Vicarious Traumatisation in Therapists Working with Victims of Violent Crime in Contemporary South Africa

By

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Declaration

I declare that this research report unless specifically indicated otherwise is my own, unaided work. It has not been submitted before for any other degree or examination at this or any other university.

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01 August 2021

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Date

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Abstract

While there is a body of research on vicarious traumatisation that has been conducted on counsellors and therapists conducting trauma intervention in South Africa that had grown over time, there is arguably a gap in existing research in terms of focusing specifically on therapists who work extensively with crime victims. High rates of violent crime in South Africa and the fact that therapists themselves are not immune to victimisation suggest that the impact of this kind of trauma work may be particularly taxing. The current study explored the subjective experiences of therapists who work with victims of violent crime within a contemporary South African context. An exploratory, qualitative study was conducted in which seven participants were interviewed using a semi-structured interview schedule. The following three superordinate themes were identified as salient across all interviews: *Impact of Trauma Work, Coping within the Context of Conducting Trauma Therapy,* and *Contextual Considerations related to Trauma Work.* Falling under these three broad themes 11 subordinate themes were identified, including *Emotional effects of vicarious exposure, Heightened awareness of crime and related intentional responses, Subjective triggers, Impact on worldview, Setting boundaries, Self-care practices, Finding meaning in the work, Seeking support, The context of crime and trauma in South Africa, The context of personal exposure to crime for therapists,* and *Technique as a professional context for crime-related trauma therapy*. The findings indicate that although participants were not immune to aspects of vicarious traumatisation, they were highly attuned to detecting this kind of risk within themselves and placed considerable weight on support seeking of various kinds, as well as upon good self-care. Although several participants had themselves been affected by crime, they appeared able to continue to find work with crime victims manageable and meaningful. An interesting finding that emerged was that the nature of the therapeutic approach that therapists chose to use in their work appeared to have a substantial bearing on whether or not they found their work to be negatively impactful.

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Chapter 1: Introduction

Due to what has been referred to as a "culture of violence" and many intersecting risk factors, contemporary South Africa's crime and violence levels remain consistently high (Brankovic, 2019; Schönteich & Louw, 2001; South African Police Service, 2020). With the high prevalence of violent crime, there is a serious impact on our health system as the number of trauma victims is significant and escalates as crime levels increase (Gould, 2014). Studies have shown that since the end of Apartheid, high levels of violent crime have led to 80% higher levels of trauma exposure across the South African population, with over 70% of the adult population generally having been exposed to at least one potentially traumatic event (Atwoli et al., 2013).

The demand for counselling interventions to address trauma-related responses proves challenging for trained psychologists who constitute only 0.014% of the country's population and form part of the limited and thinly spread resource personnel for trauma victims (Health Professions Council of South Africa, 2016; World Health Organisation, 2015). Mental Health Professionals (MHPs) who work with trauma victims are chronically exposed to clients' explicit retellings of their traumas and as such, are at significant risk of vicarious traumatisation. Parallel to its primary counterpart in the form of direct exposure impact, vicarious traumatisation challenges interventionists' pre-existing cognitive worlds and produces secondary traumatic stress symptoms which can be debilitating for MHPs involved in trauma intervention (Lerias & Byrne, 2003; Pearlman & Mac Ian, 1995).

While previous studies have been conducted into aspects of vicarious traumatisation among South African trauma therapists and counsellors, it seemed important to expand this research in the context of high levels of exposure, high levels of violence associated with crime, and high levels of poly-victimisation among clients, more especially since therapists live within the same context in which their clients have been victimised. Broadly, this study aimed to contribute to the existing literature on the experience of vicarious traumatisation among mental health professionals, and more specifically to expand this theoretical base by contextualising therapists' responses and reactions in relation to working with victims of violent crime in a high violence society.

1.1. Rationale

Vicarious traumatisation has been extensively researched internationally amongst various populations, including therapists. Whilst South African research on vicarious traumatisation is

evident and has increased over time, the body of national research on this topic lacks cohesion as studies are spread across populations and phenomena, and generalisations cannot be made (Howlett & Collins, 2014). Studies in South Africa have tended to focus on either burnout or secondary traumatic stress and have generally been conducted using quantitative methods, such as survey type designs (see Jordaan et al., 2007; Ludick et al., 2007; MacRitchie & Leibowitz, 2010; Du Plessis et al., 2014.) Quantitative studies are useful for establishing prevalence rates and correlations between variables but cannot offer more detailed insight into subjective conceptualisations and experiences. Ludick et al. (2007), in their quantitative study, recommended further qualitative research to broaden exploration into vicarious traumatisation. It, therefore, appeared useful to complement existing quantitative research with an interview-based study in which it would be possible to explore more precisely and deeply how it is that trauma therapists in South Africa report being affected by their work.

While there has been some qualitative research into vicarious traumatisation conducted in South Africa this has generally been conducted on samples that include social workers, volunteers, nurses and police workers, and less so, psychologists, and research has tended to focus on working with HIV/AIDS and intimate-partner violence (Howlett & Collins, 2014; Demmer, 2006; Gumani, 2017; Masson & Moodley, 2019; Van Dyk, 2007) rather than working with crime victims in a context of high general exposure. A recent qualitative study by Sui and Padmanabhanunni (2013) explored the psychological impact of working with trauma survivors on a group of South African psychologists. Their findings indicated that all participants experienced both vicarious traumatisation and vicarious posttraumatic growth in relation to their work. However, Sui and Padmanabhanunni (2013) did not focus on those working with a particular form of trauma exposure. Existing South African studies have examined aspects such as self-care, secondary traumatic stress, resilience, and coping (Howlett & Collins, 2014; Demmer, 2006; Gumani, 2017; Masson & Moodley, 2019; Van Dyk, 2007), but not necessarily vicarious traumatisation which is understood to involve cognitive shifts as well as symptomatic responses (as will be further elaborated later). This suggests that there is a gap in the existing body of research in terms of focusing on those who work extensively with crime victims and on the potential impact of such work in the form of vicarious traumatisation.

The focus of this study was on the subjective experiences of psychotherapists who work with victims of violent crime within a contemporary South African context given that levels of vicarious exposure were perceived to likely be demanding on therapists in specific kinds of ways. It was hoped to deepen understanding of vicarious traumatisation in relation to working with victims of violent crime in particular, and to allow for an appreciation of how socio-

political and environmental contexts may influence the ways in which therapists become vicariously traumatised. Although the study was not explicitly designed to shape policy it provides some useful insight into what renders therapists working with this kind of population, in this kind of context, vulnerable to work stress and into what factors appear to be protective.

1.2. Structure of the Research Report

Including this introductory chapter, this research report consists of five chapters that outline and describe the research aims, process, and findings, including how findings from this study appear to articulate with existing research findings in this area.

Chapter 2 presents a literature review that was conducted in relation to the research topic. The phenomenon of violent crime in South Africa is expanded on to contextualise the experience of vicarious traumatisation for South African therapists. Vicarious traumatisation, specifically for therapists, is discussed, with consideration of implications, risk factors, protective factors, and potential positive outcomes.

Chapter 3 presents the research question and the method and qualitative design of this study. It further outlines the steps followed in obtaining data and extrapolating from this, focusing on sampling, data collection, and data analysis. This chapter concludes with considerations of research quality and ethical issues and practices that required consideration.

Chapter 4 presents and discusses the key findings that emerged from the collected data. *Impact of Trauma Work, Coping within the Context of Conducting Trauma Therapy,* and *Contextual Considerations related to Trauma Work* were identified as superordinate themes, and a collective total of 11 salient subordinate themes were identified. The material under each theme is elaborated and where relevant, findings from prior research are introduced such that the findings of this study are integrated into this broader body of work.

Chapter 5 presents a concluding summary of the findings and engages with contributions, limitations, and future recommendations.

Chapter 2: Literature Review

This chapter presents a review of relevant literature pertaining to the research topic. It begins by defining the concept of trauma and its relation to vicarious traumatisation. Thereafter, the phenomenon of violent crime within a South African context is expanded on, with an emphasis on risk factors for exposure and implications of violent crime for everyday living. This is followed by a discussion on vicarious traumatisation amongst therapists, including how the impact of exposure to trauma is conceptualised within McCann and Pearlman's (1990) Constructivist Self-Developmental Theory and Wilson and Lindy's (1994) framework on countertransference and empathic strain. The implications of suffering from vicarious traumatisation, risk factors, protective factors, and possible positive outcomes of vicarious traumatisation are also discussed. The chapter concludes by summarising key points of the reviewed literature in support of the rationale for this study.

2.1. Conceptualising Trauma

Formulating a general definition of psychological trauma is challenging. In its simplest form, trauma is defined as "a deeply distressing or disturbing experience" (Oxford Dictionary Press, 2019). According to criterion A of the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders 5th ed.), trauma is defined as "exposure to actual or threatened death, serious injury, or sexual violence", which can be experienced directly, witnessed directly, learnt of from others or experienced through repeated/extreme exposure to traumatic details or events (American Psychiatric Association, 2013, p. 271). Between the dictionary and the psychiatric diagnostic definitions lies a wide spectrum of possible experiences that may or may not be construed as traumatic, depending on what perspective they are viewed from. It is also generally acknowledged that victims of trauma of human as opposed to 'natural' origin are more at risk of developing traumatic stress-related conditions, in part because of the intentionality of interpersonal attacks (Sadock, Sadock, & Ruiz, 2015).

Recognizing that what is experienced as traumatic is to some extent subjective, the working definition of trauma utilised in this study is based in large measure on individuals' perceptions of experience. That is, traumatic stimuli are any primary or secondary event/experience which a person perceives as a threat to their survival or self-preservation which subsequently challenges their cognitive world and may result in physical and/or psychological distress symptoms (Janoff-Bulman, 1992; Joseph, 2012). In this instance, the

interest is in vicarious[1] traumatisation which is viewed as similarly subjective in nature to direct trauma exposure but is likely to arise as a consequence of working with individuals who have experienced extremely threatening life events (Salston & Figley, 2003).

2.2. Violent Crime in a South African Context

In post-apartheid South Africa in its continuing transitioning state there is evidence of widespread chronic and complex trauma with over 70% of the population reporting having been exposed to potentially traumatic events (Atwoli et al., 2013). Of those exposed to traumatic events, a substantial proportion is victims of crime, including crime in which there is contact between victim and perpetrator and in which there are often threats or acts of violence. Two studies (Atwoli et al., 2013; Kaminer et al., 2008) that have assessed forms of trauma exposure have reported that an estimated 38% of the South African population is exposed to some form of interpersonal violence or violent crime in their lifetime.

In attempting to conceptualise violent crime within a contemporary South African context it is useful to first begin by briefly outlining some of the implications of the Apartheid era for current levels of violence and crime. The ideological underpinnings of Apartheid contributed in no small part to the culture of crime, in that Apartheid in itself was deemed criminal, and the resistance towards it cultivated criminal and violent behaviours (Glaser, 2008). Historical factors which contributed to crime include, but are not limited to, the violent nature of Apartheid, political cover for violence and crime, socioeconomic inequalities, the migrant labour system, youth socialisation within the context of Apartheid, resistance to emasculation, and the normalisation of criminal and violent acts (Glaser, 2008). Criminal acts in contemporary South Africa tend to be shaped by this history and to continue some of these trends. Therapists[2] who are vicariously traumatised may be aware of some of these dimensions and this may shape the meaning that they attach to the nature of events that they are exposed to in their work.

When looking at crime in post-Apartheid South Africa over recent decades there is a greater increase in violent contact crime, such as rape and assault, as compared with other types of crime (Bhagel, 2010; Schönteich & Louw, 2001; South African Police Service, 2020). Accompanying concerns in relation to these reported trends are that it is claimed that over 50% of violent crimes are underreported and also that there is a lack of successful violence prevention interventions (Legget, 2002; Seedat et al., 2009). Attempting to reduce levels of

[1] In the context of traumatic exposure, the terms “vicarious” and “secondary” are used interchangeably.
[2] The term therapist(s) is used to signify any mental health worker delivering trauma intervention.

violent crime is further complicated by the many intersecting risk factors that enable violent crimes (Brankovic, 2019).

For purposes of this study, violent crimes will include all criminal acts that are intentionally aimed at inflicting harm upon others (Reiss & Roth, 1993) and those incidents that are characterised as contact crimes by the South African Police Service (2020). This category of events includes murder, attempted murder, both attempted and contact sexual offences, sexual assault, rape, common assault, assault with the intent to inflict grievous bodily harm, common robbery, and robbery with aggravating circumstances (South African Police Service, 2020).

2.2.1. Risk factors for violent crime

Although this may seem more pertinent to thinking about crime prevention and direct victims it is important to elaborate on some of the historical and contemporary contextual factors that produce violent crime in order to appreciate aspects of the environment in which trauma therapists in South Africa work. Studies have shown a link between crime increases and countries in transition, such as those moving from repressive to less repressive governments, and from this perspective, it is necessary to consider the deep-rooted patterns of violence and crime within our society (Collins, 2013; Shaw, 1997). Schönteich and Louw (2001) refer to South Africa's 'culture of violence' as a contributor to high levels of violent crimes. They explain how Apartheid's institutional and political violence, disruption of family life, and the resistance culture of liberation movements all cultivated a potentially destructive climate on both a macro and micro level, where South Africans have tended to adopt the use of violence for conflict resolution. Problems with a propensity to move quickly to violence in situations of frustration and tolerance of lawlessness lead to greater criminality, levels of which are further compounded by an ill-equipped criminal justice system, and a society that still mistrusts law officials and is yet to develop respect for the law itself (Gould, 2014; Schönteich & Louw, 2001).

Several studies have identified common individual, social, and contextual risk factors for violent crime in post-Apartheid South Africa. These include socioeconomic inequalities, frustrated masculinity, weak parenting and socialisation, vulnerability and exposure to violence developmentally, access to firearms, high levels of substance misuse, the existence of organised crime, and lack of social cohesion (Brankovic, 2019; Seedat et al., 2009; Schönteich & Louw, 2001). Therapists working with crime victims cannot remain unaware of these kinds of contextual factors underpinning a high risk of victimisation. Violent crimes tend to involve

males between the ages of 15 and 25, tend to peak during holiday seasons and weekends, and often occur within groups and are executed by known perpetrators. However, many of those most traumatised by crime tend to become victims unexpectedly (Masuku, 2002; Seedat et al., 2009; Schönteich & Louw, 2001).

2.2.2. Implications of violent crime for victims and society

There are obvious physical and psychological impacts of exposure to violent crimes which not only affect direct victims but also their families and the wider community (Masuku, 2002). High rates of violent victimisation have a serious impact on our health system as the number of trauma victims requiring hospital treatment increases as crime levels escalate (Gould, 2014). Studies have shown that post-Apartheid, traumatisation amongst the South African population has shifted from being largely political in nature to being somewhat more criminal in nature (Seedat et al., 2009), and the increased levels of violent crime have led to an estimated 80% higher level of trauma exposure across the population (Atwoli et al., 2013).

High levels of exposure to crime, including multiple incidents of exposure, create several additional challenges: firstly, there is a heavy demand for intervention on trained mental health professionals who constitute only 0.014% of the country's population, and form part of the limited and thinly spread resources for trauma victims (Health Professions Council of South Africa, 2016; World Health Organisation, 2015); secondly, it is evident that many victims do not have access to appropriate aftercare; and thirdly, both professionals and victims find themselves having to deal with instances of continuous traumatisation which are more complex to address at the level of intervention (Eagle & Kaminer, 2013). In addition, the prevalence of crime in South Africa has been normalised and to an extent, justified (Collins, 2013). The constant awareness of crime creates a climate of fear, which Bhagel (2010, p. 71) describes as "hysteria, paranoia, or obsession". Fear of crime is experienced widely among victims and non-victims alike and contributes towards anxiety about actual and perceived risks (Bhagel, 2010) – anxiety that therapists living in the same context as victims are not immune to.

The experience of violent crimes coupled with the fear of crime among South African citizens has serious implications. Both the state and its law officials are widely criticised for their inadequacy in addressing crime, and citizens are encouraging the use of violent law enforcement (both formal and informal) to make spaces safer (Bhagel, 2010; Collins, 2013; Masuku, 2002; Shaw, 1997). This threatens the consolidation of democracy as it reflects a continued mistrust in the state and a preference for violence as a defence tool (Collins, 2013; Shaw & Gastrow, 2001). Violence as a defence tool is further normalised as people express

justified rage towards perpetrators, resort to vigilantism, and move towards legal ownership of firearms justified by the need to combat the use of illegal firearms (Bhagel, 2010; Collins, 2013; Shaw, 1997). People also react in more avoidant kinds of ways by, for example, emigrating from South Africa, or isolating themselves from the 'others' to whom they attribute evil intent (Bhagel, 2010; Shaw & Gastrow, 2001; Shaw, 1997). This deepens existing prejudices, contributes to social divides, and lessens social cohesion. Lastly, the experience of continued trauma breeds severe emotional reactions which, in some cases, results in victims becoming perpetrators (Collins, 2013).

South African trauma therapists do not live outside of these parameters in their personal lives and in counselling crime victims may face particularly high exposure to accounts of brutality. They may not only have to engage with clients'[3] attitudes and defences as shaped by living in this kind of context but also hold their own views about causality and how to respond to threat. They may well struggle to separate the personal and professional given that they live often in similar environments to those from which their clients come.

2.3. Vicarious Traumatisation Among Therapists

The discussion of vicarious traumatisation that follows in a number of sub-sections pertains to work with a broad range of trauma victims and is not limited to the effects of working with victims of (violent) crime, although this is the main focus of this particular research study. What will become evident is that the broad theory and findings can be applied to work with crime victims and that in some instances observations may have particularly strong significance for the likely impact of working with victims of interpersonally inflicted trauma. There appears to be very little research that has investigated the impact of working with crime victims specifically. However, it is apparent that many aspects of the research relate to crime-related victimisation and that some findings relate to working in contexts in which therapists work in similarly risky environments to those in which their clients live.

Mental Health Professionals (MHPs) who work with trauma victims are chronically exposed to clients' explicit retellings of their traumas, and further have the responsibility of conducting psychological interventions. The work involved in such trauma intervention is known to indirectly distress and traumatise MHPs and has been interchangeably represented in literature as compassion fatigue, professional burnout, secondary traumatic stress, and vicarious trauma(tisation). Although these terms are often used interchangeably, each one has

[3] The terms "client(s)" and "patient(s)" are used interchangeably.

its own distinctive emphasis, which is important to note to avoid representing well defined experiences by using incorrect terminology (Branson, 2019; Newell & MacNeil, 2010).

Firstly, while vicarious traumatic exposure is a prerequisite for secondary traumatic stress and vicarious trauma, burnout and compassion fatigue do not depend on exposure to trauma (Newell & MacNeil, 2010). Secondly, whilst secondary traumatic stress is reported to have a sudden onset and is known to occur after even a single traumatic exposure, vicarious traumatisation tends to result from an accumulative process of exposure to trauma (Aparicio et al., 2013; Branson, 2011). The occurrence of burnout and compassion fatigue is also reported to be accumulative in nature, however, these experiences tend to result from insufficient resources (mainly internal, but also external in the case of burnout) to meet the chronic demands expected of helping professionals (Newell & MacNeil, 2010). Both burnout and compassion fatigue are explained as an overall state of exhaustion resulting from chronic exposure to the suffering of clients. Burnout involves a reduced sense of personal accomplishment and self-efficacy, and a sense of depersonalisation. Burnout is further differentiated from vicarious traumatisation by its prognosis as burnout is reported to improve with slight changes, whereas vicarious traumatisation involves going through a process of salient internal changes (Branson, 2011). Compassion fatigue is characterised by the burden of exercising chronic empathy where MHPs tend to take on too much responsibility for their client's recovery due to a deep investment in a case or many cases over time (Newell & MacNeil, 2010). While both compassion fatigue and vicarious traumatisation entail a level of empathic engagement, compassion fatigue is focused on the discrepancy between emotional demands and emotional resources, irrespective of traumatic exposure (Branson, 2011; Newell & MacNeil, 2010).

Secondary traumatic stress refers to symptoms that are commonly displayed in posttraumatic stress disorder – such as re-experiencing the event, persistent avoidance, and increased arousal – but in response to a secondary traumatic exposure, such as hearing about exposure from direct victims (Lerias & Byrne, 2003; Newell & MacNeil, 2010). A significant difference between secondary traumatic stress and vicarious traumatisation is that the former does not include the development of an ongoing empathic relationship (Branson, 2011). This study focuses on vicarious trauma, recognising that vicarious traumatisation has been reported to contribute to the manifestation of compassion fatigue or burnout, and often includes secondary traumatic stress symptoms (Newell & MacNeil, 2010). Vicarious traumatisation is thus often understood to be a more broadly encompassing construct.

Vicarious trauma is defined as "the response of those persons who have witnessed, been subject to explicit knowledge of, or, had the responsibility to intervene in a seriously distressing

or tragic event" (Lerias & Byrne, 2003, p. 130). MHPs are at frequent risk of vicarious traumatisation, including experiencing challenges to their cognitive beliefs concerning the self, others, and the world, which is one of the features understood to characterise vicarious traumatisation. This cognitive transformation may produce secondary traumatic stress symptoms or may exist alongside symptomatic manifestations, which can be debilitating for MHPs involved in trauma intervention (Lerias & Byrne, 2003; Pearlman & Mac Ian, 1995). Alterations to core beliefs as a consequence of doing work with trauma victims can sometimes become relatively permanent, especially if MHPs are unaware of such shifts.

2.4. Constructivist Self-Developmental Theory - a Theoretical Framework

Various frameworks have been put forward to capture the phenomenon of vicarious traumatisation, the most prominent of which is that developed originally by McCann and Pearlman. The authors (McCann & Pearlman, 1990, p. 133) described the experience of vicarious traumatisation for trauma therapists as having "profound psychological effects" which are "disruptive and painful for the helper and can persist for months or years after work with traumatised persons". They further conceptualised vicarious traumatisation within their constructivist self-development theory (CSDT). CSDT is an integrative perspective that suggests that people develop their own cognitive schemas consisting of core beliefs and assumptions and that they tend to construct their perception of reality through these schemas. Within the CSDT framework, vicarious traumatisation is viewed as arising from the interaction between the nature of client material and the therapist's existing cognitive schemas. That is when clients share their traumatic experiences this has the potential to disrupt or alter the therapist's core beliefs and assumptions. The manner in which the therapist reacts to this disruption depends on the importance of the disrupted schemas and the degree or discrepancy created by the disruption (McCann & Pearlman, 1990).

The notion that trauma disrupts the cognitive world was previously established by Janoff-Bulman (1958) who claimed that three basic assumptions are challenged during the process of exposure to traumatic events: the belief in personal invulnerability, the belief that the self is worthy, and the belief that the word is meaningful and benevolent (Janoff-Bulman, 1985). While Janoff-Bulman (1958) wrote about direct victims, her theory has been expanded to apply to the cognitive shifts that may occur in those indirectly or vicariously affected by trauma exposure. When faced with trauma, either directly or vicariously, one is also exposed to new, overwhelming information that often contradicts and threatens existing beliefs. Ideally, people tend towards assimilating new information so that it corresponds with their existing

beliefs and thus enables them to continue viewing reality through a familiar, pre-existing lens. However, in the case of direct and vicarious traumatisation, studies have shown that one's core beliefs become challenged or shattered, and a rebuilding of existing schemas is required to accommodate the new information that the trauma exposure brings. This allows one to restore the disruption and incongruence caused by the traumatic event, but at the same time, results in permanent change at the schema level (Janoff-Bulman, 1992; Joseph & Linley, 2005). The idea that traumatic experiences may well result in permanent schema changes has been supported and elaborated by several authors who conducted trauma-related studies in later years in order to explore the theoretical premises put forward concerning vicarious traumatisation (Epstein, 1989; Joseph & Linley, 2005; Tedeschi & Calhoun, 2004).

McCann and Pearlman (1990) use the cognitive portion of CSDT to describe potential disruptions to specific schemas experienced by therapists who are vicariously traumatised, and how these disruptions impact emotions, thoughts, and behaviours. Their descriptions are based on the premise that people construct their own realities using complex cognitive structures, and that these developed schemas are then used to make interpretations and form meaning of experiences. The experience of vicarious traumatisation tends to modify schemas in a negative way, which causes distress and heightened awareness in relation to the newly accommodated traumatic material. The authors conceptualised the experience of both direct and vicarious traumatisation in relation to the following schemas, which they believe are fundamental psychological needs: Dependency/Trust, Safety, Power, Independence, Esteem, Intimacy, Independence, and Frame of Reference.

Dependency/Trust: humans have an inherent need to trust others and themselves, however, this need and the manner in which it may be challenged by exposure to accounts of other trauma-related sufferings, especially in situations of interpersonal attacks, serves as a vulnerability for therapists who are vicariously exposed to trauma. When therapists are exposed to stories of deception, violated trust, cruelty, or exploitation of dependency, their internal foundation of trust becomes disrupted. As such, they are likely to become more suspicious of others, cynical, or distrustful. These reactions may also filter through to previous relationships that were experienced as trustworthy. Furthermore, therapists may also begin to experience self-doubt and find it difficult to trust their own professional abilities, which subsequently affects their esteem needs too (McCann & Pearlman, 1990). *Safety:* feeling a sense of security is central to one's safety needs and when these schemas are disrupted therapists may feel that there is little to protect, themselves, or their friends and family members, from imagined or real threats. When vicariously exposed to a loss of safety, threats, or violence, therapists also tend

to experience increasing thoughts and images related to heightened personal vulnerability. As a result, therapists may become more protective over their loved ones and may engage in self-defensive and security-enhancing behaviours (McCann & Pearlman, 1990). *Power:* exposure to the feelings of vulnerability and helplessness experienced by trauma victims raises concerns for therapists regarding their own power, control, and efficacy. Therapists who have stronger internal needs for power tend to be more vulnerable to such exposures. In response, therapists are likely to become more dominant and fantasise about protective action, which carries the risk of therapists trying to control others and their clients, and even having obsessional thoughts. In severe cases, therapists tend to feel angry about their helplessness and lack of control and may even experience despair and depression (McCann & Pearlman, 1990). *Independence:* therapists with salient independence schemas are vulnerable to exposure to clients' trauma-associated lack of autonomy and restrictive experiences, and identification with clients who have been subjugated in some way can be particularly painful for them (McCann & Pearlman, 1990). *Esteem:* esteem is related to the assumption that others are worthy in terms of their humanity and therapists who hold this as a core belief are likely to experience a disruption in their belief system in hearing both about how perpetrators have behaved and how victims have been treated. As such, therapists experience diminished esteem for other people, or even the human race when exposed to persons who are harmed through malicious intentions and acts that are carried out by other humans. This experience can be especially painful as it involves a loss of ideal views about the world and others, and often results in a more cynical, pessimistic worldview. It is also possible that therapists may experience diminished self-esteem that compromises their professional abilities (McCann & Pearlman, 1990). *Intimacy:* due to confidentiality practices, therapists are limited when it comes to speaking about their experiences with clients, and even in supervisory spaces where they can process therapeutic material, therapists may be concerned about how other professionals may perceive them if they appear traumatised by their work. Often, assumptions are also made about trauma therapists and their capacity for trauma work, especially in terms of associating traumatisation to the therapist's own unresolved conflicts. Because of these factors and the need to maintain a sense of competence, therapists may alienate themselves from others when exposed to traumatic material. This disrupts a core human need for connection with others and may leave therapists feeling empty or isolated. Additionally, therapists may also feel disconnected from themselves and find it difficult to be alone, often needing to distract from being by themselves and becoming overly dependent on significant others (McCann & Pearlman, 1990). *Frame of Reference:* this refers to the therapist's need to form meaningful attributions or causations to

make sense of traumas. Being negatively impacted by exposure to client material may contribute to disruptions in existential and spiritual beliefs and positions, such as the level of hopefulness a therapist may generally feel. There are serious professional implications to such a disruption as the therapy may be directed in accordance with the therapist's need to make sense of the trauma, thus neglecting the client's needs. Personally, this can be quite distressing, and therapists may feel a sense of uneasiness and disorientation (McCann & Pearlman, 1990).

It is evident that vulnerability to these kinds of schema disruptions is likely to be exaggerated in relation to exposure to accounts of human inflicted victimisation as is the case in relation to victims of crime and particularly victims of violent crime. In addition, when therapists are located in a social context in which they are compelled to engage with considerations of crime causality, risk, and impact, by virtue of living in a society in which there is a considerable preoccupation with rates and incidents of crime, their vulnerability to schema alteration may likely be heightened.

In addition to experiencing shifts in core schemas, vicarious traumatisation also entails symptomatic responses that tend to parallel those experienced by direct victims and McCann and Pearlman (1990) have also incorporated such features of experience into their conceptualisation of vicarious traumatisation. *Disruptions in Imagery:* therapists may be vulnerable to re-experiencing their clients' traumatic imagery through flashbacks, dreams, or intrusive thoughts. This causes a disruption in memory systems and therapists may find themselves at risk of having their imagery system of memory either temporarily or permanently altered. Furthermore, the affected imagery is often related to some of the previously mentioned schemas that are most salient to the therapist, and as such, disruptions in imagery and related negative cognitions and affects are often the most painful consequence of vicarious traumatisation. As a consequence of such symptomatic experiencing therapists may feel emotionally overwhelmed due to powerful affective states associated with disruptions in imagery, which are experienced both consciously and unconsciously and make processing of these states particularly challenging (McCann & Pearlman, 1990).

McCann & Pearlman (1990) provide a useful framework for understanding how therapists are affected at a schema and symptomatic level when exposed to vicarious traumas. They highlight schemas that may be affected through working with trauma victims, and caution therapists to be aware of negative shifts in their salient schemas. Without awareness, coping strategies, and support, therapists may experience both subtle and obvious alterations to schemas and intrusion-related imagery.

2.5. Countertransference and Empathic Strain in Trauma Work

Wilson and Lindy (1994) have also provided a useful framework that emphasises the importance of empathy and creating a safe-holding environment for trauma victims, and how this process impacts on the dynamic therapeutic interaction between therapist and client. This framework delineates short-term reactions that occur in response to working with specific trauma clients, which may contribute to long-term effects or vicarious traumatisation if not worked through. Wilson and Lindy (1994) believe that the "capacity for sustained empathy [when working with trauma victims] is pivotal for the recovery process" (p. 6) and that a rupture in empathy subsequently means that therapists are not able to maintain a safe, holding environment for the patient. While empathy is at the core of all therapeutic processes, Wilson and Lindy (1994) state that in the treatment of PTSD deep empathy is more necessary to help patients work through their trauma and integrate its effects into their self-structure. At the same time, the authors acknowledge that sustained empathy is more difficult to maintain for therapists trying to contain intense trauma affect, and as such, empathic strain should be anticipated.

Empathic strain is caused by a variety of factors that vary across therapists, but one of the more prominent causes seems to be the transference-countertransference relationship between therapist and patient. The terms transference and countertransference have long been used in psychoanalytic literature to describe the redirection of feelings between patient and therapist, and the roles that each one assumes as a result. In trauma work, there seems to be common trauma-specific transference (TST) where therapists are cast into one or more trauma-specific roles, and subsequently may respond as though they have entered such a role. In this instance, a therapist's countertransference position may include (but is not limited to) being seen as a perpetrator, a collaborator, a fellow survivor, a comforter, a rescuer, and even as occupying a combination of multiple trauma-specific roles, some of which may appear contradictory (Wilson & Lindy, 1994).

The therapeutic dynamic is likely to be shaped by TST and by therapists' capacity to recognise and work with the complexities of such a process, including their own affective reactions. Intense affective reactions tend to result in negative countertransference reactions, which subsequently lead to empathic strain and potential ruptures in the therapy. Wilson and Lindy (1994) differentiate between objective and subjective countertransference reactions (CTRs) that cause empathic strain where (1) objective reactions are expected reactions brought about in response to the client behaviour, personality, and traumatic content, and (2) subjective

reactions develop from a therapist's personal unresolved conflicts and idiosyncrasies. It is evident that subjective reactions will to a large extent be informed by the kinds of pre-existing schemas identified as salient by McCann and Pearlman. The authors further distinguish between Type I CTRs (avoidance) and Type II CTRs (overidentification) and combine these with objective and subjective CTRs to produce four distinct styles of empathic strain. These are termed (1) empathic withdrawal, (2) empathic repression, (3) empathic enmeshment, and (4) empathic disequilibrium (Wilson & Lindy, 1994).

Empathic withdrawal occurs when therapists experience a combination of objective reaction and Type I CTRs. Here, therapists tend to over-rely on conventional "blank-screen" or new therapeutic techniques that block them from interacting with and integrating painful traumatic material. Often, this means that therapists may become misattuned due to previously held assumptions, subsequently resulting in an empathic rupture. This style of empathic strain is further characterised by intellectualisation and misconception of the therapeutic dynamic. Therapists who have no prior experience of trauma are more likely to develop empathic withdrawal as they are not prepared to be exposed or fully open to the severely traumatic experiences of their patients. As such, they may unconsciously need to withdraw in order to avoid the intolerable, painful emotions that come with such exposure and to protect their worldview from being threatened (Wilson & Lindy, 1994). *Empathic repression* occurs when therapists experience a subjective reaction and are predisposed toward Type I CTRs. In order to cope with their personal conflicts that are evoked by the therapy process, therapists tend to distance from and deny the significance of their patients' issues, and further tend to withdraw from their therapeutic role. Therapists with personal experiences of trauma are more vulnerable to empathic repression, especially if their trauma is similar to that of their patient(s) and if they continue to suffer from its effects (Wilson & Lindy, 1994). *Empathic enmeshment* occurs when therapists tend towards Type II CTRs in combination with subjective reactions. Here, therapeutic boundaries are often lost, and therapists tend to become overinvolved or to overidentify with their patients, at the risk of becoming pathologically enmeshed with a patient. Therapists with a history of personal trauma are more vulnerable to empathic enmeshment and may adopt a rescuer role as an unconscious means to process their own unintegrated trauma. Therapists are further at risk of re-enacting their own problems and this, together with pathological enmeshment, increases the risk of secondary victimisation for patients (Wilson & Lindy, 1994). *Empathic disequilibrium* occurs when therapists are predisposed to Type II CTRs and experience objective reactions, and is characterised by uncertainty, vulnerability, and unmodulated affect. Therapists who underestimate the intense psychological and physiological

effects of exposure to trauma seem to be most vulnerable to empathic disequilibrium, and often become overwhelmed, experience somatic symptoms, and are even flooded with vivid imagery. In this state, one's usual defences or coping mechanisms no longer serve as effective, and therapists find themselves at risk of becoming depressed or experiencing burnout.

Wilson and Lindy's (1994) framework helps understand the impact of empathic engagement with traumatic material, however, the authors caution against assuming that all CTRs will fit neatly into one of the four styles of empathic strain. Rather, they emphasise that their model provides a starting point and that there is likely a dynamic interplay between the four styles, which varies across specific therapists and cases.

2.6. Symptomatic Consequences, Implications of Vicarious Traumatisation and Related Research Findings

As discussed in Section 2.4 and Section 2.5 above, frequent empathic engagement is especially challenging when working with trauma victims and places the therapist at risk of becoming vulnerable to alterations or compromises in functioning at both the schema level and at a symptomatic level. This section outlines some further symptoms and implications that have been identified as occurring when therapists are vicariously traumatised by their work.

Schema changes, if not successfully accommodated, can produce secondary traumatic stress symptoms (Salston & Figley, 2003). Secondary traumatic stress symptoms are experienced similar to those outlined as occurring in Posttraumatic Stress Disorder (PTSD) and include intrusive re-experiencing of traumatic material, persistent avoidance of stimuli associated with the trauma, and increased emotional arousal. However, in cases of vicarious traumatisation, symptoms may occur at a lower intensity which does not always result in significantly impaired functioning (Lerias & Byrne, 2003). However, the fact that symptoms are low grade may also mean that they are less easily detected by the sufferer. Cohen and Collens (2013), in their meta-synthesis of 20 qualitative articles on vicarious trauma, reported similar trends in findings across studies where vicarious exposure was predictive of both short and long-term increases in psychological distress. Regarding emotional responses to traumatic client material, the authors reported that trauma workers tend to feel sadness, anger, fear, frustration, helplessness, powerlessness, despair, and shock. The authors further reported that some trauma workers experienced somatic symptoms such as tiredness, nausea, numbness, and even sweet cravings. Sui and Padmanabhanunni (2016), in their study using a South African sample, also reported schema disruptions, secondary traumatic stress, and somatic complaints as characteristic of vicarious traumatisation for therapists. While these symptoms are often

experienced sub-clinically, emotional, and somatic responses tend to persist beyond a particular session (Shamai & Ron, 2009). This has implications in that those who experience vicarious traumatisation often overlook their tension or unease or tend to push through until their distress increases to problematic levels (Lerias & Byrne, 2003; Sui & Padmanabhanunni, 2016).

The implications of vicarious traumatisation translate into both personal and professional difficulties and affect not only therapists working with traumatised populations, but their families and close friends too (Salston & Figley, 2003; Trippany et al., 2004). On a personal level, therapists can become emotionally detached from their loved ones, thus distancing themselves from supportive environments during a time when support may be needed (Trippany et al., 2004). Some therapists tend to distance themselves from friends who they feel cannot understand their work and what they are experiencing (Benatar, 2000), and others tend to change their friendship groups (Splevins et al., 2010). It has further been reported that therapists may have intimacy difficulties with their partners (Trippany et al., 2004) and that therapists with children may find themselves becoming overprotective parents (Clemans, 2004).

In terms of worldview, studies have shown that the perception of safety seems to be a dimension of experience that is most threatened and therapists tend to experience the world as unsafe (Bell, 2003; Benatar, 2000; Clemans, 2004; Schauben & Frazier, 1995), which also tends to heighten feelings of personal vulnerability (Benatar, 2000; Clemans, 2004). Cohen and Collens (2013) also found that through identification, therapists may begin to feel unsafe in spaces, which affects their interactions with the world. Feelings of unsafety were also extended towards other people, with therapists reporting both feelings of mistrust towards mostly unknown others and overprotectiveness towards close others. Studies further indicate that mistrust seemed to become over-generalised and was usually directed towards people who resemble perpetrators of violence and trauma in their clients' accounts (Clemans, 2004; Schauben & Frazier, 1995). While views on human resilience seemed to be generally positive (Cohen & Collens, 2013), trauma therapists were reported to hold somewhat dark, cynical views of reality (Benatar, 2000; Schauben & Frazier, 1995).

In relation to work, therapists may either experience detachment from trauma material in some instances (Clemans, 2004; Sui & Padmanabhanunni, 2016), or they may find it difficult to switch off and to create distance from client material after sessions (Splevins et al., 2010). Studies further report that therapists who work with traumatised populations may experience diminished job satisfaction over time and inefficiency in treatment delivery (Sui & Padmanabhanunni, 2016), and may also struggle to work effectively with victims because

maintaining boundaries and establishing trust is challenging (Schauben & Frazier, 1995). An American study on the impact of vicarious trauma on self-efficacy looked at 82 mental health professionals working with trauma clients, where most of the participants' trauma caseloads ranged between 30% - 60% (Sartor, 2016). Sartor (2016) reported a strong negative correlation between the experience of vicarious trauma and self-efficacy, where self-efficacy tended to decrease in MHPs who were vicariously traumatised.

As a result of countertransference and identification, therapists tend to internalise their clients' experiences and, in some instances, mirror their symptoms (Howlett & Collins, 2014), as outlined previously. In addition to concerns about therapist wellbeing this raises ethical concerns if the therapist begins to make clinical errors, crosses therapeutic boundaries, or experiences countertransference in such a manner that this becomes harmful to the therapeutic relationship (Trippany et al., 2004). Furthermore, the prolonged experience of secondary stress symptoms in therapists who are vicariously traumatised has been reported to be a risk factor for compassion fatigue and burnout (Newell & MacNeil, 2010; Sui & Padmanabhanunni, 2016). Eagle et al. (2013) reported on intergroup prejudice as a common consequence of violent crime-related victimisation and highlighted the discomfort often experienced by therapists in response to client prejudice as well as the reluctance of therapists to work with it. The authors further outline the technical and ethical complexities of engaging with clients who bring prejudiced content, and the thoughtful intervention required by therapists to understand and engage with prejudiced content as part of a trauma response without retraumatising the client or neglecting such content (Eagle et al., 2013).

Smith et al.'s (2007) paper reported on three empirical studies that looked at how therapists cope with and react to trauma clients. One of their studies analysed how both trauma therapists and other psychotherapists tend to cope with therapeutic difficulties, as well as how therapists react towards traumatic material in comparison to other difficult clinical material (Smith et al., 2007). The authors (2007) reported that trauma therapists were generally more cynical about the goodness of people when compared with client-centred therapists. Smith et al. (2007, p. 209) further found that therapists reported a "strong sense of responsibility for the client or the therapeutic process" and they tended to experience a deep feeling of hopelessness in relation to their clients' emotional and traumatic situations. While there was no distinct difference between expert trauma therapists and other expert therapists in terms of feeling hopelessness and responsible in relation to working with traumatised clients, therapists in private practice were reported to feel more responsible for client welfare than those working in clinic settings (Smith et al., 2007). Smith et al. (2007) did not report on why therapists in private

practice may feel more responsible for their clients, but it was noted that therapists who worked in trauma centres tended to use more active interventions unlike the other psychotherapists who reported more reflexive/experiencing interventions, and the authors suggest the difference in therapeutic attitude may contribute to differences in impact.

Although many studies have reported on the impact of vicarious traumatisation on mental health professionals, there is still a degree of stigma attached to self-disclosure in this regard. Molnar et al. (2017) outlined a research agenda for addressing vicarious traumatisation in the workplace and reported that stigma serves as a barrier to interventions aimed at improving the impact of vicarious traumatisation. The authors further report that the social norms governing mental health professionals tends to discourage self-disclosure of professional struggles as consequences are often anticipated. The authors recommend that further work needs to be done to change this narrative, thus creating a platform for therapists to engage with the impact of vicarious traumatic exposure (Molnar et al., 2017)

2.7. Risk Factors for Vicarious Traumatisation

Exposure to and empathic engagement with traumatic material are the primary risk factors for vicarious traumatisation among therapists. Several studies conducted with populations that deliver trauma interventions have identified additional risk factors that increase vulnerability, the intensity of experience, and the expression of symptoms. One of the more prominent vulnerabilities identified in literature was having a history of personal trauma exposure (Cohen & Collens, 2013; Finkelstein et al., 2015; Howlett & Collins, 2014; Newell & MacNeil, 2010; Pearlman & Mac Ian, 1995; Salston & Figley, 2003). Pearlman and Mac Ian (1995) reported that therapists with a previous history of personal trauma exposure were further at risk for vicarious traumatisation if they were newer therapists with less experience.

Other researchers have also found that trauma therapists with no previous trauma experiences but with less professional experience are somewhat more at risk of vicarious traumatisation, indicating that levels and length of professional experience may be implicated in resilience or vulnerability (Finkelstein et al., 2015; Howlett & Collins, 2014, Pearlman & Mac Ian, 1995). Smith et al. (2007) also found there was a higher emotional impact for younger, less experienced therapists. When analysing the impact of vicarious trauma on a sense of self-efficacy, Sartor (2016) emphasised that years of professional experience does not appear to influence levels of self-efficacy but rather the level of vicarious trauma a therapist manifested, irrespective of how long they had worked in the field, was a risk factor for decreased self-efficacy. It is evident that experienced therapists are not necessarily immune to vicarious

traumatisation even if they are somewhat less at risk than their less experienced counterparts. As further discussed below, longer-term exposure to working with victims is also a risk factor for vicarious traumatisation so there is a somewhat paradoxical relationship between experience and risk of vicarious traumatisation.

Studies also suggest that shared trauma – when a therapist and their client have experienced the same or a similar trauma – increases the risk for vicarious traumatisation, increases the occurrence of countertransference reactions, and tends to cause difficulties within the therapeutic relationship (Baum, 2010; Bell & Robinson, 2013; Saakvitne, 2002). Tosone et al. (2012) suggest that treatment efficacy in the case of shared trauma is largely dependent on the therapist's ability to work through their own trauma. Another prominent theme that emerged as contributing to the risk of vicarious traumatisation was high case load or frequency of exposure to trauma cases and high intensity of trauma cases in terms of the severity of events clients had been exposed to (Cohen & Collens, 2013; Finkelstein et al., 2015; Howlett & Collins, 2014; Newell & MacNeil, 2010; Salston & Figley, 2003). Sartor (2016) has also cautioned therapists against taking on high trauma caseloads, having established that rates of exposure to cases have a relationship with levels of vicarious trauma.

Finklestein et al. (2015) investigated the relationship between vicarious traumatisation and environmental factors for therapists treating trauma victims in war zones and reported the following two risk factors for vicarious traumatisation, both of which resonate with other findings: (1) an influx of trauma clients due to continuous trauma exposure, and (2) therapists who are most likely exposed to similar traumatic environments as their clients. Finklestein et al.'s (2015) findings seem to be of likely relevance within a South African context, considering the prevalence of violent crime and the fact that therapists are not themselves immune to threats of violent crime. Considering the South African context of continuous trauma exposure for many living in dangerous contexts it is instructive that one study reported exposure to clients' repeated traumas as a risk factor for vicarious traumatisation (Sui & Padmanabhanunni, 2016).

Personal motivation to do trauma work was also reported as a possible risk factor, depending on the nature of the motivation, especially when motivations for engaging in such work were based on personal experiences of trauma or a historically adopted caretaker role (Bell, 2003). In instances where people are drawn to offering trauma therapy based on these kinds of motivations, therapists are reported to experience increased vulnerability to vicarious exposure-related stress. For prior victims, the work becomes closely related to their own experiences, thus creating additional challenges to the already taxing trauma work. For

therapists who identify as helpers or caretakers, it appears that their self-worth may be tied to this role, thus making them vulnerable in particular ways in doing the work (Bell, 2003).

From a psychodynamic perspective, countertransference and identification with the client's traumatic experience were reported as risk factors in both an American sample (Salston & Figley, 2003) and in a South African sample (Sui & Padmanabhanunni, 2016). Newell and MacNeil (2010) also reported on organisational risk factors that can produce vulnerability to vicarious traumatisation which include lack of supervision, lack of resources, and lack of peer support. In the case of psychotherapists working in private practice, there are often very limited opportunities for formal debriefing and support.

Other risk factors for vicarious traumatisation include having a history of anxiety and mood disorders (Newell & MacNeil, 2010), personal stress levels (Cohen & Collens, 2013), maladaptive coping mechanisms (Newell & MacNeil, 2010; Schauben & Frazier, 1995), and depletion of coping resources (Finkelstein et al., 2015).

2.8. Protective Factors for Vicarious Traumatisation

It is difficult to prevent traumatic exposure for mental health professionals who choose to work with trauma victims. Studies have, however, reported on an array of protective factors that help mitigate the distress, cognitive shifts, overwhelming emotional states, and somatic responses resulting from vicarious trauma.

On a professional level, it is important for therapists to both diversify and manage their caseloads to avoid only seeing trauma clients and to commit to a manageable amount of trauma cases (Cohen & Collins, 2013; Howlett & Collins, 2014; Newell & MacNeil, 2010). Studies have also reported on the benefit of diversifying work roles to not only include face-to-face therapy, but also teaching and supervising (Cohen & Collens, 2013), and the importance of engaging in continuous training and education (Finkelstein et al., 2015; Newell & MacNeil, 2010; Salston & Figley, 2003; Trippany et al., 2004). It is also helpful to avoid having to cope with the potentially harmful effects of trauma work in isolation and studies show that seeking out organisational support (Cohen & Collens, 2013; Howlett & Collins, 2014), formal supervision, and peer supervision (Finkelstein et al., 2015; Salston & Figley, 2003; Trippany et al., 2004) gives therapists access to available resources, and to spaces to debrief and share the emotional load. Within the therapy, it is also important for therapists to set clear boundaries to firstly, create a separation between their own experiences and their client's experiences, and secondly, create a separation between their personal life and their work-life (Cohen & Collens, 2013; Howlett & Collins, 2014).

Smith et al. (2007) in their study comparing trauma therapists and general psychotherapists reported that trauma therapists reported using more active interventions as opposed to the reflection and experiencing position preferred by psychotherapists. They suggest that this active therapeutic style may represent a coping strategy that helps mitigate against the high emotional burden and feelings of helplessness that result from working with severe traumatic material. Craig and Sprang (2010) also reported on those offering trauma interventions and their study indicated that employing manualised evidence-based interventions appeared to reduce the negative impact of interacting with trauma material, specifically reducing the risk of burnout and compassion fatigue. Their findings also concur with Fonagy's (1999) suggestion that using evidence-based practices tends to increase a sense of self-efficacy for therapists as such deployment creates boundaries and structure, which are in line with the protective factors listed above. Craig and Spring (2010) do, however, raise concerns about whether a scripted, manualised process may limit empathic engagement.

On a personal level, prioritising self-care practices (Cohen & Collens, 2013; Howlett & Collins, 2014; Newell & MacNeil, 2010; Trippany et al., 2004) and maintaining a healthy work-life balance (Cohen & Collens, 2013; Newell & MacNeil, 2010; Salston & Figley, 2003) were reported as daily coping strategies that may help therapists manage their exposures and regulate their emotions. Reported self-care activities include exercising, healthy eating, resting, meditating, and conscious efforts to engage in pleasurable, leisure activities (Cohen & Collens, 2013). Part of maintaining a work-life balance and separating work life from personal life also included reports of therapists engaging in symbolic activities to mark the end of the workday (Hunter & Schofield, 2006). Several studies also reported that being in one's own personal psychotherapy served as a protective factor (see Bell, 2003; Hunter & Schofield, 2006; Lonergan et al., 2004; Pistorius et al., 2008; Splevins et al., 2010) as it facilitates coping with the emotional impact and distress that often results from trauma work (Cohen & Collens, 2013). Studies have further highlighted the importance of dealing with unresolved personal conflicts and/or previous traumatic experiences (Bell, 2003; Cohen & Collens, 2013; Salston & Figley, 2003); with cultivating ongoing awareness of salient beliefs and how these may be shifting (Howlett & Collins, 2014; Newell & MacNeil, 2010; Trippany et al., 2004); and with developing self-insight (Salston & Figley, 2003); all of which can be facilitated by a psychotherapy process.

Personal characteristics that were reported as significant protective factors include humour, optimism, positivity, and hope (Cohen & Collens, 2013); beliefs about self-efficacy (Finkelstein et al., 2015); and tending to use effective coping mechanisms (Trippany et al.,

2004). In a study on secondary trauma amongst counsellors, Bell (2003) reported that it was not any specific coping action that ameliorated the distress associated with trauma work, but rather feeling a sense of competence about coping. Bell's (2003) findings concur with those of Finkelstein et al. (2005) regarding beliefs about self-efficacy, i.e., maintaining a sense of professional competence and believing in one's ability to cope with traumatic exposures serves as a significant protective factor for therapists who are vicariously exposed to trauma. Bell's (2003) findings further seem to contradict the idea of effective versus maladaptive coping strategies that were reported in other studies (Newell & MacNeil, 2010; Trippany et al., 2004, Schauben & Frazier, 1995), suggesting that a specific coping strategy is only effective to the extent that therapists feel competent in coping, and one can infer that decreased self-efficacy may reduce the protective aspects of some coping strategies.

A strong sense of spirituality was also reported as a protective factor (Bell, 2003; Cohen & Collens, 2013; Newell & MacNeil, 2010; Trippany et al., 2004) with spiritual beliefs often proving useful in countering the negative impacts of trauma work and helping therapists to find meaning in their work (Shamai & Ron, 2009). Bell (2003) emphasises that spiritual beliefs are only useful to the extent that they serve as a buffer against stress by facilitating a positive outlook and suggests that traumatic content may well overwhelm personal beliefs or worldviews, thus causing higher stress levels for those whose important spiritual beliefs cannot be sustained in the face of vicarious exposure to traumatic material. In terms of motivation, helping professionals who chose this line of work with a more objective motivation (for example, through an academic or professional enrichment interest) seemed to experience less distress than those with personal motivations (Bell, 2003).

2.9. Positive Outcomes of Vicarious Exposure to Trauma Material as Therapists

While it may seem rather strange to suggest that therapists may experience benefits from being impacted by doing trauma work, in the same manner that direct trauma victims may experience posttraumatic growth, therapists may experience something similar. Several studies have focused on the benefits of working with trauma victims and have reported that therapists who successfully accommodate their schema changes (see section 2.3 above) may proceed to experience growth benefits because of their vicarious exposure – also referred to as Vicarious Posttraumatic Growth (VPTG) (see Arnold et al., 2005; Cohen & Collens, 2013; Sui & Padmanabhanunni, 2016). While this is outside of the main aims of this study, a brief discussion on the existing literature on VPTG seems useful as growth benefits are an integral component of vicarious traumatisation and may well be part of the participants' experiences.

Research on both Posttraumatic Growth (PTG), which pertains to the growth experienced by primary victims of trauma, and on VPTG, has shown that growth benefits may be experienced similarly among primary and secondary victims of trauma and tend to occur within the following broad domains: changes in self-perception, changes in interpersonal relationships, and changes in life philosophies (Arnold et al., 2005; Manning-Jones et al., 2015). Interestingly, these domains seem to be linked to the basic assumptions that are challenged and transformed on a schema level during the process of exposure to traumatic events (Janoff-Bulman, 1985) (see section 2.3 above) as both are related to beliefs about the self and the world (or others). More specifically, Tedeschi and Calhoun (1996) have identified the following key growth outcomes within these broad domains that have been quantified by their Posttraumatic Growth Inventory: (1) a greater appreciation of life (and a changed sense of priorities), (2) more intimate relationships, (3) greater personal strength, (4) recognition of new possibilities, and (5) spiritual development.

For those vicariously affected by trauma, growth benefits are also experienced in these domains but tend to manifest somewhat differently (Manning-Jones et al., 2015). For example, within the spiritual domain, a primary victim is likely to experience personal spiritual growth or changes, whereas a person who is secondarily exposed tends to experience a spiritual broadening or an appreciation for different spiritual paths (Arnold et al., 2005). The assumption here is that the schema changes differ between primary and secondary victims since the experience is not rooted within the person's direct self-concept for secondary victims and growth outcomes are thus shaped in a less personal way (Manning-Jones et al., 2015). In addition, a systematic literature review of VPTG (where 28 studies were reviewed) identified the following growth outcomes in helping professionals that were exclusive to VPTG: increased professional competence, realizing the value of being in a helping profession, and realizing the beneficial impact on the lives of primary trauma victims (Manning-Jones et al., 2015).

In terms of vicarious posttraumatic growth experienced amongst South African psychologists, Sui and Padmanabhanunni (2016) reported that all six participants in their study experienced growth benefits in one or more domains, which included changes in life philosophies, changes in self-perception, and improved interpersonal relationships. Several participants in their study also reported experiencing a greater sense of optimism and hope in their own lives through witnessing their clients overcome traumatic events.

Hernández et al. (2007), in their qualitative study on psychotherapists who work with victims of political violence and kidnapping, introduced the concept of Vicarious Resilience

(VR) to explain the positive impact experienced by therapists who witness their clients' capacity to overcome adversity. They reported that through empathic engagement with clients' trauma material and in response to their clients' own resiliency, a specific resilience process occurs that transforms therapists' inner experiences, resulting in a unique and positive effect on therapists. The findings from their study further indicated that "therapists who work in extremely traumatic social contexts learn about coping with adversity from their clients" (p. 237) and while generalizability was a limitation of their study, it is possible to argue that this may be the case for South African therapists working with victims of violent crime within a larger context of continuous trauma and crime. In terms of practice implications, Hernández et al. (2007) suggest that conscious awareness of VR serves as a useful tool to counteract the negative impact of working with trauma victims and may also strengthen existing processes, such as motivation and persistence, that allow therapists to deal with the emotional aspects of trauma work. They further report on the concept of vicarious learning and how therapists may learn from their clients' experiences of dealing with adversity and apply this to their own lives.

2.10. Concluding Remarks

Contemporary South Africa is characterised by high levels of traumatic exposure and high levels of interpersonally inflicted and violent trauma-related events (Atwoli et al., 2013; Kaminer et al., 2008). The distinctive criminal and violent nature of a substantial proportion of life traumas faced by South Africans have serious implications for both victims and therapists who provide trauma intervention (Bhagel, 2010; Collins, 2013, Lerias & Byrne, 2003; Shaw, 1997, Shaw & Gastrow, 2001; Trippany et al., 2004). Therapists are potentially at high risk of vicarious traumatisation and psychological distress that may be aggravated by a range of risk factors (Cohen & Collens, 2013; Finkelstein et al., 2015; Howlett & Collins, 2014; Newell & MacNeil, 2010; Pearlman & Mac Ian, 1995; Salston & Figley, 2003), some of which are clearly present for therapists working with victims of violent crime in South Africa. It thus seems useful to investigate how therapists report and reflect on how they are affected by conducting such work and also to consider what kinds of resources they draw upon to protect against or ameliorate negative impacts.

Chapter 3: Research Design and Method

This chapter presents the research design of this study indicating how the research question was explored. The sampling process is outlined, and participant profiles are presented to describe the population on which the study findings are based. Thereafter, the method of data collection and data analysis is discussed. This chapter concludes with sections on research quality and ethics as they pertained to this particular study.

3.1. Research Question and Design

As informed by the rationale, this study was conducted within an exploratory, qualitative paradigm. The study focused on exploring and further understanding the subjective experiences of vicarious traumatisation among therapists in relation to working with victims of violent crime, and as such, the central research question was:

"How do therapists describe, make sense of, and deal with their experiences of vicarious traumatisation when working with victims of violent crime in contemporary South Africa?"

The methodological aim was centred on capturing the therapists' point of view and experiential accounts. The therapists were considered experts in appreciating their own experiences and the role of the researcher was to listen to their stories, understand them, and describe their experiences (Heppner et al., 2004).

Heppner et al. (2004, p. 136) used an analogy that likens qualitative research to meditation. That is, qualitative research involves a focused observation, but "what you see depends on how you look" (Heppner et al., 2004, p. 136). Within a qualitative paradigm, researchers view data through a naturalistic lens that is respectful of the subjective reports of participants. In this kind of qualitative research, it is important to ensure that data is not reduced to items, numbers, or objective absolutes, but rather to focus on the quality and texture of subjective experiences (Heppner et al., 2004; Willig, 2008).

Heppner et al. (2004) further equate the researcher to a traveller who is exploring a known phenomenon (vicarious traumatisation) within a new environment, in this instance in relation to working with crime-related trauma in South Africa. In essence, the role of the researcher in this study was to witness and understand how participants manage, make sense of and attribute meaning (Heppner et al., 2004; Willig, 2008) to their experiences of vicarious traumatisation within the context of working with victims of violent crime/s in South Africa.

For the purposes of this study, the research design was largely exploratory and descriptive. However, to contextualise the findings within existing literature and reflect the researcher's understanding, there is a level of explanation involved (Henning et al., 2004), as further discussed in section 3.4 below.

3.2. Sampling and Selection of Participants

Exploring vicarious traumatisation within a qualitative paradigm entailed acquiring rich descriptions of specific aspects pertaining to participants' experiences. Achieving this level of insight into subjective experiences required careful data collection and a thorough analysis of the data corpus. A small sample size of seven participants was considered suitable for generating credible findings given that the focus was on quality, rather than quantity (Heppner et al., 2004; Willig, 2008). A purposive sampling approach was used to identify the target population for this study, that is, therapists who conduct trauma intervention with crime victims. To be eligible to participate, therapists needed to meet all of the following inclusion criteria, which were formulated to suit the scope of this study:

i. Be a mental health professional or counsellor currently working therapeutically with crime-related trauma cases.
ii. Have at least two years of experience working with crime-related trauma cases.
iii. Be comfortable being interviewed in English.

A non-probability, snowball sampling procedure was used to recruit participants. According to Noy (2008, p. 330), "snowball sampling is arguably the most widely employed method of sampling in qualitative research in various disciplines across the social sciences". This process involved first accessing potential participants through known informants or through public directories in which practitioners advertised themselves as experts in therapeutic trauma intervention. The idea was that the first round of potential participants would perhaps provide access to other potential participants. Both my supervisor and I have access to a network of therapists, through which the recruitment process was initiated, as outlined in section 3.3 below. Table 1 below displays profiles for each participant based on relevant demographic information and is aimed at contextualising the data by giving the reader an indication of the lens through which the data was procured. Information on the participants' religious affiliations (in the original demographic section of the interview schedule) was excluded as it had no clear impact on the findings of this study.

Table 1
Participant Profiles

	Age	Race	Gender	Profession	Experience[4]	Specialisation	Cases[5]	Support
P1	60	W[6]	F[7]	Counselling Psychologist	30	Trauma, depression, anxiety	1 - 10	Colleagues; support group
P2	44	W	F	Social Worker	23	Trauma, grief	5 - 9	Professional supervision
P3	40	W	F	Clinical Psychologist	15	General psychopathology	Min. 1	Profession and peer supervision
P4	52	W	F	Counselling Psychologist	6	Attachment, trauma	10 - 12	Clinical psychologist
P5	56	W	F	Registered Counsellor	8	Trauma	5 - 10	Supervision and mentorship
P6	29	B[8]	F	Clinical Psychologist	4	Depression and anxiety	1-2	Formal and informal supervision
P7	74	W	F	Lay Counsellor	10	Victim support	4	yes

3.3. Data Collection

The data corpus was collected using semi-structured interviews, shaped by an interview protocol consisting of open-ended questions (see Appendix D). This method of data collection allowed the participants a relatively open platform to tell their stories in detail and to make sense of their experiences. An interview agenda was used to flexibly guide the line of questioning, but not to over-influence the answers given. Using an open-ended structure ensured that researcher bias was kept at bay and helped in maintaining coherence throughout the interview. The only direction given was to initially contextualise the interview within the context of the study. However, at all times, emphasis was placed on procuring an in-depth subjective account of their reality from the participants (Willig, 2008).

[4] Experience in years.
[5] Crime-related trauma cases per week on average.
[6] W = white
[7] F = female
[8] B = black

3.3.1. Procedure

Potential participants were identified in the following ways: (1) through a known network of therapists who work with trauma-related cases, (2) through public directories of therapists who list trauma work as one of their specialisations, (3) and by distributing the participant information sheet to secondary networks through known colleagues. Four potential participants initiated contact after being informed of my study and an estimated 15 potential participants were identified and then contacted via an email, which read as follows:

> Dear [title] [surname]
>
> As part of my training for my MA in Clinical Psychology degree, at the University of the Witwatersrand, I am conducting a qualitative research study under the supervision of Professor Gillian Eagle. I am in search of therapists who work with crime-related trauma cases to participate in my study and am aware that this is a treatment area in which you specialise as a therapist. If you are interested in and potentially willing to take part, I have attached a participant information sheet which provides further details about what participation in the study would entail.
>
> Thank you for giving this message your time and consideration.

The participant information sheet (see Appendix A) detailed the purpose and procedures of this study, as well as the rights and responsibilities of the participants. It further directed those who were willing to participate to the attached informed consent form (see Appendix B), which needed to be signed and returned before further contact. The informed consent form also included a short demographic-related questionnaire (see Appendix C). The answers to these questions were not treated as data but assisted in creating the participant profiles presented above. Upon receipt of the signed informed consent form, the participants were contacted via email again to arrange an interview at a suitable time.

Based on restrictions related to the COVID-19 pandemic, interviews were mainly held online via a password-protected Zoom meeting room. Participants were required to consent to be both audio and video recorded for the duration of the interview as Zoom does not make provisions for audio-only recordings. However, only the audio files were kept after the interview and the video files were permanently deleted. Two of the participants preferred being interviewed in person at a place of their choosing. Extreme care was taken in these instances to meet protocols in terms of protection against the COVID-19 pandemic which was a concern at the time of conducting the research. Interviews ranged between 30 – 60 minutes across the

participant group and it was not necessary to contact any participant for a follow-up discussion as there was sufficient clarity on issues from the initial interviews.

3.4. Data Analysis

The guidelines for thematic analysis, as outlined by Braun and Clark (2006), informed the data analysis processes of this study. Customarily, thematic analyses are seen as a foundational method upon which other, more complex qualitative analysis methods can be built. However, Braun and Clark (2006) advocate for thematic analysis as a useful, primary method of analysis. Thematic analysis is a flexible method for "identifying, analysing, and reporting themes within data" (Braun & Clark, 2006, p. 6) and is suited to a rich and detailed data corpus, in that it seeks to do justice to the complexity of the data. Furthermore, a thematic analysis does not necessarily need to be grounded within any theoretical framework, but rather has its own range of assumptions which are made transparent at the onset of the research process (Braun & Clarke, 2006). The assumptions underlying the analysis process of this study are outlined below.

For purposes of this study, what constitutes a theme was determined based on its importance in relation to the research question, and not primarily on its prevalence across the data corpus. The prevalence of themes was only considered once the entire data corpus had been thoroughly analysed and a detailed account of each theme within the data corpus had been laid out (Braun & Clarke, 2006).

Themes were identified primarily through a data-driven, inductive approach. This approach prioritised the data itself and the participants' voices, thus ensuring that the data was analysed without the researcher fitting the material into any personal or theoretical preconceptions. However, once the data corpus had been thoroughly analysed for themes, a theoretical approach was employed in order to situate the findings within the context of existing literature (Braun & Clarke, 2006).

In terms of epistemology, the thematic analysis was conducted within a realist paradigm. The assumption here is that the language used by the participants is sufficient to theorise meaning, as experiences and its meanings are inherent to a person. As such, themes were identified at a semantic level and not by examining underlying assumptions that might have informed the semantic data (Braun & Clarke, 2006).

Guided by these assumptions, a thematic analysis essentially begins by looking for patterns of meaning and ends with an analytic narrative. The researcher continually moved between these two points when conducting the analysis. The following recursive steps by Braun and Clark (2006) were followed:

3.4.1. Familiarising yourself with your data

The objective here was to fully immerse myself in the data in order to become familiar with the depth and breadth of the participants' experiences. After transcribing the interviews verbatim the transcripts were read and reread in search of meanings and patterns. Throughout this process, it was important to make analytic notes that would assist the analysis process but still allow for a flexible, data-driven analysis.

3.4.2. Generating initial codes

Generating the initial codes entailed formulating an initial, flexible list of interesting features found in the data. The program ATLAS.ti was used to assign initial codes to sections of text in the transcripts. Here, each transcript was read and analysed independently from the other transcripts and material was either sorted into existing codes generated from prior transcripts or new codes were generated when interesting new themes emerged in each transcript. As seen in Table 2 below, this stage of coding generated a fairly exhaustive list of codes that did not seek to reduce or thematise the content, but rather organise the material into meaningful groups. Table 2 further indicates the frequency of sections of data pertaining to each code across the seven transcripts. The names given to codes at this stage were aimed at organising and keeping track of the different 'sets' of material and were refined at later stages of the analysis.

Table 2
Initial data codes

	P1	P2	P3	P4	P5	P6	P7	Totals
Advice	0	1	3	2	3	3	2	14
Awareness/Hypervigilance	2	2	0	0	0	3	0	7
Context	3	8	1	9	8	5	1	35
Coping	8	18	4	7	7	6	4	54
Early responses	2	0	0	0	0	0	0	2
Experience	0	0	3	0	0	0	0	3
Impact	0	6	0	3	7	10	6	32
Motivation for trauma work	1	1	2	3	4	4	2	17
Other[9]	0	0	1	0	0	0	0	1
Personal trauma/crime	1	0	2	1	1	4	1	10
Reactions	0	2	3	0	1	1	1	8
Stop working	1	3	3	1	1	2	0	11
Support	1	2	2	2	2	3	0	12
Technique	4	3	2	5	1	5	0	20
Triggers	3	3	1	5	0	1	0	13
World view	2	2	2	0	2	1	2	11
Totals	28	51	29	38	37	48	19	250

3.4.3. Searching for themes

This phase focused on analysing the initial codes displayed in Table 2 and establishing how certain codes might relate to each other. This process led to the formation of potential superordinate and subordinate themes. For example, *coping* was the code under which most pieces of text were categorised and seemed suitable as a superordinate theme as the quotes grouped here pertained to various ways of coping that were then considered subordinate themes. At this point, I consulted with my supervisor who had also read the transcripts and had made initial notes on key themes. I presented the initial ATLAS.ti findings and we agreed on key observations concerning the codes that seemed to represent the data.

[9] 'Other' refers to interesting statements found in the data that did not seem significant for further analysis.

3.4.4. Reviewing themes

The objective in this fourth stage of the analytic process was to refine the themes to ensure that they were distinctive and that the data within each theme formed a coherent pattern. To achieve this, it was necessary to check the themes, first, in relation to the initial codes, and then in relation to the entire data set. For example, during the coding stage, it seemed that *early responses*, i.e., responses to trauma in the earlier stages of one's career, would have been a distinctive theme in comparison to impact at a later stage of one's career. However, in relation to the entire data set, it was more appropriate to group the various ways that participants found themselves impacted across their careers together under one theme, given that there was insufficient material to generate a full meaningful theme on *early responses*. My supervisor again assisted with the refinement of themes at this point in the analysis.

3.4.5. Defining and naming themes

When defining themes, it was important to provide a clear analysis of what each theme was designed to capture. It was just as important to capture the distinctiveness of each theme in relation to other themes, as well as the relation of themes to the research question. At this phase, themes were grouped and named to form superordinate and subordinate themes. As seen in Chapter 4, the superordinate themes are distinctive in the sense that each captures a key aspect of working with trauma and victims of violent crime. Together, the superordinate themes describe an overall experience of vicarious trauma for therapists and how the participants of this study reported that they manage the effects they observed or were aware of.

3.4.6. Producing the report

The report, which is largely articulated in the findings and discussion section of the full research report presented in Chapter 4, consists of an analytic narrative of the themes which was aimed at: (1) illustrating the story told by the data, and (2) arguing this story in relation to the research question and existing literature in keeping with the Braun and Clarke method. The report also includes data extracts as evidence for each theme. Certain extracts were condensed for length and to emphasise relevant data in relation to a particular theme. This is indicated by "[…]" in Chapter 4 and does not change the meaning of what participants have said.

3.5. Ensuring Research Quality

Given the subjective and interpretive nature of qualitative studies, quantitative criteria such as reliability, representativeness, validity, generalizability, and objectivity are not necessarily

applicable measures of what constitutes good research. Several authors have presented guidelines for ensuring good practice within a qualitative paradigm, which accommodates the inherent complexities of such studies (Elliot et al., 1999; Henwood & Pidgeon, 1992; Willig, 2008; Yardley, 2000). Several of these guidelines were followed in this study, as outlined below.

3.5.1. Rigour

Rigour relates to the thoroughness of the data collection and analysis processes. This depends both on the suitability of the sample and the researcher's commitment to the data. Theoretical sampling was employed such that the chosen sample could contribute meaningfully to the phenomenon of interest. In terms of analysis, it was necessary to engage in negative case analysis too in order to explore themes that might generate new insights into existing theory (Henwood & Pidgeon, 1992; Yardley, 2000). Thus, in conducting the study I had to remain mindful of both confirming and disconfirming inputs across interviews. As described previously, my supervisor also co-analysed the data as well as provided feedback on the report, thus, assisting with possible researcher bias.

3.5.2. Coherence

To construct a meaningful narrative, there must be clarity and reasoning throughout. This was ensured through a good fit: (1) between the research question, literature, and research method, (2) between the themes and the data categorised within each theme, and (3) in the integration of theory into the findings. This was further made explicit through detailed accounts on each process in this study (Elliot et al., 1999; Henwood & Pidgeon, 1992; Yardley, 2000).

3.5.3. Transparency

Transparency involves full disclosure of all relevant aspects of the research process that shaped the outcome of the study, and this was prioritised throughout the entire research report. It further involves a comprehensive account of the strengths and limitations of the study, which in this instance is presented in Chapter 5. Related to limitations is the issue of transferability. It was further necessary to disclose the extent to which the findings might be generalisable beyond the context of this study (Henwood & Pidgeon, 1992; Yardley, 2000).

3.5.4. Sensitivity

It is important to consider and remain aware of the various contexts that shape the research process. In terms of the theoretical context, it was important to integrate related and empirical literature that meaningfully contributed to the study. In relation to the context of the participants and the context of the researcher, it was important to be sensitive to the socio-cultural perspectives that each person may hold, and how this might shape interactions. It was also necessary to situate participants to some degree within their life contexts as this provided insight into the relevance and applicability of the findings. The description of the participant group provided earlier was intended to provide some context for the study findings and some further contextual observation is provided in the findings and discussion chapter. Throughout the research process, it is useful to be mindful of participants' possible reactions towards the interpretations made within the study, as well as the reader's resonance with the study findings (Elliot et al., 1999; Henwood & Pidgeon, 1992; Yardley, 2000) and to this end an attempt was made to write the material up in a respectful manner.

3.5.5. Reflexivity

Reflexivity is an introspective process in which the researcher acknowledges and documents how their involvement in the study may have informed the research process. It includes personal reflexivity and critical language awareness. Personal reflexivity refers to the ways in which the researcher's experiences and beliefs may have influenced the study, and in turn, how the research process may have influenced the researcher. In this instance, I am alerted to the fact that my identity as a trainee therapist may have been salient in conducting the interviews and that, for example, experienced therapists may have felt somewhat compromised in acknowledging any struggles in their work. My identity as a young Indian woman also seems important to consider as influencing the data collection and analysis processes. Limiting researcher bias was crucial to the research process, but the interpretations of the data cannot be completely separated from the analysis process. For one participant, my identity as a young Indian woman was of particular interest and seemed to influence our interaction. Critical language awareness addresses the notion that the language (or words) that the researcher uses during the research process impacts how others will ascribe meaning to these words (Elliot et al., 1999; Henwood & Pidgeon, 1992; Willig, 2008; Yardley, 2000).

3.5.6. Impact

Conducting quality research is to a large extent only as important as the impact and importance of a study. As such, it is necessary to have a clear and significant rationale for conducting research (Yardley, 2000). The rationale for this study is presented in Chapter 1.

3.6. Ethical Considerations

Throughout the study, the primary objectives were to do no harm to any of the participants and to report on the research process and findings accurately and transparently. To maintain these objectives, several guidelines were adhered to, as outlined by the APA Ethical Principles of Psychologists and Code of Conduct (2017) and the HPCSA's General Ethical Guidelines for Health Researchers (2016). This study also adhered to the rules and regulations prescribed by the Human Research Ethics Committee (Non-Medical) at the University of the Witwatersrand.

The first step involved acquiring ethics clearance (Protocol number: MCLIN/20/02; see Appendix E) from the Human Research Ethics Committee (Non-Medical) (APA, Section 8.01; HPCSA, Section 10.1.1). Thereafter, potential participants were approached with a participant information sheet and an informed consent form, which detailed the purpose and procedures of the research study, as well as informed participants of their responsibilities and rights throughout the study (see Appendices A and B). If a person met the inclusion criteria and chose to participate, they were first asked to read, understand, and sign an informed consent form (APA, Section 8.02; HPCSA, Section 4.1.2).

3.6.1. The research process

The research title and aims were provided to the participants and they were informed of the data collection processes, and the intended use and distribution of the collected data (APA, Section 8.02; HPCSA, Section 4.1.3 & 6.3.1).

3.6.2. Requirements for participation

The inclusion criteria were formulated to seek out participants who could contribute meaningfully to this study and did not pose any forms of unfair discrimination towards any groups of people (APA, Section 3.01; HPCSA, Sections 4.1.3 & 6.5.2). Participants who willingly chose to participate were required to provide both verbal and written consent. The data collection process involved the completion of a short, biographical questionnaire and a face-to-face or online interview. Participants were required to provide verbal and written consent to being audio and/or video recorded for the duration of the interview only. Although

the participants consented to further communication after the data had been collected, it was not necessary to contact any of the participants for further interview information (APA, Sections 4.03, 8.02 & 8.03; HPCSA, Sections 4.1.2 & 6.3.13).

3.6.3. Privacy and confidentiality

Awareness of privacy and confidentiality remained integral throughout the entire research process. Participants did not remain anonymous from the researcher. However, from the first point of contact, all participants were assigned a number, which moving forward, has been used in all representations of the participants and the data collected. Any identifying or confidential information that arose during the data collection process has been retracted from this study. Furthermore, participants were not required to refer to specific clients or cases, but in instances where they did so by way of illustration, all privacy and confidentiality practices were understood to apply here as well. (APA, Section 4.01; HPCSA, Sections 4.1.2 & 6.4).

3.6.4. Risks and benefits of participation

There were no incentives provided for participation, nor did the researcher guarantee any personal benefits to the participants. The research findings are, however, aimed at contributing to the larger body of knowledge on vicarious traumatisation in therapists, especially with regard to working with crime victims in South Africa. With regard to risk factors, this study was a low-risk study as it required participation from a non-vulnerable population. It further involved no forms of deception or intended harm. It is acknowledged that asking participants to speak of their personal experiences of the impact of working with victims of violent crime in their therapy practice had the potential to induce heightened awareness of their experience(s). By signing the informed consent form, participants were understood to have attested that as mental health professionals they were aware of potential personal triggers and that they had access to the necessary resources for debriefing (APA, Sections 3.04, 8.06 & 8.07; HPCSA. Section 4.1.1). As a precaution, the interview was carefully monitored as it proceeded for potential risks of distress, however, none of the participants appeared or expressed feeling distressed during the interview. As is common practice, the participants further reported having access to existing supports in the form of peer or expert supervision or personal psychotherapy.

3.6.5. Rights of the participant

All participants had the right to choose whether to participate in this research study. Participants further had the right to decline participation, or even withdraw at any phase of this study prior

to the examination, without facing any consequences. Although participants were approached through existing professional networks in some instances it was emphasised that agreement to participate was dependent upon their time and their inclinations to do so. Contact details of the researcher, the research supervisor, and the University of the Witwatersrand were provided in case any queries were necessary. On completion of the study, all participants will have the right to access the written findings in the form of the research report which will be accessible through the Wits library portal (APA, Sections 8.02 & 8.08; HPCSA, Sections 6.3.10 – 6.3.11).

3.6.6. Responsibilities of the researcher

There were two major ethical responsibilities to be continuously upheld by the researcher: the responsibility towards the participants of this study, and the responsibility towards the research process. With constant support and guidance from my supervisor, I ensured that I was appropriately informed on all the processes involved in my study, that I conducted my research in a professional, transparent and ethical manner. Due to the somewhat sensitive nature of my topic, I debriefed with my supervisor when necessary – while maintaining the privacy and confidentiality of my participants. For example, one participant seemed to be seeking an ongoing connection and also shared some overly personal information not related to the study, despite attempts to refocus her. I discussed my feelings about the difficulty of containing this participant with my supervisor and managed to end the contact in a cordial manner. At all times, participants were treated with respect and dignity, and all contributions made by participants are held in the same regard. The data corpus and representations thereof will always be stored securely on a password-protected electronic device, to which only I will have access. Furthermore, I declare that there are no current or foreseeable potential conflicts of interest entailed in my conducting this study (APA, Sections 3.06, 6.02 & 8.10-8.12; HPCSA, Sections 6.1, 6.2, 6.7 & 13).

Chapter 4: Findings and Discussion

This chapter includes the findings yielded from the seven interviews and a discussion hereof. The findings are presented as structured according to superordinate and subordinate themes. Each theme is discussed in a narrative format using verbatim excerpts from the interviews to illustrate arguments and amplify the participants' voices. The analysis includes a discussion of observations from the researcher's perspective which provides a deeper interpretation of the themes. Within this narrative discussion, the findings are further situated within the context of existing literature which provides a comparative analysis of the findings in relation to other documented findings on aspects of vicarious traumatisation.

The following three superordinate themes were identified as salient across all interviews: *Impact of Trauma Work*, *Coping within the Context of Conducting Trauma Therapy*, and *Contextual Considerations related to Trauma Work*. These themes are intentionally broad but capture the key considerations when working with both victims of violent crime and other trauma-related clients and the prominent material that was identified in the interviews. The overarching themes to some extent reflect the discussion in the key areas of focus identified within the interview schedule. By virtue of providing trauma-related therapy, therapists are susceptible to being impacted by the work and need to develop coping strategies in order to facilitate their own health and professional capability, and as South African therapists, this work cannot be done without inclusion and consideration of context.

Each superordinate theme expands into subordinate themes, which provide a more nuanced unpacking of the complexity of each theme in relation to the participants' subjective experiences. The subordinate themes are introduced at the beginning of the discussion of each of the three main themes.

4.1. Impact of Trauma Work

The nature of trauma work and working with victims of violent crime is such that therapists are inevitably impacted by the work. While the nature and severity of impact may present differently for each therapist, both existing research and the findings of this study emphasise trauma work as an immersive and challenging experience. To elaborate on how therapists in this study reflected on this experience the following subthemes are presented and discussed: *Emotional effects of vicarious exposure*, *Heightened awareness of crime and related intentional responses*, *Subjective triggers,* and *Impact on worldview*. P6 gave an account of her

experience with trauma work that aptly and eloquently encapsulates the theme of impact and its interrelated subthemes:

> But as a therapist, your experience to trauma is more than that. It's the burglary of the one client and then the next client that was hijacked, and then the next client that was raped, and then the next client, right? So, it's like you actually have, like, all of these different exposures from different people and their experiences and it makes your world feel unsafe. Like that bubble of naivety that you live under of, "oh these things don't happen". You're suddenly so much aware of it because you have real people every day coming into your therapy room and telling you how real they are, uhm, and how much they happen to them. So, you kind of feel – to some extent – that you actually carry more because of the different clients that you work with that have experienced different kinds of traumas.

4.1.1. Emotional effects of vicarious exposure

In general, the therapy process requires a level of empathic engagement with clients' experiences, and when working with traumatic material in particular therapists are at risk of being vicariously traumatised and experiencing secondary traumatic stress symptoms (Salston & Figley, 2003). Five participants described the emotional effects that they experienced through exposure to their clients' traumas.

Comparative to other kinds of therapy cases, P2 found trauma cases to have a greater emotional impact:

> P2: So, always, feelings are very intensely felt, and the experience is very intensely felt. So, in some - in some cases it feels very comfortable, and I can hold it and it's fine. But sometimes certain spaces and cases – I feel quite heavy afterwards.

Reflecting on her earlier experiences as a therapist, P2 also recalled a time when she became emotionally detached both personally and professionally, which according to literature are known indicators of vicarious traumatisation (Sui & Padmanabhanunni, 2016; Trippany et al., 2004):

> P2: […] but I noticed I was disconnecting from my client, but I was also disconnecting from myself […] then I need to do something about my humanness, which is concerning for me.

P2 emphasised her concerns about feeling disconnected, and when juxtaposed with the increased emotional arousal that was also reported by participants (as illustrated in quotes below), her observation about her own state of being emphasises the careful balance required of therapists to facilitate a genuine empathic connection with their clients and simultaneously

manage their own emotional responses. The quotes further illustrate how each participant is uniquely impacted through interactions with different types of trauma-related cases.

P4, who is also a mother, described her painful experience when treating a child crime victim and the need to manage her level of affective involvement and professional responsibility to this child:

> P4: Uhm, I had one little boy who, I remember, that it - and it – it - it had an effect on me – because as I speak about it, I feel a visceral response to it – he literally dove onto me and he just started sobbing. And I remember my shirt was wet […] that really breaks your heart […] you do have to realise that you - you can't take them all home […] and you are doing the best that you can.

P5 also reflected on an experience with a young victim and here one sees how she needed to manage an instinctive reaction towards the violent rape of a teenager while trying to maintain a sense of neutrality that is often expected of therapists:

> P5: I'm thinking of a very specific, very violent rape case, where this girl shared with me […] She wrote me a letter about what happened to her. As a child – as a young, uhm, pre - prepubescent teenager […] And I remember I was just keeping - trying to keep my face neutral, but it was virtually impossible because what was written down there was just so horrific.

It was evident that the nature of the event described left the therapist emotionally disturbed as indicated by her reference to the account being 'just so horrific'.

For both P6 and P7, the emotional impact involved developing a sense of fear:

> P6: I've never been hijacked before, you know? But they were talking about it, which kind of really made me feel quite scared. Uhm, and they talking about how they found that even when a, you know, a person comes to their window to ask for something, or beg or whatever, it kind of makes them feel so startled because they're like, "is it someone coming to hijack me?" […] Because I started being very conscious of people coming to my window. For like a good two to three weeks, uhm, where I was just like, "I'm literally feeling this - this secondary trauma".

> P7: I'm not scared to stay here. I mean I've got beams and that. I'm not scared of that. But I'm scared where it becomes with my loved ones.

For P6, fear was related to her own sense of safety and led her to mirror some of her client's symptoms, such as feeling anxious when people approached her in her vehicle. Research has shown that through identification with certain cases, therapists tend to internalise their clients' experiences and may display similar symptoms as a consequence (Howlett & Collins, 2014). P7 seemed to feel safe in her own space, although this is qualified by her reference to having

security beams, but she was aware of feeling fear directed to her loved ones. It is possible that P6 was able to process and to some extent resolve her responses by recognising them as a form of secondary traumatisation, whereas in the case of P7 it is possible that she has displaced some of her anxiety into being concerned about the safety of those she cares about.

All the participants were aware of the aims of the study and seemed to be relatively well informed about the possible impact of working with crime-related trauma cases. Nevertheless, they were able to identify both specific cases that had affected them emotionally and to recognise that hearing many accounts could have a cumulative effect, as illustrated in the opening quotation. As might be anticipated, typical affective responses were those of heaviness, horror, anxiety, and fear. It was also evident that therapists worked quite hard to regulate moving between over-identification and strong empathy versus relating in a more detached and 'neutral' manner. This seems to highlight an interesting issue of whether being distant or emotionally attuned becomes necessary in conducting therapy with traumatised victims, and how each end of the empathy spectrum may impact on the therapist's functioning. Wilson and Lindy (1994) emphasised the importance of being emotionally attuned to trauma clients and the negative effects of empathic strain both for the client and the therapist. However, they also highlight the unique trauma-specific transference that occurs in the therapeutic dynamic, which is a prominent cause of empathic strain. Although sustained empathy is pivotal in helping clients work through their trauma, empathic strain and negative countertransference reactions are expected outcomes due to the nature of trauma work. The participants of this study seem to have experienced either Type I CTRs (avoidance) or Type II CTRs (overidentification), and further describe both objective and subjective reactions in response to their clients' traumatic material. In the context of Wilson and Lindy's (1994) framework, one can see how it may have been necessary for some participants to withdraw from their clients and how easy it is to potentially become enmeshed with their clients' experiences. This further highlights the challenging nature of trauma work, and the inevitable emotional impact on therapists. Perhaps of significance for effective therapeutic practice is not *if* and *how* therapists experience empathic strain or negative countertransference, but rather the extent to which they become aware of and work through this.

4.1.2. Heightened awareness of crime and related intentional responses

The participants' experiences of heightened awareness can also be considered an emotional impact given the aspects of fear and feeling unsafe that are illustrated in the quotes below.

However, it is significant to present this as its own category of impact as it highlights how interacting with clients' traumatic experiences tends to affect how therapists then interact with their own environments. It is worth noting that as South African therapists, participants were well aware of context-related crime risks, and this awareness, together with frequent exposure to primary victims, seemed to produce a heightened consciousness about the safety of their environment. It was also evident how participants engaged in intentional behaviours to combat their sense of fear and make their spaces and interactions feel safer.

For both P1 and P2, their added caution involves a constant awareness of situational risks and unsafe spaces. P1 tends to engage in routine behaviours to increase her sense of safety and P2 highlights the unpredictable nature of South African spaces and the need to accommodate to living with uncertainty:

> P1: Uhm … and if it's dark when I'm coming home, I'll be careful at traffic lights. If I end up at a traffic light with no traffic, I will go through it. I will not stop there for hours and wait for it to change. I will always be aware if there's a car behind me that is sticking a bit too close behind me – that sort of thing. And I will go round the block and check if they are - they've disappeared or whether they are going to continue following me.

> P2: But I am aware that certain spaces or certain areas, uhm, I am more heightened […] It isn't just an awareness. Uhm … I think generally in South Africa 'coz we live in a space of continuous trauma […] is that we don't know when things happen.

Given the context of crime in South Africa, it seems appropriate that participants would generalise about the lack of safety associated with certain spaces and events. However, for P2 it felt important to challenge these generalisations when they involved people and specific population groups:

> P2: […] knowing how trauma generalises so much. So, me for, also having – well, especially working in South Africa that when so many perpetrators are black men – for me, having friends and people I know who are black men […] especially with gender-based violence – noticed my reaction being very-suddenly becoming very anti-men […] So, very consciously also making sure that I can connect it with good men *(laughs)* to help kind of keep that perspective that not all men are bad.

P2's laughter at this point may also suggest an unconscious need to lighten the tension and discomfort that often accompanies one's awareness of responses to trauma.

For P3, her contextual awareness was extended to other, relatively safer spaces in which she interacted, and one is alerted to how her responses are less heightened in environments which she feels are lacking danger when compared to her usual environments:

> P3: And it just feels completely different to any other lived experience, you know. We're not looking over our shoulders, uh, it's - the kids are able to freely play, we're not worried about them being snatched or, you know, dodgy looking characters loitering around.

Despite her reference to feeling safer in some contexts, P3's reference to snatching of children and 'dodgy characters' suggests that she is aware of risk, even when this is related to the absence of a sense of risk.

P6 highlights her relative desensitisation to the crime context in South Africa and how, through her work with victims of crime, she is alerted to specific risks that increase her vigilance and her precautionary behaviours:

> P6: And they were getting robbed and they were taking their phones and wallets and all of that. And that was right in front of me. That also kind of like, felt like, "oh no, this is not safe". But my vigilance and, or hypervigilance rather came from that particular experience. Because I think on a normal day, I probably wouldn't have even noticed that.

> P6: […] from another client – I found that I was actually making sure "is the door locked?", uhm, you know? And coming into the house, checking, you know, is - is this - are the windows locked?

Similar to P6, P7 illustrates both the need for precaution and the tendency to counter the sense of potential threat with safety precautions – once again pointing to a sense that crime in South Africa is both unpredictable and continuous:

> P7: No, I'm very cautious. I had a break-in here […] and then I put beams around.

Although it is the case that many South Africans are attuned to risk and alert to danger in a range of contexts it was evident that for these psychotherapists a degree of heightened attunement to potential threat stemmed from their work experience and exposure to their clients' accounts of crime-related trauma exposure. They were aware that their vigilance made them sensitive to particular cues (such as whether they were being followed or whether people were displaying stealable possessions in public) and shaped the lens through which they interpreted the world. In many instances they found themselves adopting behaviours to minimise their sense of potential harm. In these respects, their behaviour tended to mimic that

of people who had been directly victimised or indirectly exposed as one might be through harm coming to a colleague or family member. However, indirect exposure in this instance arose through professional contact.

Considering the heightened awareness of personal vulnerability, security-enhancing behaviours, and feelings of protectiveness over loved ones indicated in the extracts above, it seems plausible to infer that participants may have experienced shifts in their safety schemas (McCann & Pearlman, 1990). Within the context of prevalent crime-related trauma in South Africa, participants seem to generally have lowered expectations about safety and one would assume that their vicarious exposures may be congruent with their pre-existing assumptions about safety. However, the findings of this study highlight that even with a general awareness of spaces being unsafe, trauma work involves an added degree of exposure that cannot be avoided. As such, by virtue of delivering trauma intervention, therapists' need for a sense of safety and security is constantly impacted on and threatened, and they tend to have a heightened vulnerability to schema disruptions.

4.1.3. Subjective triggers

When exploring vicarious traumatisation, it is expected that therapists will be exposed to specific triggers within their clients' traumatic experiences that will elicit particular kinds of reactions. This is, firstly, due to the threatening and triggering nature of trauma, and secondly, because therapists are likely to experience a personal resonance with traumatic content based on their own life experiences. The participants of this study are experienced in providing trauma intervention and interacting with traumatic material and are predominantly able to tolerate their vicarious exposures to trauma. Although this is to be expected as a certain level of tolerance is required to provide trauma intervention professionally and adequately, the quotes below illustrate that even trained professionals are susceptible to the impact of certain cases.

Overall, of the seven participants, P1 seemed to be impacted the least by vicarious exposure, but still reported that she finds herself reacting to clients who have visible injuries. Research has shown that human-inflicted trauma tends to produce greater traumatic stress-related conditions (Sadock et al., 2015), and in terms of vicarious traumatisation, it may be that visible injuries reinforce awareness of a human attacker and intentionality behind the infliction of harm.

> P1: Especially if there're visible injuries – because they visible. Uhm … and it's always nasty. It's not fun. You got a reaction to that.

Although P1 minimises her account, by using the phrase 'it's not fun' it is evident that she finds it hard to be in a room with someone with physical injuries. For P2, the trigger was related to rape victims, which once again highlights the severity of human-inflicted trauma. P2 reflects on the personal violation involved, and for a female therapist living within a context of gender-based violence, it appeared that she was greatly impacted through empathising with her clients' experiences:

> P2: […] working with rape victims is a big thing for me. And then I kind of – it took me a while – but then recognising that was one of my greatest fears […] Like, that still would for me be one of the worst - worst things. Just in terms of the violation and personal violation around it.

Several studies have shown that an experience of personal trauma serves as a risk factor for therapists who are exposed to and empathically engage with traumatic material (Cohen & Collens, 2013; Finkelstein et al., 2015; Howlett & Collins, 2014; Newell & MacNeil, 2010; Pearlman & Mac Ian, 1995; Salston & Figley, 2003). Studies have also reported on identification with a client's traumatic experience as posing increased risk for vicarious traumatisation as might be expected (Salston & Figley, 2003; Sui & Padmanabhanunni, 2016). It is hypothesised that a considerable psychic risk is posed when these two factors intersect. Wilson and Lindy (1994) outline some of the empathic strain-related disturbances that therapists may face when they experience a combination of Type II countertransference reactions (i.e. overidentification) and subjective reactions (in this instance personal trauma), emphasising the increased risk for empathic enmeshment with clients. In four instances during the interviews participants made reference to having been victims of crime themselves, three of which were violent crimes. Interviewees brought up this information spontaneously but it was apparent that their own experiences came to mind in reflecting on how their work with clients had affected them.

Reflecting on cases that could potentially re/traumatise her, P3 described being able to identify with certain clients based on her own previous experiences:

> P3: […] there are times when I can very much identify with what clients are bringing. Uhm, and it may be through having experienced something very similar on a very tangible level. They might explain how they screamed, or someone screamed, and the sound of the scream was traumatising. I can definitely relate to that.

Here P3 suggests that there was something about references to screaming that brought back recollections of her own experience and one has the impression that her imagination of what is being described is particularly vivid because it resonates with imagery or sensory perceptions in her own mind. P3 states that 'the sound of the scream was traumatising', and as the literature suggests, disruptions in imagery are often the most painful consequence of vicarious traumatisation as this is accompanied by powerful affective states that are challenging to work through (McCann & Pearlman, 1990).

For P4, it was trauma inflicted upon babies and animals that served as a trigger, which also paralleled her own experiences in some ways as her history of violent crime-related trauma involved risk to her children. Once again, the role of a human perpetrator is emphasised, and also the vulnerability and helplessness of the victims involved. P4 seems particularly affected by the levels of implied cruelty or callousness entailed in the actions she describes.

> P4: Fortunately, uhm … the only time where I find myself- where I recognise that- that- that charge is when people are speaking about, uhm, very small babies and animals. I- I've- I do battle to grasp how somebody can take a three-month-old, break their arm, burn them.

Of further significance is P4's use of the word 'fortunately', which alerts one to both the prevalence of crime-related trauma in her practice world and the expectation for therapists to develop a level of tolerance in working with this material. She suggests that she is only emotionally affected by 'extreme' cases that entail having to imagine quite sadistic acts and the harms they cause.

It is not surprising that most commonly reported triggers involved accounts of human inflicted victimisation. It is argued that firstly, due to the intentional nature of such crimes/traumas and the levels of sadism or cruelty that may be involved therapists find themselves shaken or preoccupied in trying to assimilate awareness of these kinds of events. Secondly, it is expected that therapists will experience a heightened sense of vulnerability when hearing about events that parallel occurrences to which they have been subjected as there is the possibility of the overlay of their own memories onto the clients' accounts. Literature also indicates that exposure to acts of cruelty is known to cause disruptions in one's internal foundation of trust, which for the participants, may likely have resulted in them becoming suspicious and distrustful of others. Shifts in one's trust schemas have the potential to influence views on humanity and worldview more generally (McCann & Pearlman, 1990).

4.1.4. Impact on world view

The quotes below illustrate the varying effects of trauma work on the participants' world view and how this frames aspects of their professional and personal experience. It is worth noting that participants were explicitly asked if their world view was impacted in any way based on both trauma work and context.

Both P1 and P7 seemed to have structured their beliefs in order to manage their expectations of the world as a benign or safe place, which seemed to contribute to reasonably adaptive reactions to the work content they were exposed to. For P1, this involves being cynical in relation to expectations of other human beings, whereas P7 tends to hold a more general negative outlook. Both participants suggest that their lack of naivety protects them against being easily disillusioned as a consequence of the work they do.

> P1: […] a colleague of mine will say that we've all become more cynical, which we probably have. I don't think I was ever not. Uhm … so, maybe that's exacerbated a bit – maybe. But I think I've always been tending towards the cynical side […] I think a lot of it comes down to expectations. So, my colleagues' idea of cynicism is right. That I don't expect too much of mankind.
>
> P7: You see what I feel is … to think … negative. But it's very difficult. You know, I - I'm inclined to think - think the worst is going to happen. I don't know why. It's not fear.

P7 states that her negative outlook is not related to fear but considering that she sees herself as a hopeful person, one can imagine that at some point this cynicism may have been generated out of a fear-related response, predicated on needing to recognise that people may inflict harms on other people. Perhaps in order to cope with and adapt to threatening events, P7 may have needed to restructure her outlook on life. By preparing herself for the worst she is less likely to experienced shock or disillusionment.

Likewise, P3 also seems to hold a more negative view in the sense that crime-related trauma in South Africa has become somewhat normalised for her. Her sense of hope is also implicated, and one sees how maintaining hope means considering other "safer" contexts.

> P3: So, it definitely does impact on … hope, I guess. The hope that things can be different, uhm, because I do think that there's a- a desensitisation to it being something that is inappropriate […] it does definitely impact, uhm, worldview. Uhm, not just because locally it feels like this is part of - part of an experience to be expected, but also, kind of, definitely has us considering whether there might be more viable options for raising our children, you know? Looking at other countries, potentially, it might be better options in the long term.

Although P3 indicates that she is 'desensitised' to crime-related stimuli, she is able to recognise that this constitutes a particular kind of worldview that might be protective but is not necessarily psychologically healthy. She is able to offer a meta-reflection on her own thought processes and to allow that in a different context there may be less need to resign herself to the threat of crime as commonplace.

In contrast to the three sets of reflections presented thus far, P4 indicated that she does not find her view of South Africa negatively impacted by her work and she seems to maintain a somewhat realist approach to the prevalence of crime in other spaces. Throughout the interview, P4 emphasised the need to empower oneself through awareness and action, and it seems appropriate to suggest that she strives to take control of her thinking about spaces and safety in South Africa, in part by emphasizing a global risk of crime.

> P4: We may have violent crime. So does LA, so does New York, so does London, so does Perth, and the - the fantasy land of Australia and New Zealand also actually has crime […] there's nowhere else in the world that I'd rather be […] it definitely has not given me a negative perception or view of South Africa at all.

P2 described being affected both positively and negatively in relation to her core schema. In comparison to the negative views expressed by P1 and P7, P2 refers to an increased awareness of threat in the world and the likelihood of developing the kinds of disturbing generalisations that are often produced by trauma exposure, but also mentions that her view of the world contains references to the ability to overcome adversity based on her therapeutic observations.

> P2: I think in - in both positive and negative ways […] part of positive, is recognising that even after awful experiences, people – once we've managed some of our reactions and symptoms – the power and the ability to be able to survive, I think is really powerful […], where it negatively impacts […] So, I think just sometimes, living generalisations, or sometimes, I suppose, yeah, being more anxious or aware of stuff that other people would just - would not be thinking around or touching on.

Both P5 and P6 described a more positive view that seems to be shaped by their understanding of context and the experiences of others. For P6, offering trauma therapy meant experiencing a greater appreciation of her life, which is an outcome commonly found in research on the experience of posttraumatic growth for primary trauma victims (Tedeschi & Calhoun, 1996). Although research on *vicarious* posttraumatic growth (Arnold et al., 2005) suggests responses may be somewhat different for indirect exposure, P6 seemed to describe an experience akin to direct posttraumatic growth. This raises the question of whether the awareness of being

similarly at risk as one's clients – given the context of crime in South Africa – impacts therapists' processing of secondary exposure such that they may experience both vicarious distress and vicarious transcendence in a parallel manner to their clients.

> P5: It doesn't make my worldview any negative because I am – in any way negative – because I am a positive person, and I believe that … I understand the reasons of why we have all of these problems in South Africa. It doesn't mean you condone anything that happens. You understand just why it happens. And if you have that kind of empathic view and understanding.
>
> P6: But it does change your worldview in that you - you really recognise that "wow" people are going through a lot […] Uhm, but also at the same time it gives you a little bit of an appreciative sense of your own experiences and your own life because it's like, "wow, people are actually going through a lot". And I'm grateful for the spaces that I have. I'm grateful for the worlds that I live in.

In somewhat different ways both P5 and P6 recognise that their exposure to work with crime-affected clients compels them to engage with the complexity of the South African situation and to take perspectives on their own and others' living circumstances in relative ways. For P6 this exposure leads to an increased sense of gratefulness for aspects of her life that she might otherwise take for granted.

The subjective nature of the impact of traumatic exposure is highlighted in the range of world view moderations observed and reported by the participants. On the surface, it is tempting to want to compare the kinds of world views (e.g., cynical, positive, realistic) held by the participants and discuss how a particular world view may seem more helpful. However, upon closer analysis and in the context of vicarious traumatisation, it appears that one's specific world view may not be the only significant aspect when considering how therapists may be impacted through trauma intervention. Regardless of the world view held, of significance is also the extent to which a particular world view is experienced as trustworthy and secure, i.e., the extent to which their world view is confirmed as true. It appears that having a somewhat negative outlook may be as protective as a positive outlook if it gives the participant a sense of meaningfulness and cohesion in their belief system. Research has shown that exposure to accounts of traumatic events has the potential to disrupt therapists' core beliefs about the world, specifically when traumatic information contradicts and threatens one's existing beliefs about the world. The greater the incongruence between existing beliefs and new traumatic information, the harder it becomes to integrate traumatic exposures into existing schemas, which increases the risk for vicarious traumatisation (Janoff-Bulman, 1985; Joseph & Linley, 2005). As such, if there is less incongruence, the process of integration should be easier and

subsequently decrease the risk for vicarious traumatisation. This provides some understanding as to why the participants held a range of world views, yet found themselves impacted on some idiosyncratic level. The findings of this study further emphasise the importance of being able to integrate traumatic material. Based on each participant's subjective experience it appears that the participants generally hold consistent and trustworthy beliefs about the world – or the South African context at least – and that this provides some stability for them. However, it is worth noting that the impact of traumatic exposure on a person's worldviews is generally only responsive to amelioration if there is minimal disruption to core beliefs, and even with experience, it is likely that specific cases may have the potential to cause larger disruptions. Although one can appreciate how the participants have managed their shifting worldviews, it is important not to dismiss the complex and demanding nature of trauma work in this regard and the strenuous internal work that therapists are continually required to engage in so as to integrate their clients' experiences within their own schematic frameworks. McCann and Pearlman (1990) highlight how painful it can be for therapists to have their world views disrupted, especially when this involves a loss of ideal views of the world and others. Although the participants in this study appeared to be reasonably robust in terms of their worldview positions, it is evident from some of the material cited in previous sub-sections that there had been cases that had unexpectedly challenged their belief systems and that they might encounter such cases in the future.

4.2. Coping within the Context of Conducting Trauma Therapy

As demonstrated by the theme *Impact of Trauma Work*, it is difficult for therapists to prevent some vicarious traumatisation as a consequence of exposure to crime-related therapy work. The theme of coping shows how the participants of this study were able to ameliorate the negative impacts of conducting trauma work such that they were able to cope both personally and professionally. The following subordinate themes are first discussed: *Setting boundaries, Self-care practices, Finding meaning in the work,* and *Seeking support*. Discussion of these four sub-themes is followed by a brief discussion on some other aspects of coping that were not identified as key themes during the analysis, but which are noteworthy in terms of broadening the understanding of coping for the participants and practical implications.

4.2.1. Setting boundaries

It is not unusual that therapists set boundaries within their professional capacity in relation to a number of features of their work, as in many respects this is an ethical requirement of the

profession that ensures good practice and aims to minimise harm for both client and therapist. Given the context of crime in South Africa, one can assume that maintaining boundaries in relation to the degree of involvement with clients can become challenging for therapists due to potentially sharing experiences with regards to crime exposure and the sense of living in the same 'risky' environment as their clients do. The large number of trauma victims that require trauma intervention also means that therapists need to think about the amount of crime-related trauma exposure they engage with. With this in mind, the quotes below illustrate the various ways in which the participants established boundaries and a sense of structure in order to separate themselves from their clients' experience and cope with their trauma therapy work.

P1 and P7 both emphasised the importance of cutting off from work. For P1, this has become a natural process which she attributes to her years of experience.

> P1: Uhm … but I've become very, very good at, as they leave the office to cut off from it […] I really do not remember at night what I have done in the day. I've obviously perfected that over the years.

Her account of her extensive experience and cultivated capacity to 'cut off' may also explain why she seemed less impacted by the work than several other participants. P7 highlighted her need to avoid burnout by switching off and by holding in mind what the limits of her responsibility are.

> Participant 7: Because you have to switch off. If you don't switch off, you're going to burn yourself out […] You cannot make this world a better place. You would like to, but you can't do it. 'Coz you'll burn yourself out. So, you step away, think about it, and think how you think you've done your utmost. You can't do more.

P1 also referred to being aware of her specific role as a therapist and recognising that there are limits to what a person can offer in this role.

Likewise, in relation to cutting off, P6 described how she has specific rituals that signify a separation of work from her personal life, and further describes how this symbolic boundary setting is particularly important as working from home creates the potential for intrusion into her personal space.

> P6: The other thing is also just kind of like leaving- like having to- having different kinds of rituals of leaving your office […] So, I have different kinds of things that I do, uhm, that kind of like help me leave spaces or leave my therapy office and all of that, which is- which is actually why I don't like working at home. Because I feel like I don't want that intrusive- those intrusive thoughts in my own space.

Another aspect of boundary setting that was common amongst the participants was how they schedule their clients. This practice was shared by P1, P2, and P6. Each participant had their own unique practice of scheduling clients, but the shared objective was to ensure that they did not feel overwhelmed by working with too many traumatised clients and to create adequate space for processing their interactions with traumatic material in the context of their overall practice work. This is illustrated in a quote from P2:

> P2: I would usually always give an hour and a half for a first session – not necessarily I use the whole hour and a half – still try and use the hour. But that I have more space after the session or before seeing other clients.

For P5, maintaining boundaries further involved maintaining her professionalism and not stepping outside the bounds of relating as a therapist. In referring to 'empowerment' of the client the implication is that P5 wishes to resist creating any over-dependence.

> P5: I have a very secure sense of boundary, where I know not to get involved with a client personally and stay behind the- the- the line where I can facilitate empowerment.

In all the interviews there was an implication that the pain, distress, and helplessness of crime-related trauma victims might be such as to pull particularly strongly at the therapists' limits in terms of involvement and sense of responsibility. Wilson and Lindy (1994) highlight the intense emotional impact on therapists that results from sustained empathy and the transference-countertransference dynamic when working with trauma clients, and subsequently the increased risk that therapists face of overidentifying and becoming pathologically enmeshed with clients. The authors further emphasise just how fragile therapeutic boundaries can become in trauma work, especially for therapists who have their own history of personal trauma. In the quotes above, one sees how the participants engage in conscious efforts to maintain both emotional (such as cutting off and encouraging victim self-sufficiency) and practical boundaries (such as changing workspace and scheduling breaks) in order to sustain themselves in doing this kind of work. The potentially all-consuming nature of trauma work is emphasised by the need for therapists to strike a careful balance between immersing themselves in their clients' experiences for therapeutic benefit, but also ensuring that they are able to separate their clients' experiences from their own, where the latter is also reported as a protective factor against vicarious traumatisation (Cohen & Collen, 2013; Howlett & Collins, 2014). Another reported protective factor is maintaining a healthy work-life balance (Cohen & Collen, 2013; Newell & MacNeil, 2010; Salston & Figley 2003), which includes being able to separate one's work experiences from personal experiences of traumatisation

(Cohen & Collen, 2013; Howlett & Collins, 2014). The quotes above show how some participants seem to use boundary setting to maintain a divide between work life and personal life, such as consciously cutting off from work and even engaging in specific activities to signify the transition from work to personal life. Engaging in symbolic activities to mark the end of the workday has been reported to be a protective coping factor against vicarious traumatisation by some authors (Hunter & Schofield, 2006).

4.2.2. Self-care practices

In addition to setting clear boundaries, the interviewees also reported consciously using self-nurturing strategies. The quotes below illustrate how participants dealt with the impact of their work through engaging in self-care practices. For three of the participants, self-care meant cultivating and ensuring other interests outside of work.

In earlier years, P1 engaged in creative activities such as painting, and at the time of the interview, she was working on writing a book. Here one sees how she prefers isolated self-care practices over social interactions:

> P1: Anything creative. Uhm … that's about all. So, I have for many years – I did that for many years, I haven't done it for a while – I would paint. Many acrylics. I would've, for quite a long time, I used some of the evenings as sort of a bridge from the one week to the next. That worked quite well. Uhm, I've written few books. Busy with one again. That I like doing. I … there is not a craft I have not done. I have done them all. So, that sort of thing. Yeah, more people are just exhausting, so it's not social.

Both P2 and P5 prioritise physical activity in order to manage their emotions and stress:

> P2: Not that I'm like a hyper athlete or anything but just – even if it's certain stretching or moving or making sure that I walk. Uhm … doing some sort of space or movement is- is very key. And I know this when my emotions or anxieties are going higher. I also check in and I'm like "oh yeah, I haven't actually done any moving". Like, there's quite a- there's a strong correlation of just like actually I need to be moving, I need to be walking.

> P5: For me, exercising and … and uhm … I do mountain biking. Sometimes a bit extreme – the adrenaline rush. That- that's what make- gives me hope and sense- and sense of … being alive and- and- and purpose, you know. So, that's definitely how I also deal with [stress].

Interestingly both P2 and P5 seem to suggest that they need to actively discharge stress associated with doing trauma work, implying that doing this kind of work may create bodily tension alongside the more affective impacts described earlier. P5 appears to need to enliven herself through engaging in intense, almost risky, activity – but activity in which she has a

sense of control. She seems to indicate that she needs to match the intensity of the trauma work impact with the intensity of the relief valve.

For P3, self-care involves a more personal, internal process where she prioritises her own mental well-being when affected by her work:

> P3: Uhm … and I'm not currently in my own therapy, so it's really just about, sort of, treating myself more kindly and giving myself that compassion and that understanding, and then sort of feeling okay to continue.

It is evident that participants used a range of strategies that appealed to them personally ranging from creative pursuits to exercise and in the case of P3 engaging in what sounds like a form of mindfulness practice. Most of the participants described solitary pursuits rather than social contact as ameliorating their work-related stress. Research has shown that prioritising conscious efforts to engage in pleasurable and emotionally regulating behaviours serves as a personal protective factor for therapists who are vicariously exposed to trauma (Cohen & Collens, 2013; Howlett & Collins, 2014; Newell & MacNeil, 2010; Trippany et al., 2004), and this finding seemed to be echoed in the experience of these South African participants.

4.2.3. Finding meaning in the work

Despite the challenges faced in working with victims of trauma, research suggests that therapists still generally tend to find meaning in and feel fulfilled by the work that they do. The quotes below illustrate that this kind of experience of meaningfulness was true for six of the seven participants of this study.

P2 describes how she finds meaning in making sense of the context and history of trauma in South Africa, and through working towards making a difference in this regard:

> P2: Uhm … and I've always had a passion for- for history and for the country and trying to understand that as well. And so- so then, I think it just hooked into my kind of wanting to kind of make some sense and also wanting to … how we can actually shift and change. Uhm … from the- the generational trauma. The horrors. The, uhm, things of where we came from. And actually- could actually be … could actually do stuff that can actually help people's systems that actually could make a difference.

P2's personal interest and investment in her work are evident in this quotation, and it appears that her professional contribution is personally fulfilling as she perceives her work with traumatised victims as potentially providing something reparative in the lives of populations who have historically suffered in South Africa.

Likewise, in terms of making a difference, P5 sees herself as privileged to be in a helping role:

> P5: The fact that you can make a difference, uhm, by giving them hope and by giving them empowerment, and facilitating that process of … uhm … you know … independence […] I see myself as privileged to be in a situation where I can make a role in other people's lives.

As P5 speaks about the many ways in which she can meaningfully help her clients, one also gets the sense that she may feel empowered by virtue of being the person who can 'give' hope, empowerment, and independence to others. She says, 'the fact that you can make a difference' is meaningful to her, suggesting that a sense of having beneficial agency is fulfilling. In all of the quotations cited in this sub-section, it is evident that the therapists find meaning not only in the outcomes of their work, but also in being the person who can facilitate healing and growth in others.

Both P3 and P4 also find meaning in the role that they are able to fulfil for their clients, especially when they are able to witness their clients' resilience and growth:

> P3: The ability to see patients and clients develop resilience to push through, uhm you know, any residual effects of the trauma […] Uhm, it just is- is invigorating for me that it's- it's something that … I can help with and contribute to.

> P4: Uhm, it's very powerful work. And uhm, I have a huge passion for it because the minute you empathise and you're able to support somebody through that, the growth that you see is exceptional.

P3's indication that she feels 'invigorated' by her work and P4's describing 'exceptional' outcomes of her work both suggest a sense of excitement and significance associated with delivering trauma intervention.

For P6, meaning extends beyond just working with victims of violent crime and involves loving her work as a therapist. P4 shared a similar sentiment but in her case specifically in relation to working with victims of crime and trauma as indicated just above.

> P6: Uhm … well I don't think this is specific just to victims at- uhm- victims of violent crimes. But I think what generally sustains me as a therapist is: I just love what I do – I love the work that I do.

Again, one might imagine that part of the appeal of being a therapist for P6 involves the sense of being a helper to others.

P7 also expressed the positive effects of witnessing a client's movement through a violating experience during the course of their therapeutic work, and in her case, it was witnessing the

relief expressed by clients at the end of a course of therapy that felt fulfilling. During the interview, she physically breathed out to demonstrate the sense of being unburdened that a client might express.

> P7: […] but the most rewarding thing is when you finish with a- a person, like, if I counsel you … at the end, they go (demonstrates sighing) and that to me is like a golden star.

Although it is beyond the scope of this study to explore whether the participants experienced vicarious posttraumatic growth as a result of their work, it is of significance to observe that part of their coping experience tends to resemble such growth outcomes. It was evident that in keeping with observations about posttraumatic growth in direct trauma survivors, it was the recognition of extremity of client distress and witnessing the overcoming of this that was meaningful, as opposed to working with victims who were less severely taxed by their experiences. Studies on vicarious posttraumatic growth have reported the following growth outcomes, which resonate with some of what is reflected in the quotations from the interviews presented here: developing increased professional competence, realizing the value of being a helping professional, and realizing the impact one has on the lives of primary trauma victims (Manning-Jones et al., 2015). Although the interviewees did not mention increased competence in trauma work as a personally meaningful outcome, they emphasised that it was the capacity to accompany people through very difficult experiences and to assist them to become alleviated from distress and to transcend negative impacts that were profoundly satisfying. In P2's case, she also reflected upon the fact that conducting crime-related trauma work compelled her to engage with socio-political and ethical issues and that she found this personally stimulating (as discussed to some extent with reference to alterations to worldview).

It also seems important to highlight what seems to be a somewhat narcissistically gratifying aspect of delivering trauma intervention. The quotes above suggest a strong personal investment in being a helping professional and one assumes that therapists are motivated to dedicate time and effort to trauma work to some extent because of intrinsic incentives, such as perhaps finding the intensity of trauma work stimulating or deriving a sense of potency in facilitating recovery from life-negating events. For some, this may be in line with the growth outcomes mentioned above but may also extend to other aspects of the self which are valued by an individual. This is not to say that therapists are not invested in their clients, but rather to emphasise the complex motivations involved for therapists who commit to an especially demanding and impactful line of work. Being aware of one's motivations to engage in this field of work is important for practice implications as research has shown that therapists who are

drawn to trauma intervention because they identify as rescuers or parental kinds of caretakers tend to experience increased vulnerability to vicarious traumatic exposures (Bell, 2003).

McCann and Pearlman's (1990) framework on vicarious traumatisation offers insight into why therapists working with trauma may need to find a sense of meaning in their work. As previously discussed, exposure to traumatic material has the potential to disrupt therapists' existential and spiritual beliefs, and when considering the *frame of reference* schema, therapists tend to form meaningful attributions or causations in an attempt to make sense of trauma. For South African therapists, one imagines that aligning *frame of reference schema* in light of therapeutic content is not only related to making sense of their clients' experiences, but also involves processing and making sense of a shared context of trauma. Finding meaning in clients' healing processes and positive outcomes may also assist therapists with the effects of living within a context of continuous trauma because it gives a sense of reassurance that people can 'recover' from trauma. For therapists with salient *independence* schemas, it seems appropriate to suggest that they may also feel fulfilled when they are able to facilitate a sense of independence and autonomy for their clients.

4.2.4. Seeking support

The aspects of coping discussed until now have largely pertained to self-sufficient processes conducted within the participants' own space and environment. However, it was evident that certain kinds of interpersonal contact were also viewed as helpful by the interviewees. The quotes below illustrate the benefit of seeking support from others – both in a personal and professional capacity. Friendships, peer and formal supervision, and psychotherapeutic support were all described as important to managing work with crime-related trauma victims.

P2 described the importance of social interactions with people who she knows in contexts unrelated to her work, and how this allows her to maintain perspective in the context of her work:

> P2: Also, like I said, being- having, uhm, friendship groups that are not involved with the work that I do. That are involved with other things in society […] I get my energy from people so it's important to be able to connect and with people, uhm, to kind of also hold that both/and stuff. Like bad stuff happens and good stuff happens.

In addition to contact with people outside of the profession, it was also evident that collegial support was useful. The importance of seeking supervision, either formally or informally, was

expressed by all participants in this study. P3 and P 4's words illustrate how they appreciated supervisory support from fellow practitioners.

> P3: You know, I've really- like I've said – and I really mean it – my- my godsend has been peer supervision with my colleagues.
>
> P4: And I'm- I'm aware of when a client does elicit some … there is a countertransference and I do take it to supervision.

In addition to referring to supervision, almost all the participants mentioned how important personal psychotherapy was in managing the impact of the work they engaged in. P6 emphasised the need for personal therapy in terms of increased self-awareness:

> P6: I mean I really believe in your own kind of therapy in- in getting your own support, you know […] Because if you don't know how to isolate to say, "this is my stuff" versus "this is this person's stuff", then you get, you know like, you get pulled into very murky kind of countertransference and ground.

Just as primary trauma victims are encouraged to seek support from others, it is pertinent for therapists who are vicariously exposed to avoid coping in isolation. The quotes above illustrate the importance of therapists having a space to debrief and process the emotional impact of trauma work. What also seemed significant from the interviews was having both professional and personal supportive spaces, as each space served its own function. Professional spaces such as supervision seemed to help participants with therapeutic aspects, such as making sense of cases and one's reactions to cases and appearing to be helpful in maintaining professional boundaries. As seen with P2, personal support from friends is helpful in that it creates a space separate from work and allows for emotional sharing that perhaps feels less self-conscious than sharing in professional spaces. McCann and Pearlman (1990) write about the tendency of therapists to alienate themselves when impacted by vicarious exposure to avoid seeming incompetent, which again, emphasises the importance of multiple supportive spaces for therapists who cannot share certain aspects of their experience socially due to case confidentiality and who do not feel comfortable sharing their complete emotional experience in more professional settings. The participants also emphasise the importance of being in their own psychotherapy process to work through and separate themselves from their clients' experiences, and for introspective processes that decrease the risk of being vicariously traumatised. Both seeking supervision and being in one's own personal psychotherapy are reported as protective factors against vicarious traumatisation (Bell, 2003; Salston & Figley, 2003)

4.2.5. Other aspects of coping

Along with the key aspects of support discussed above, other pertinent aspects of coping were identified in the interviews. These coping mechanisms were mentioned by fewer participants so were not viewed as sufficiently common to report as sub-themes. Nevertheless, they were viewed as important to report upon, in part because several of these strategies for coping resonate with findings in the existing literature. P3 and P6 reported that they do not only work with crime-related trauma and this is of significance in relation to the fact that research has shown that diversifying one's caseload serves as a protective factor against vicarious traumatisation (Howlett & Collins, 2014; Newell & MacNeil, 2010). Additionally, engaging in continuous training and education was also identified in the literature as a protective factor (Cohen & Collens, 2013; Finkelstein et al., 2015; Newell & MacNeil, 2010; Salston & Figley, 2003; Trippany et al., 2004) and the importance of ongoing learning was emphasised by P2, P3, and P4. In terms of significant personal characteristics, research has identified a realistic sense of optimism (Cohen & Collens, 2013) and self-insight (Salston & Figley, 2003) as protective factors. Throughout the interview process, P5 emphasised her optimistic nature and attributed her ability to cope with trauma work to this. For all participants, the general sense throughout the interview processes was that each one appeared to have a considerable level of insight into the potential and actual impact of offering crime-related trauma therapy, and several of the interviewees emphasised the importance of self-reflection and the fact that ongoing awareness of ones' personal states was crucial. While it may be expected of therapists to be generally committed to self-reflection, awareness of the impact of working with trauma and crime can be particularly taxing because of the extremity of the material one is exposed to, and in the case of South African therapists, because of the potential for identification with crime victims given the high prevalence of crime in the country. When self-awareness and self-insight are maintained, it assists in minimising the impact of vicarious traumatisation. During the course of the interviews, it was quite striking how knowledgeable and reflective about vicarious traumatisation the participants were as a group and it seems that this assisted them to limit the potentially toxic impact of working with many crime-related cases.

4.3. Contextual Considerations related to Trauma Work

As mentioned at the start of this chapter, working with trauma and victims of violent crime in South Africa necessitates a consideration of contextual factors pertaining to both the client and the therapist. The following subordinate themes that emerged as salient from the data in this

respect are discussed below: *The context of crime and trauma in South Africa, The context of personal exposure to crime for therapists,* and *Technique as a professional context for crime-related trauma therapy.* Rather than focusing only on socio-political and environmental contextual considerations pertaining to crime and trauma in South Africa, it seemed significant to expand this theme to consider a range of contexts that appeared to intersect in the accounts of participants – as made evident through the analysis of the data. In terms of trauma work and the impact of vicarious traumatisation, therapists need not only consider the broader context within which their clients have been traumatised, but also the context of their own experiences and how this frames their interactions with their clients' material. When conducting trauma intervention, therapists further select techniques through which they deliver such intervention, and subsequently create an additional professional context that impacts on the nature of their interactions with their clients.

4.3.1. The context of crime and trauma in South Africa

Working with victims of crime-related trauma in South Africa often extends beyond considerations of the individual's unique experience and includes mindfulness of aspects pertaining to a broader context within which crime takes place and how this shapes the understanding of experiences. The quotes below illustrate some of the various contextual considerations that the participants have observed to be salient in conducting crime-related trauma therapy. It is evident that at times therapists felt challenged by encountering socially and ideologically loaded material in their work.

P1 and P2 both described the challenge of working with generalisations resulting from traumatic experiences particularly in relation to racism and racial identity assumptions:

> P1: It's the racism that comes into everything. So, if you are going to work with- if you choose to work with it, you will be confronting racism all the time. And that's what I mean: you got certain groups of people who will generalise and say all people do this. It's always racist.

P1 seems to suggest that crime-related trauma work cannot be separated from racism and that racism not only enters the therapeutic space, but therapists are challenged in working with both the impact of traumatic material and the impact of racist beliefs.

As a white therapist, P2 finds herself challenged when working with both white and black clients. At times, she is likened to a perpetrator given the historical context of trauma and crime in South Africa and this is something she needs to navigate when in a helping role. At other

times, clients attempt to draw her into agreeing with racist generalisations which can also mean drawing her in towards a historically based perpetrator role.

> P2: But also because of- especially white people being such perpetrators […] If they've been traumatised- people being traumatised by a white person who, like, again that generalisation of, like, "well, why would a white person help us?" […] even sometimes being with people that- if you help me with a home invasion, and their assumption … also, so we white, you're white, so obviously then you'll also hate all black people like us.

P2 highlights the role of her racial identity as a therapist and how it impacts on the therapeutic dynamic between therapist and client. P1 and P2's contributions highlight three significant considerations of working with interpersonally inflicted crime-related trauma in South Africa: (1) the tendency of traumatised victims to generalise and liken entire groups to perpetrators, (2) the historically internalised racialised assumptions that seem to be heightened for victims of crime-related trauma, and (3) how these two factors intersect within the therapy. These observations are in line with Eagle et al.'s (2013) report on intergroup prejudice as a common consequence of violent crime-related victimisation. The authors further highlight the discomfort often experienced by therapists when faced with client prejudice, and the technical and ethical complexities of engaging with clients who bring prejudice content. Although not explicitly stated, one gets the sense that P2 often feels uncomfortable because of how her clients experience her as a white therapist – perhaps even as a white therapist in a perceived position of power.

P2 and P5 further highlight the context of multiple exposures and continuous trauma in South Africa, and how this impacts on therapists in terms of frequency of exposure and maintaining a contained level of awareness:

> P2: But I think it's holding the sense of context. That we're in a context of continuous trauma. But how do we live at awareness and be aware therapists, and not hyper-alert therapists?
>
> P5: Uhm … because we live in a country where we are often- need support because we've been traumatised, you know. Uhm … yeah. So, if I think of the people that I saw this week, uhm … they were all exposed to some sort of trauma.

In referencing the notion of not becoming a hyper-alert therapist, P2 seems to reinforce that she may be impacted by the work in such a way as to develop a trauma loaded consciousness herself, but also suggests that it is possible that if her own levels of anxiety become extreme because of chronic exposure to numerous accounts she may in turn almost contaminate her

clients with this awareness. Thus, she needs to find an optimal balance in terms of engaging with the reality of a high crime context and her awareness of the import of this, both for her own and for her clients' sake. P5 refers to the volume of cases she sees and the burden of working with poly-victimisation if she thinks about the range of cases she has seen in the week. Given the context of continuous traumatic stress (Eagle & Kaminer, 2013) and the increased prevalence of crime in South Africa, exposure to direct and indirect crime-related victimisation has almost become normalised (Collins, 2013). The words of P3 just below illustrate how, in keeping with this kind of normalisation, there is an expectation that one will eventually be exposed to or become a direct victim of violent crime. The same kind of sentiment was shared by P5 and P6.

> P3: And he said to me – all of 13 years old – he said to me he knew … the one thing that's making him feel fine with what's happened is he knew it was a case of, when, and not, if. And that's very hard to hear from a child, where you think surely, they should be preserved in their innocence or protected from understanding, you know, this is a natural phenomenon in our country.

One is alerted to P3's belief that crime-related trauma is a 'natural phenomenon in our country' and it is when a child articulates this understanding that she finds herself particularly affected. She further implies that as a professional or adult this is information that she – and perhaps even others – is supposed to be able to withstand. It seems appropriate to suggest that this kind of sense of the inevitability of exposure to criminal violation may impact on therapists either by becoming desensitised to their clients' experiences because of the need to normalise such experiences in order to feel safer in their environment, or by becoming hypervigilant in their own space due to overwhelming vicarious exposures that interact with their awareness of a high crime context.

P5 expressed a sentiment, which although not necessarily shared by the other participants, seemed significant to mention. In talking about working with crime victims she demonstrated her ability to understand violent crime from the perspective of the perpetrator, and here one sees how she attempts to make sense of the prevalence of crime within her space and context.

> Participant 5: He's experiencing himself as being a successful … uhm, entrepreneur … in creating an income. And that is the saddest part because we live in a world where a person can have that kind of subjective experience.

P5 suggests that crime perpetration may be viewed as akin to a job in creating earning potential and she suggests that there may be something problematic about living in a society in which a person can adopt this perspective. Although this study focuses on therapists working with

victims of violent crime, many therapists work with perpetrators too, and in both instances needing to hold the perspective of both the victim and perpetrator is likely demanding for therapists on a personal and professional level.

In P5's reflection one sees yet again some attempt to engage with the complexity of crime in South Africa and what kinds of moral and explanatory systems one might be drawn to. It seemed almost inevitable that working with survivors of crime, and more particularly violent crime, compelled therapists to develop their own attributions about motivations and causes, in part in order to engage with the causal attributions of their clients. It was evident that in some instances their explanatory systems aligned with those of their clients but that in other instances they were not necessarily in accordance with their clients. For example, when clients moved to essentialist explanations related to race stereotyping, they found themselves needing to stand somewhat apart to recognise these client contributions as over-generalisations. One also has a sense that although P5 may be able to entertain the idea that for many perpetrators their actions might be viewed as a legitimate way of making money, it would be unlikely that she would share this view with her traumatised clients. What was evident in the interviews, however, is that despite working with many damaged people, therapists did not move to over-simplified representations of victims or of perpetrators or of South African society as a whole. Their work seemed to encourage more elaborated explanation seeking.

4.3.2. The context of personal exposure to crime for therapists

As with any therapeutic or mental health-related intervention, the way in which therapists experience their clients is in part based on their own life experiences. Although this has been touched on previously, this sub-section elaborates in a more focused manner on the context of personal exposure to crime as a trauma therapist in South Africa. Five of the participants (P1, P3, P4, P6, and P7) made reference to their own traumatic life experiences in talking about their engagement with crime-related trauma cases, several of them mentioning having been direct crime victims themselves. While all participants interact with traumatic material in a professional capacity, the quotes below illustrate how personal experiences pertaining to crime and trauma exposure have created a unique life context for each therapist, which in turn, framed their interactions with client material. Multiple studies have identified previous personal trauma exposure as a prominent risk factor for vicarious traumatisation in populations that conduct trauma interventions (Cohen & Collens, 2013; Finkelstein et al., 2015; Howlett & Collins, 2014; Newell & MacNeil, 2010; Pearlman & Mac Ian, 1995; Salston & Figley, 2003).

However, it was not clear that the interviewees in this South African study viewed their own exposure as rendering them more vulnerable to work-related stress.

P1, who had experienced crime-related trauma, described how this experience did not have any negative effects on her in terms of feeling unsafe and restricted in her home:

> P1: I mean I've been in an armed robbery many years ago. We do not live in a closed neighbourhood. Because I will not […] We live in a free-standing house in an ordinary suburb. I do not like the idea of people being restricted from entering […] Uhm, I don't think that's the way to deal with it. And if I want to go out in the morning, my only risk is someone's left the gate open and their dogs out – they don't know how to deal with strangers. And there might be a rat. But that's about the danger.

It is worth pointing out P1's cautionary behaviours discussed in Section 4.1.1 and highlighting that those behaviours were related to specific events that she perceived to be unsafe, and her mention of the fact that she did not carry a general sense of feeling unsafe. Of significance here, as well, is that generally P1 seemed to be the least impacted by conducting trauma work relative to other participants, despite her own personal exposure to an armed robbery. Research has shown that therapists with a previous history of trauma are more at risk of vicarious traumatisation if they have less experience (Pearlman & Mac Ian, 1995), and that even with no history of trauma, therapists with less experience are somewhat more at risk (Finkelstein et al., 2015; Howlett & Collins, 2014, Pearlman & Mac Ian, 1995). Given that P1 has the most experience of those in the participant group, one can hypothesise that the opposite holds true as well, i.e., therapists with more experience are potentially less at risk, even with a history of direct victimisation as in this case. A further protective factor for P1 may also be the amount of time that has passed since her traumatic experience.

The relationship between level of exposure and history of trauma is also interesting when considering P6 who has no history of trauma but also has the least professional experience relative to the sample group. Even though she reported experiencing heightened awareness in Section 4.1.1, this was temporary and based on specific cases. Her quote below shows that generally she does not find herself overwhelmed by her work. P6 attributes this, at least in part, to not having experienced her own trauma.

> P6: So, it never really happens where it feels like I've a lot of clients that are kind of dealing with traumatic-traumatic situations. So, it doesn't feel- I don't know what I'd do when it- that happens and what I'd kind of- what would be a trigger for me- what would be an indicator for me to say, "okay, I can't do this

> anymore". Maybe if I experienced my own personal trauma it may feel different and I'd be like, "uh, I actually don't wanna do this work anymore".

P6 has a sense that if she were to suffer a personal trauma, she may well feel concerned to continue with therapeutic work with victims as she assumes this might be 'triggering' for her.

Both P3 and P4 reported previous experiences of interpersonal violence and/or crime-related trauma, and as a result, both were negatively affected on a professional level. For P3, this means choosing not to work with clients who resemble the perpetrator of her experiences:

> P3: Like, at the moment, I don't work with any substance abuse cases because of personal reasons – not because I'm a substance abuser – but because I dated a very violent substance abuser, uhm, for a period of time. It was a very short period, but in that period became quite traumatised by him and his behaviour.

P3's decision to distance herself from 'substance abusers' alerts one again to the generalisations that are often formed when one has been victimised, and that even for trained professionals, it can be particularly challenging to associate a traumatic experience with an individual perpetrator. Literature has shown that the experience of shared trauma causes great difficulties for therapists (Baum, 2010; Bell & Robinson, 2013; Saakvitne, 2002) and one imagines that the difficulties and risk of vicarious traumatisation are heightened when the shared aspect is working with clients who resemble one's own perpetrator. In instances of shared victimisation, therapists are likely to unconsciously overidentify or distance themselves from clients, but with P3, one sees how she consciously distances herself from 'perceived perpetrators' to protect herself, subsequently also protecting these kinds of clients from inefficient treatment.

P4 continues to work with child victims, but due to her traumatic experiences where her own children were involved, she finds it difficult to tolerate parents or caregivers who are perpetrators:

> P4: […] both of my sons … had … uhm, a lot of trauma before the age of six each […] The gravity of … a *parent* or *caregiver* doing this to your *own child* is something that I simply […] *cannot* understand on a human level […] Because I saw the effects and that was … it was crime-related. It wasn't done by your caregiver – your attachment figure.

Based on her observations of how her young children were affected by trauma inflicted by perpetrators outside of their intimate circle, P4 indicates that she is even more concerned about working with the impact of harm inflicted on children by caretaker figures. Her vicarious identification with her own children's responses extends to a vicarious identification with child client victims. As discussed in the literature there is a fine line between over and under-

identification with trauma survivors given that a degree of identification underlies the capacity to empathise (Wilson and Lindy, 1994). Personal exposure to similar events to those experienced by clients (even if by indirect exposure to close relatives or friends) may well place therapists at risk for over-identification, but in some instances may also contribute to unconscious distancing. In this instance P4 seems aware of the potential for some resonance, and as was the case with almost all of the participants. One sees evidence again among the participants of a capacity to reflect upon the work and various contextual features that might place them at risk of vicarious traumatisation, including personal exposure to traumatic events.

Unlike the other participants, P7 reported a history of multiple losses that were traumatic although these were not crime- or violence-related. She believed that her own grieving experience might assist her to be more aware of what others were suffering but equally that she needed to be careful of imposing her own strategies for coping on anyone else in her practice. Her words show how her previous trauma experiences positively affect her ability to work with similar cases:

> P 7: You know what I have often thought … when I started counselling in, uh. So, if I had to counsel a person and they say, "you know I've just lost my husband", I'll say "walk in the park". But I wouldn't say that to them.

Of significance here is also what P7 does not say, and one gets the sense that working with violent crime-related trauma victims may be more challenging for her as she cannot draw on her own experiences as a yardstick for what her clients may be experiencing.

The findings in this section indicate just how pervasive violent crime exposure is in that three of the seven participants mentioned having been crime victims, including two participants having had multiple experiences of violent crime-related trauma. It is evident that the participants live in a context in which they are aware of personal risk and yet still manage to continue delivering trauma intervention. Although it was only P4 that explicitly mentioned working with shared trauma, it seems important to keep in mind that due to a shared context of crime, therapists with a history of personal crime-related trauma are generally likely to encounter clients who have experienced similar traumatic experiences as they have. In terms of treatment efficacy and their own personal well-being, therapists who have been previously victimised will likely undergo increased emotional strain, needing to potentially re-work through their own experiences of trauma.

4.3.3. Technique as a professional context for crime-related trauma therapy

As became evident in the interviews, the trauma intervention techniques used by therapists shape their interactions with traumatic material and formed part of the background context in which they conducted their work. Several participants linked their technical approach to conducting crime-related trauma therapy to their reflections about how they were impacted by doing this kind of work. An interesting finding of this study was that participants preferred somewhat varying intervention techniques, yet still appeared to be similarly impacted by their work. As will be evident in the quoted material below, interviewees used approaches such as Eye Movement Desensitisation and Reprocessing (EMDR), Brain Working Recursive Therapy (BWRT), and more general psychoeducational, narrative, and integrative therapy approaches. Due to the limited scope of this study the more pronounced differences in impact based on technique could not be systematically explored. However, it is suggested that in terms of impact, the specific technique may be of less significance than the therapist's efficacy in administering the technique and the visible results derived from their adoption of a particular approach. The quotes below illustrate the various techniques used by the participants bearing in mind that participants did not necessarily exclusively make use of these techniques.

P1 prefers using EMDR when working with trauma. Here one sees that for her this technique is experienced as predictable in its efficacy and restricts the traumatic material to which she is exposed:

> P1: I use mainly EMDR […] Within 10 minutes I know if- whether what I'm doing is going to work or not […] If I'm looking at something like a rape. We're not talking previous sexual abuse. We are not talking HIV positive or something like that. Uhm, but it was just a rape. It will take three sessions. That is not hard work. It's relatively easy.

What is very striking in this reflection from P1 is the business-like approach she adopts in her work and her indication that with even as extreme a traumatic experience as a rape she is able to effect improvement in three sessions. In fact, P1 goes so far as to suggest that using EMDR with serious crime-related trauma is 'relatively easy', providing there are not complicating factors such as a prior history of abuse. When reflecting on employing a more unstructured, narrative-based therapeutic approach, P1 highlighted the increased time and energy it requires:

> P1: It's always harder. It's more energy. It's actually more energy and it takes longer.

For P1 it was evident that she preferred to avoid using a narrative approach that might entail exposure to a more detailed explication of events and would only use this approach if complications or client preference necessitated this. She was very clear in her mind that using the highly structured approach of EMDR generally protected her from vicarious traumatisation.

Likewise, P3 also prefers using a structured process, in her case Brain Working Recursive Therapy (BWRT), and finds this technique more containing than engaging in the more depth processing that she associates with interpretive, psychodynamic work:

> P3: I think with the BWRT, it's a very structured process. So, it almost allows to- to have, uhm … your own personal or visceral trauma contained because it's- it's a scripted process – so there's a script […] it's really only when the trauma is expressed more psychodynamically through other processes that it becomes more palpable or more emotional- emotive, I guess.

It appears that, for some therapists, conducting more structured trauma interventions tends to lessen the negative impact of the work, and P1 and P3 indicate that this may result from decreased exposure to traumatising details of the clients' experiences. As P1 says, engaging with the client's more extended narrative 'is harder' and P3 suggests the scripted BWRT approach lessens vulnerability to 'your own personal or visceral trauma'.

P4 also reported using BWRT on occasion, but generally prefers employing educational techniques to empower her clients, as seen in the quote below. Likewise, P3 also favoured incorporating educational processes into her trauma intervention.

> P4: So, I explain it to them neurologically, where I have a very … uhm … a very simplified drawing of- a- a picture of the brain so they can understand the prefrontal cortex pretty much shut down […] I haven't yet engaged in a therapeutic process. But I've given them a lot of information and knowledge. And- and knowledge really is power.

P4 seemed to ameliorate some of the potential stress of working with highly traumatised cases by using an explanatory system that linked symptomatology to brain functioning and sharing this with clients at the outset before she seems to talk about the events with the person ('I haven't yet engaged in a therapeutic process'). She seems pleased to be able to give her clients something to hold onto and this, in turn, reduces her risk of becoming pulled into the client's sense of powerlessness or distress.

P6 seemed to agree that trauma intervention involves a somewhat structured process, but she prefers working on a more meaning-related, individual level with each client:

> P6: I'm very much a case-by-case kind of person […] I try and understand what is it about this particular incident that's affecting you in particular way […] Because I find *that* works much better than just following, uhm, a model and you kind of go through the different kinds of steps.

However, when reflecting on more structured processes, P6 expressed that it can make the work easier in terms of impact by creating distance between the therapist and the client's experiences:

> P6: […] if I'm not in a great space or I'm feeling very exhausted or I'm feeling very tired, then, yes, it is. Uhm, because what it does is it kind of removes you in a little bit from being, you know, like there, emotionally, engaging with all of the raw emotions and all of that.

What P6 further highlights is that therapists need to be in a relatively 'great space' to conduct trauma therapy, and although this is generally expected of all therapists, one gets a sense of the emotional demands placed on therapists who work with trauma and who choose to work with detailed narratives of trauma. The quotes above show to an extent how several participants decrease the impact of trauma work through their chosen techniques and P6 seems to highlight an important aspect of less involved techniques when she says, 'it removes you from being there emotionally'. This is interesting as Wilson and Lindy (1994) suggest that compared to other kinds of therapy processes, the treatment of PTSD requires a deeper empathic engagement to facilitate healing, although they acknowledge that it is the therapist's empathic involvement that makes trauma intervention especially straining for the therapist. It seems that the participants are all aware that being exposed to their clients' narrative material is potentially riskier for them in terms of vicarious traumatisation. Some of the participants not only prefer the amelioration of emotional distress that comes with using highly structured approaches like EMDR and BWRT but are satisfied with the efficacy of such approaches. However, for some there is also an awareness that this might be an overly 'safe' option and that there are times in which a more extended, meaning-related, narrative-based approach may be required, placing them at more risk of impact. Literature has also shown that using more active, manualised, evidenced-based interventions may contribute to a sense of increased self-efficacy in therapists and may reduce the negative emotional impact of interacting with traumatic material (Craig & Spring, 2010; Fonagy, 1999; Smith et al., 2007), however, there are also concerns about the effects on clients and the therapeutic process when empathic engagement is limited (Craig & Spring 2010; Wilson and Lindy, 1994). Perhaps one also needs to consider the need for South African therapists to employ more structured interventions due to the high rate of trauma victims needing therapeutic services in relation to the relatively few therapists who are

available to provide such services. One imagines that therapists have more internal resources to see more trauma cases when they are able to limit empathic engagement, and perhaps this is also needed to allow therapists to practice in the risky environments in which their clients are victimised. Considering the context of continuous crime in South African, it is important to think about whether this is a necessary sacrifice to maintain an already scarce resource (i.e., therapists delivering trauma intervention), and to allow therapists to continue to work in this terrain. However, it is also important to consider long-term treatment efficacy in the work that therapists do and whether such approaches produce enduring effects. While considerations of the efficacy of therapeutic modality are not in the purview of this study there is potentially interesting work to do in exploring whether therapist choice of modality is motivated by considerations of protection against vicarious traumatisation alongside considerations of efficacy.

What is apparent from the discussion of the thematic material is that this group of therapists who work with victims of crime-related trauma in South Africa is impacted in generic and specific ways by conducting such work. However, they appear to be highly attuned to detecting vicarious traumatisation in themselves, perhaps most explicitly at a symptomatic level, but also to a large extent at the level of belief systems and personal schemas. They employ a range of strategies to protect themselves from vicarious traumatisation, including selecting to work in particular kinds of therapeutic modalities. Despite introducing several accounts of personal trauma exposure, in the main, they seemed reasonably phlegmatic about working with victims in a context of high crime prevalence. The concluding chapter will draw the main findings together and offer some critical evaluation of the study.

Chapter 5: Conclusive Overview

This concluding chapter summarises the research findings that were presented and discussed in chapter 4 and highlights the contributions made by the findings. The limitations of this study are also outlined and recommendations for future related research are made.

5.1. Summary and Contributions

This research aimed at exploring the subjective experiences of vicarious traumatisation among therapists working with victims of violent crime within a contemporary South African context. It also aimed at understanding how the nature of clients' narratives and the awareness of socio-political and environmental context may impact on therapists delivering trauma intervention, and how therapists manage the harmful effects of working with victims of violent crime. It was concluded that being vicariously exposed to violent crime-related trauma is inevitably part of the experience for South African therapists, both professionally and personally, and the ways in which therapists find themselves affected by vicarious traumatic exposure is ranged and idiosyncratic.

It emerged that all seven participants found themselves negatively impacted on some level and had internal demands placed on them that required attention, reflection and working through in order to cope. A striking observation was that all participants indicated in some way having a heightened awareness of the crime context in South Africa, however, they also seemed to express a defensiveness around being as vulnerable as their clients. It may be that living in a high crime environment and working with the effects hereof made some participants more vigilant and focused on safety precautions rather than being prone to traumatisation. Although the participants seemed to be managing their sense of safety and personal vulnerability, it also emerged that there is significant emotional distress associated with heightened awareness, and the participants also expressed a range of emotional responses brought about through vicarious exposure such as heaviness, horror, anxiety, and fear.

Of significance was also how participants needed to manage their empathic involvement with their clients to regulate their own emotional responses. It was observed that during the interviews participants generally struggled to stay focused on the effects of vicarious traumatic exposure on one's thoughts and emotions and required prompting to offer more experiential narratives. It may be that the participants needed to manage the impression they gave off and perhaps even reassure themselves about their ability to manage the effects of trauma work. This is an important consideration for all therapists because openly presenting

with traumatisation may well be felt to be associated with some lack of professional competence, which makes coping with adverse effects more difficult and complicated. It was not possible to determine whether participants were generally minimally affected by working with crime victim clients or whether there was some minimisation of the effects of conducting such work.

It further emerged that while participants are generally able to tolerate traumatic exposures, specific cases tend to affect therapists more strongly than others, as might be anticipated. The general sense among the participants was that human-inflicted victimisation and more powerful identification with a victim seemed to have a stronger emotional impact. In addition, participants conveyed that aspects of their belief systems and ideal views of the world and others had been challenged at times by their work. The findings of this study emphasise both how important it is for therapists to integrate their traumatic exposures such that their worldview feels secure, and how therapists' worldviews shape how they interact with and are impacted by traumatic client material.

The findings further indicate that the participants engaged in conscious efforts to manage and cope with the negative effects of traumatic exposures, such as putting in place measures that promoted boundaries and good professional practice, prioritising self-care, and seeking support. The demanding nature of trauma work appears to be validated by the fact that the therapists interviewed noted that they needed to establish protections for themselves to mitigate the implications of vicarious exposure.

Of interest was also that most participants seemed to find trauma work meaningful and to feel fulfilled in their role as a therapist who could facilitate growth and healing for clients, and this generally seemed to be what sustained them most in continuing with trauma work. However, based on the literature it is worth cautioning that there appears to be a fine line between fulfilment being a positive outcome of trauma intervention as opposed to being a possible risk factor for therapists who (over)identify as helpers. Within the participant group, it did not appear that any of the participants were over-invested in the role of helper or rescuer, but the caution is worth noting.

Another significant finding concerned how the participants felt required to think about and navigate multiple intersecting contexts when interacting with their clients' traumatic material. When considering the shared context of crime and trauma, it was interesting to see how participants engaged with the complexities of being a victim or perpetrator, and also the significant role that issues of class and racial identities played in the construction of crime-related trauma in the therapeutic encounter. It was also striking that nearly half of the

participants had their own history of crime-related trauma yet continued to deliver trauma intervention without any indication of wanting to withdraw from some work. It was evident that the three therapists who had been victimised themselves were mindful of possible over or under-identification with certain clients but in the main felt that their experiences might contribute to greater empathy. Although they did not explicitly discuss whether and how they had worked through their own traumas their manner of speaking suggested that they felt largely resolved in terms of how they had processed their own traumatic experiences, as is recommended as important in the literature.

An unexpected finding of this study was that the participants' choice of intervention or technique shaped how they interacted with traumatic material, and subsequently seemed to shape how they were impacted as well. It emerged that participants were generally aware that interventions that require deep empathic engagement with traumatic material were more emotionally demanding on them, and that interventions that created some emotional distance seemed to decrease the risk for vicarious traumatisation. For this reason, several participants favoured more manualised treatment approaches than more interpretive, narrative-based approaches. It is, however, considered that structured, manualised approaches do entail intensive emotional engagement and that perhaps these are experienced as less emotionally draining as structured processes tend to yield quick symptom reduction, thus resulting in a somewhat shorter duration of engagement and a more immediate sense of self-efficacy.

Finally, the findings of this study further suggest that beliefs about self-efficacy may have been important for participants of this study as they presented as quite secure in their ability to cope with and make sense of vicarious traumatic exposures, and also in their ability to provide trauma intervention.

Given the existing research and high trauma caseloads that South African therapists work with, the assumption at the onset was that most therapists who participated in this study would have experienced high levels of vicarious traumatisation. However, it was evident in the findings that the participants of this study represented a particularly resilient group of trauma therapists, some of whom have managed to sustain themselves in working in the field for a long time. In terms of contributing to the research on vicarious traumatisation, it is as instructive to observe therapists who experience subclinical effects of vicarious traumatic exposure and also to identify some of those features that appear to contribute to stamina for those who continue to deliver trauma therapy.

5.2. Limitations

The following limitations should be taken into consideration in terms of the validity of the research, generalisability of findings, and considerations to guide future research:

i. While a smaller sample size is suitable for qualitative, exploratory research, it is noted that the group of seven participants was relatively small and that the findings of this study cannot necessarily be generalised to other groups of therapists working with crime-related trauma victims.

ii. Six of the seven participants were white, and all the participants were female. As such, the racial and gender demographics of the sample group do not represent the larger South African population. However, given the feminisation of many helping professions, it is not uncommon that more women than men are involved in delivering trauma therapy. It is noted that the largely white group may be more protected from some of the crime risk features of South African society than a black group of therapists might be, or than therapists working in more deprived communities might be. In this respect, the participant group was perhaps somewhat protected from some of the aspects of contextually loaded exposure that it was believed might contribute to vicarious traumatisation at the outset of the study.

iii. A further limitation may also be that the sample group represented a more resilient group of therapists, and this may have limited the exploration into vicarious traumatisation. Both the researcher and supervisor are aware of many anecdotal accounts of South African trauma therapists feeling overwhelmed or vicariously traumatised by work with victims of violent crime, to the extent that therapists have chosen to move out of this field of specialisation in their practice. It is possible that the group of therapists who took part in the study were not only resilient in that they were comfortable to remain working in this field, but also that their willingness to volunteer to take part in a study that required examining vulnerability to vicarious traumatisation also suggested a particular kind of resilience. The volunteer nature of the recruitment may have meant that those who chose to take part were relatively secure in themselves as trauma therapists.

As mentioned in the brief discussion on reflexivity in the method chapter, it is possible that the participants may have felt a need to ‘protect’ the interviewer as a trainee clinician in relation to generating anxiety about trauma work, and also that they may have felt a need to demonstrate their professionalism in managing any risk of

vicarious traumatisation. They were also aware that the project was being supervised by someone who works in the field of traumatic stress and may have had this in mind during the interviews. However, in the main, participants seemed open to discussing their therapeutic work and their personal experience of working with crime victims, and the overall finding that they seemed relatively unaffected by vicarious traumatisation appeared a valid representation of their experiences.

iv. It is also worth noting that while the intended focus of the study was on working with victims of crime and violent crime, in particular, the participants found it difficult to disaggregate this aspect of their work from working with other kinds of trauma despite attempts to re-focus on this aspect of work in the interviews. Some of the findings thus pertain to conducting trauma therapy more generally.

5.3. Recommendations for Future Research

In consideration of this research process and findings, the following recommendations are made for future research:

i. For generalisability, it is recommended that further research be conducted with a larger, more broadly representative sample group, with perhaps a particular focus on therapists working and living in what would be considered high crime risk environments.

ii. As discussed under limitations, it was evident when approaching some potential participants that a number of people who had previously specialised in working in this area had stopped taking violent crime-related cases into their practice precisely because they recognised that they had become overly sensitised in their environments, found their worldviews changing, and felt the work was too taxing to continue. It may well be interesting to study the group of therapists who have moved out of this therapeutic specialisation in terms of documenting experiences of vicarious traumatisation in this regard.

iii. The suggestion that employing technique-based or manualised trauma treatment forms appeared to protect therapists from vicarious traumatisation was an interesting finding that appears to warrant further systematic research, in part because there appears to be some similar findings in the literature. Further research in this regard is also necessary to explore what specifically about these approaches serve as protective factors.

iv. It may also be useful to explore the use of various trauma intervention approaches from the perspective of clients to understand how their experiences of therapy may differ

depending on whether therapists use manualised (and perhaps more emotionally distanced approaches) as opposed to more ideographically tailored, narrative approaches where the therapist might be experienced as more emotionally engaged.

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Appendix A: Participant Information Sheet

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

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1 Jan Smuts Avenue, Johannesburg, South Africa
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PARTICIPANT INFORMATION SHEET

Title of Project: Vicarious Traumatisation in Psychology[10] Therapists Working with Victims of Violent Crime in Contemporary South Africa.

Researcher: Nasreen Lorgat

Ethics Clearance Number: MCLIN/20/02

Dear Therapist

My name is Nasreen Lorgat and I am a Masters student in Clinical Psychology at the University of the Witwatersrand, Johannesburg. As part of my studies, I am required to undertake a research project. I have chosen to investigate the experiences of therapists engaged in trauma work in South Africa. I am working under the supervision of Professor Gillian Eagle. The aim of the research project is to explore the subjective experiences of mental health professionals who work with victims of crime, including violent crime, within the contemporary South African context. I am interested in better understanding how therapists observe and describe being affected by such work and how they make sense of and manage their experiences related to working with crime victims.

As someone who works with crime victims in your therapeutic practice, I would like to invite you to take part in an interview related to the research focus. Participation in the research project will involve answering questions related to your experiences of working therapeutically with crime victims and how you have observed that this has affected you. Interviews will take about 60 minutes and will be conducted at a time and venue that is convenient for you. For example, if this is feasible in terms of COVID-19 related restrictions, I would be very willing to come to your workplace to conduct the interview. There is also the option of conducting online interviews via Zoom or a similar online platform. If you agree to be interviewed via an online platform, we will enable whatever privacy settings are available, such as using a password for setting up the meeting and the 'room locking' function in Zoom. If we use an online interview platform there is also the option of being purely audio interviewed or using the video function, depending upon your preference. With your permission, I would like to audio record the interview using a digital device, and in the instance of using Zoom (or similar)

[10] Note that after the data had been collected, the title of this study was changed to exclude the word "Psychology".

with video enabled I would like your permission to record the interview with the understanding that for purposes of the study, only the audio file will be retained for transcription and analysis.

To be eligible to participate the following inclusion criteria apply:

- Be a mental health professional, a mental health work or a supervisor of crime-related trauma cases.
- Have substantial experience in working with or supervising crime-related trauma cases during anytime of your career (i.e. a minimum total of two years' experience).
- Be comfortable being interviewed in English as this is the language in which I am fluent.

There are no risks anticipated in relation to taking part in the project and there will be no personal costs to you other than making time to take part in the interview and data charges associated with using Zoom or a related online platform device if this is the preferred option for conducting the interview. You will not receive any direct benefits from participation, but I would be very happy to send you a summary of the research findings on completion of the study. The research report in which my findings will be written up will also be available as part of the Wits library resources. Participation is entirely voluntary and there are no disadvantages or penalties if you choose not to participate or if you withdraw from the study. You may withdraw yourself or your information at any time during the study prior to submission of the research report for examination and you are entitled to not answer any question posed during the interview if you so choose. This study involves no forms of deception. I am aware that speaking of your personal experiences of the impact of working with victims of violent crime may induce heightened awareness of the impact of this kind of work. If you experience any distress or discomfort at any point in the process of taking part in the research, we will discuss either whether to resume at another time or whether you wish to discontinue participation in the study. I am aware that most practitioners have supports available in terms of expert or peer supervision and/or personal psychotherapy. However, if on the basis of taking part in the interview you feel this would be helpful, Professor Gillian Eagle, as supervisor of the project is available to offer a once-off debriefing session free of charge or to discuss other support options with you.

Due to the nature of this study, complete anonymity cannot be guaranteed during the data collection process. In this instance, I shall be the only person who has access to your identity, which will remain confidential at all times. For the purposes of writing up the study your identity will be kept anonymous. You will be assigned a pseudonym (alternative name) which will be used to represent you and your contributions in any written or oral presentation of the research findings. You are not required to disclose any client material during the interviews, but if it seems pertinent to refer to any such material, it will be kept confidential through processes of disguise and/or removal of any identifying details. The interview recordings and transcriptions will be held securely in a password protected file on my electronic device that only I will have access to and only the transcripts (stripped of identifying information) will be shared with my supervisor. If you choose to give your permission for this, the data collected from this research project, in the form of anonymised transcripts, may be used by other researchers in the future who would need to seek their own research clearance for the project and would be bound by similar ethical guidelines concerning research.

With your permission I may wish to contact you telephonically or by email subsequent to the interviews should any information need clarifying. You will only be contacted if you consent to this further communication.

If you have any questions about this research, please feel free to contact me. My contact details and those of my supervisor are listed below. If you have any concerns or complaints regarding the ethical procedures related to this study, you are welcome to contact the University Human Research Ethics Committee (Non-Medical), telephone +27(0) 11 717 1408, email hrec-medical.researchoffice@wits.ac.za

If you are interested in the study and willing to take part, please complete the attached informed consent form and biographical questionnaire. Upon receipt of this form, you will receive further information pertaining to setting up the interview by mutual agreement. Thank you for your consideration.

Yours sincerely,

Nasreen Lorgat

Researcher:
Nasreen Lorgat, 717149@student.wits.ac.za, +27 (0) 82 789 7749

Supervisor:
Professor Gillian Eagle, gillian.eagle@wits.ac.za, +27 (0) 11 717 4528

Appendix B: Informed Consent Form

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

School of Human and Community Development
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1 Jan Smuts Avenue, Johannesburg, South Africa
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INFORMED CONSENT FORM

Title of Project: Vicarious Traumatisation in Psychology Therapists Working with Victims of Violent Crime in Contemporary South Africa.

Researcher: Nasreen Lorgat

Ethics Clearance Number: MCLIN/20/02

I, _____ (full name and surname), agree to participate in this research project. The research has been explained to me and I understand what my participation will involve. I agree to the following:

I agree that my participation should remain confidential.	YES	NO
I agree that the researcher may use anonymous quotes in his/her research.	YES	NO
I agree that the interview may be audio recorded.	YES	NO
I agree that the interview may be video recorded.	YES	NO
I agree that information I provide may be used anonymously after this project has ended, for academic purposes by other researchers, subject to their own ethics clearance being obtained.	YES	NO
I agree that the researcher may contact me after the interview has been conducted to clarify information.	YES	NO

Signature: .....

Date: .....

(Please complete the attached biographical questionnaire)

Appendix C: Biographical Questionnaire

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

School of Human and Community Development
Department of Psychology
1 Jan Smuts Avenue, Johannesburg, South Africa
+27 (0)11 717 1000

BIOGRAPHICAL QUESTIONNAIRE

A. The following information is for contact purposes only and will not be shared or reflected within this study:

Name:	
Contact Number:	
Email Address:	

B. The following information is required to provide context so that I can describe the nature of the participant group who took part in the study (you may choose not to answer a particular question, but the information will be helpful for descriptive purposes):

Age:	
Race:	
Gender:	
Religion:	
Professional Registration:	
Years of professional experience:	
Expertise/areas of specialisation: (who do you work with mostly?)	
How many cases of people affected by violent crime would you see on average per week?	
Do you have access to regular professional support, and if so, of what kind?	

Appendix D: Interview Agenda

The open-ended interview will begin with a broadly focused introduction and question that will be framed as flows:

> **I am interested particularly in the manner in which working with clients who have experienced violent crime in South Africa seems to affect therapists who conduct a lot of work with these kinds of clients. To that end I would like you to share with me whatever comes to mind about what you have noticed in terms of the impact on you of doing this kind of work. It would be helpful to use examples to illustrate what you are talking about if these come to mind. What is it that you have noticed and how do you think this may be significant?**

Following on from what emerges from the response to the initial question, the following kinds of questions and associated prompts may be used to invite further elaboration.

1. **Tell me about your experiences of working with clients who have been victims of violent crime and what kinds of cases you tend to see?**
   Explore the frequency and types of cases, and therapists' conceptualisations of violent crime victims.
2. **How did you come to work with trauma victims?**
   Explore personal reasons, expertise, demand for trauma intervention.
3. **What is it like for you as a therapist working with victims of violent crime?**
   Explore cognitions, affects, relational dimensions
   Prompts: What goes through your mind? How does this work make you feel? What affects you most about doing this kind of work?
4. **What have you noticed about your responses when faced with crime victims' stories? In the room at the time? After sessions?**
   Explore immediate and longer-term impacts. Check for symptomatic responses
   Prompts: Why do you think this is? What do these responses mean to you?
5. **Can you recall an instance where a particular case affected you very strongly and tell me something about what you understood was happening in this instance?**
   Explore features of the case that contributed to its impact. Explore the experience of being affected in such a way.
6. **Do these cases affect you in any particular way that might be different from working with other cases, even other trauma cases?**
   Explore points of identification and disidentification and secondary trauma impacts, including behavioural changes.
7. **How have you made sense of what happened to these clients and how has this affected your view of the world, if at all?**
   Explore meaning related shifts and existential positioning, references to contextual features.

8. **Is there anything about working with crime victims in the South African context in particular that you feel is important?**
   Explore how contextual factors may shape aspects of vicarious traumatisation.
9. **Have other people in your life noticed anything about how you are in the world that might be related to your work with crime victims?**
   Explore second party observations and feedback that may be relevant. How have you responded to these observations?
10. **How do you attempt to process what you hear in working with victims of crime?**
    Explore personal processing, self-care strategies, attempts to distance, accessing of supports (professional and personal).
11. **What sustains you in doing this kind of work?**
    Explore supports and self-care.
12. **Was there ever a time when you felt ambivalent about working with these types of cases and if so, can you tell me about this?**
    Explore awareness of cues about becoming over-stressed as well as of limitations, and how one might navigate these spaces if particularly affected.
13. **Is there any advice you could offer to other therapists who might find working with victims of crime in their practice taxing or difficult?**
    Explore resilience, wisdom, vicarious growth.

Appendix E: Ethics Clearance Certificate

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT ETHICS COMMITTEE
CONSTITUTED UNDER THE UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)

CLEARANCE CERTIFICATE:	**PROTOCOL NUMBER: MCLIN/20/02**
PROJECT TITLE:	Vicarious Traumatisation in Psychology Therapists Working with Victims of Violent Crime in Contemporary South Africa
INVESTIGATOR	Lorgat Nasreen (717149)
SCHOOL/DEPARTMENT OF INVESTIGATOR	SHCD/Psychology
DATE CONSIDERED	18 May 2020
DECISION OF THE COMMITTEE	Approved unconditionally
RISK LEVEL	Low Risk
EXPIRY DATE	31 December 2022

ISSUE DATE OF CERTIFICATE 21 May 2020 **CHAIRPERSON** _____
(Dr Esther Price)

cc: Prof. Gill Eagle (Supervisor)

DECLARATION OF INVESTIGATOR

To be completed in duplicate and **ONE COPY** returned to the Chairperson of the School/Department ethics committee.

I fully understand the conditions under which I am are authorized to carry out the abovementioned research and I guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee.

_____ _____/_____/_____
Signature **Date**

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES