations, not only in size but also in geographical differences, an indication regarding the differences in responses may be concluded. Considering that one organisation is fairly larger than the other organisations, alternative influences other that those examined may have had an influence on the results.

7.1.4 Representation

A limitation of this study is the size of the sample, specifically the distribution of different organisations on a national base. Results are limited to organisations based in Gauteng and Northern Free State and can therefore not be generalised to the total population. The total population of five organisations were used; as such the respondents were not selected randomly. The results are therefore limited to only these organisations.

7.1.5 Limitations related to The Professional Quality of Life – Revised III, Stamm et al., (2002)

The decision was made to alter the reverse scoring procedure from that suggested by the authors for the reason mentioned in the methodology chapter. This will disable the researcher to make comparisons with previous uses of the scale in previous studies.

The fundamental limitation of the study is that it is essentially a correlational study and as such it is not possible to determine what organisational responses or which differences between the organisations cause the compassion fatigue and burnout.

7.2 RECOMMENDATIONS

7.2.1 Future research

The study, does not provide unconditional answers in these aspects, but provides the reader with areas of interest which may warrant further investigation.

As a result of unidentified factors influencing individuals in the organisation and not being able to correlate the organisation findings one could investigate what personal characteristics of counsellors make them acquiescent to the development of secondary traumatic stress, in particular compassion fatigue and burnout?

Organisational profiles indicated deficiencies between individual responsibilities and management responsibilities and raise the question of the personal characteristics of managers that make counsellors acquiescent to the development of secondary traumatic stress, in particular compassion fatigue and burnout?

When considering the interventions organisations may or may not have taken, one could investigate the extent of accessibility to policies and procedures for counsellors in order to contest secondary traumatic stress.

7.2.2 Organisational recommendations

The present provided some answers on trauma, specifically compassion fatigue and burnout, but also on organisation responsibilities towards these issues. Although the study could not provide answers to all related questions, some clarity was obtained concerning organisational influences regarding the onset of compassion fatigue and burnout.

Managerial employees are recommended to ascertain whether there are possible interventions not yet employed and whether the present interventions need to be revised.

As indicated by Valent (1995), survival strategies could be implemented, but alterations need to be made according to each organisation profile to assure the applicable strategies are employed with the corrective characteristics.

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