PART ONE

PROLOGUE

CHAPTER ONE

INTRODUCTION TO THE STUDY

"Ours is a vision of a just and democratic South Africa in which all its people will enjoy a full and rewarding life" (Nelson Mandela, 2011, p. 234).

1.1 INTRODUCTION

South African society has undergone significant transformation in more than two decades since it has changed from an apartheid-dominated state to a consititutional democracy. Despite significant political developments, the socio-economic conditions of the country are still reflective of South Africa's discriminatory past. In particular, violent crime levels have reached pandemic proportions and the role of the South African Police Service (SAPS) is paramount in the fight against crime. A sector that is not sufficiently acknowledged for their contribution to the fight against crime is the social work personnel employed at the SAPS, in both an occupational and forensic capacity. This study explores how these social workers are affected by and cope with the constant exposure to secondary trauma. In this chapter the rationale and aims of the study are delineated, the anticipated values of the study are given, a brief overview of the research design and methodology is provided and the pre-understandings and limitations of the study are identified. Key concepts which are utilised in this study are defined and finally an overview of the layout of the thesis is given.

1.2 STATEMENT OF THE PROBLEM

South Africa again made international headlines in August 2012 when 34 mineworkers who were striking for higher salaries were killed by the South African Police at the Lonmin Mines near Marikana. This massacre was the worst display of police brutality since the police killings of 69 people at Sharpeville in 1960, who were protesting against having to carry passbooks[1]. This moment at Marikana has been regarded as a turning point in the history of South Africa, a nexus of the socio-economic conditions still prevalent from the apartheid regime and the failure of the current South African government to bring about substantial transformation. What transpired on the 16 August 2012 was a tragedy for all concerned: for the miners who lost their lives; for the families of the miners who lost a husband, a son, a father, the breadwinner of the family; for Lonmin mine, which will forever wear the labels of oppressor and exploiter; for the South African Police Service (SAPS), which also lost two of its members in the massacre; and the SAPS officers involved in the massacre, that day will forever be sketched in their memories. The horrors of that day continued as two of the police officers involved in the tragedy subsequently committed suicide.

[1] During apartheid Africans were required by law to always carry 'passbooks' on their person so that the police could check their identity and determine whether these citizens were in areas where they were allowed to work

The Marikana massacre amplified the story of South Africa's traumatic past, a past that cannot easily be forgotten and without sufficient transformation will continue to infest and permeate every level of society. South Africa's history of colonialism and apartheid were the foundations for legitimising exploitation, discrimination and inequality in society. With the high unemployment rates, increasing poverty, extreme inequality between the rich and poor, the highest number of HIV positive citizens in the world, more than three million orphans and increasing child abuse cases (Meinck, Cluver, Boyes & Mhlongo, 2015), the dire socio-economic reality of the country cannot be disputed. These socio-economic realities are evidence that the country has many milestones to cover before it can shake off the shackles of its oppressed past. The reality of the country is a far cry from the ideals of the iconic leader, Nelson Mandela, who embodied the principles of social justice, equality and non racialism.

Police brutality has been an ongoing discourse in the history of South Africa, as police represent the hegemonic control of the state. The death of the teacher Andries Tatane in 2011 during a service delivery protest and Mido Macia, a Mozambican taxi driver, in 2013 after he was dragged behind a police vehicle for resisting arrest are clear evidence of human rights violations. Violations one would not deem acceptable in a democratic dispensation, especially when the price paid to obtain that democracy was so high. The recommendations of the Farlam commission of inquiry, the government's investigation into the Marikana massacre, suggested that SAPS review the manner in which police are selected, trained and commanded, particularly during public order policing (De Wet, 2015). A further recommendation of the commission was to investigate the Police Commissioner, Rhiya Phiyega's competence to hold office. Phiyega, formerly a social worker, had only been the police commissioner for a few months when the massacre took place. Many critics feel that she did not show the leadership or competence required and believe she must be held accountable.

While all the aforementioned incidents have negatively affected the image of public trust in the police, one needs to consider the highly stressful environment in which police officers are expected to operate. Of the 30 service delivery protests which occur daily, many of them turn violent and police officers are grossly outnumbered by protesters. The reduction of public order policing manpower by former police commissioner, Jackie Selebi, has had dire consequences for the police force as not all police officers have been trained to appropriately deal with mass protests (Hosken, 2015a). With the increase in violent crime, police officers are not sufficiently resourced as they often have to confront criminals who are heavily armed. The killing of police officers has been placed on the national agenda as the number of police officers killed annually has escalated in the past few years. Police officers are simply not adequately resourced and in some cases not adequately trained to deal with the levels of violence in this country. Poorly equipped police stations which do not necessarily have sufficient numbers of vehicles needed to patrol communities and to allow police to respond to emergencies

have also exacerbated the crime situation in this country. Police officers are working under the most strenuous conditions often with limited acknowledgement and support of communities. Police suicides and family murders are a great cause of concern and reflect the violent nature of South African society. Despite a well resourced employee wellness section within SAPS, there is only so much that the professionals within this section can do to assist the police officials with the daily challenges to which they are exposed.

While there are many discourses in the approach to social work, what cannot be disputed is that "from its beginnings, social work's mission has been to improve the interaction between persons and their natural environment" (Allen-Meares & Lane, 1993, p.3). Social work has often been viewed as a noble or honourable profession which strives to improve the quality of people's lives whether on a micro, meso or macro level. However, also inherent in the profession of social work are aspects such us low pay, high caseloads, demanding clients and limited resources. Consequently, it can be deduced that social work has the potential to be a stressful profession. If one accepts that social work is likely to be stressful, the question arises as to what additional stress a social worker is likely to experience while employed and working in a traumatogenic environment such as the South African Police Service.

The science of traumatology is an ever-growing and expansive one. Traditionally, empirical research has focused on primary traumatisation, the responses of victims of primary trauma and the conceptualisation of Posttraumatic Stress Disorder (PTSD). However, in the last three decades, the area of secondary traumatic stress has received significant attention and acknowledgement. In particular, the work of traumatologists like Figley, Pearlman and Hudnall Stamm has deepened our understanding of the far-reaching effects of trauma, and helped to make foundational shifts in the conceptual development of secondary traumatic stress. Figley (1995) articulates the view that the number of victims of violent crime is generally underestimated as only those who experience the trauma directly are included in statistics on crime. These figures exclude those who may suffer from secondary trauma as a result of the event, particularly the friends and family members of a victim as well as the professionals who provide trauma counselling.

Moreover, Figley (1995) argues that those indirectly exposed to trauma tend to experience similar symptoms as those directly exposed to traumatic stress. He identifies various areas in which the practitioners may experience secondary traumatic stress in their personal lives. These include: cognitive, emotional, behavioural, spiritual, interpersonal and/or physical effects. It would therefore be useful to be able to identify the area/s in which the symptomology of secondary traumatic stress presents in South African social workers exposed to such traumatic experiences. Hence, it was felt that this area needed further exploration and understanding.

Most studies, particularly those derived from outcomes-based research, which have explored the therapeutic relationship, have focused upon the clients and client outcomes. When the research focuses on the practitioner, this focus predominantly addresses counter-transference dynamics. In the past there were few studies that explored the impact of therapy upon the counsellor (Pearlman & Mac Ian, 1995). However, the growing field of trauma counselling has changed this scenario and in recent years far more focus and attention have been placed on the impact of trauma work on mental health practitioners (Bride, 2007b; Figley, 1995; Hunter & Schofield, 2006). This exposure can be understood to be a particular occupational stress of many of the helping professions. Some authors (e.g. Bride, 2007b; Robinson-Keilig, 2014) even consider this indirect exposure to traumatic material from clients to be an occupational hazard.

South Africa is a particularly violent country that has been characterised by and has experienced much brutality and social division (Higson-Smith, 2008). Following the end of apartheid, the violence changed from political violence and continued in the form of criminal violence (Hamber & Lewis, 1997). Such crime, particularly violent crime, has reached pandemic proportions (Bruce, 2006a) and consequently, the extent of trauma that police officials deal with has increased significantly (Steinberg, 2008). Police stress in South Africa has received much attention from researchers and academics (Bruce, 2007; Dixon, 2012; Steinberg, 2008), however what about the forgotten population which exists within the SAPS, the social workers who work alongside detectives or who provide assistance for these officers? It seems reasonable to assume that the amount of traumatic material to which social workers who counsel the police officers or who assist police with forensic investigations are exposed, is likely to increase. The question arises: how are these social workers affected, and what coping strategies do they employ?

Trauma counselling entails the victim disclosing often emotionally intensive and often disturbing experiences which challenge the belief that the world is a safe and just place. Wilson and Lindy (1994) explain that this experience may cause the therapist to feel disturbed and to temporarily challenge their ability to be objective, caring and nurturing which the professional role requires. The therapist therefore needs to be aware of counter-transference and the complexities that this factor may bring to the therapeutic relationship. Bride (2007a) has extensively researched the effects of secondary traumatic stress with social workers in the Unites States of America. From his findings, Bride (2007a, p. 4) concluded, “Social workers may hear about burnout and they may hear about self care, but they’re not hearing about secondary posttraumatic stress disorder”. Somehow, in the midst of the huge demands required of social workers in assisting others, their own health and well-being are often forgotten or neglected.

1.3 RATIONALE FOR THE STUDY

There is an expectation that professional therapists should be able to manage and have the necessary intellectual, cognitive and social supports to cope with traumatic situations. The very essence of trauma counselling is to help others cope with traumatic experiences. It would seem paradoxical that professional therapists working with trauma victims may themselves be unable to cope with traumatic situations or even listen to accounts of traumatic situations. For this very reason therapists may not openly acknowledge what they are experiencing, so that the extent of secondary traumatic stress of therapists may be underestimated.

The work environment and working conditions are critical aspects to explore when trying to understand the world of trauma therapists. Whilst the subjective experience of trauma influences the presence and extent of secondary traumatic stress, other variables appear to be quite consistent in their relationship to the development of secondary traumatic stress. For example, Steed and Bicknell (2001) found that a primary factor influencing this development was the extent of the practitioner's caseload. They highlighted the fact that their findings reinforced previous qualitative and quantitative studies that found that those practitioners with higher caseloads experienced more vicarious trauma (MacRitchie, 2006).

Against this backdrop, the primary aim of this research was to explore and understand the extent of secondary trauma that social workers, who were employed by the South African Police Service (SAPS) experienced. Numerous terms are used to describe professional caregivers' stress reactions that result from indirect trauma exposure, namely: secondary traumatic stress; compassion fatigue; burnout and vicarious trauma to mention a few (Badger, Royse & Craig, 2008). However, these terms have been used interchangeably and often inappropriately by various researchers. This research attempts to explore the historical emergence and development of these constructs and endeavours to delineate their meanings.

As Figley (1995) points out, there are two reasons why it is important to understand how therapists themselves become traumatised through their work with traumatised clients. Firstly, one can try to ameliorate the effects of secondary traumatic stress if one understands the process. Secondly, supervisors can enhance the quality of care that therapists give to clients if the therapists themselves are adequately supported. It is therefore necessary to explore the stressors that therapists experience and the necessary supports that practitioners identify. Moreover, if more support was offered through effective structures, this strategy might help to improve the quality of service delivery to clients who have experienced trauma.

One of the structures that is recognised in both the professions of psychology and social work as having a supportive and advisory role is that of supervision. The general functions of this role include

containment, support, validation, encouraging autonomy, assistance with administration, education, and providing opportunities for feedback and assessment. Moreover, Exley (2006, p.78) points out that "Elucidating transference and counter-transference has always been considered an important aspect of supervision". While the structures of supervision should theoretically assist the practitioner with the stressors of the job, this ideal is not always the reality.

It was therefore deemed important to explore the factors that contributed to or detracted from the development of resilience in response to the stressors engendered by trauma counselling in the workplace. In addition, another important support structure that could assist trauma therapists is their own personal growth and insight development. As Yalom (2001, p.13) emphasises, "One of the great values of obtaining intensive personal therapy is to experience for oneself the great value of positive support". Again, this scenario involves practising what we preach. If the essence of therapy is to assist clients and improve their coping ability, the question arises whether therapists utilise this resource themselves. This study therefore aimed to explore how the social workers tasked with counselling police officers personnel themselves cope with the continual exposure to secondary trauma, or if in fact they are able to cope.

The researcher's personal interest in the area of traumatology was also motivated by her previous work experience, as she had worked for eleven years as a social worker for Johannesburg Emergency Management Services and Johannesburg Metropolitan Police Department assisting paramedics, fire-fighters and Metro police officers to cope with the traumatic nature of their work. Her Masters research explored how South African paramedics coped with the ongoing exposure to trauma. Working within a traumatogenic environment deepened the researcher's understanding of the acute and long term effects of secondary trauma exposure. This awareness, as well as the researcher's own personal responses to dealing with the trauma of others, ignited her interest in understanding how other social workers experienced and coped with the traumatic material to which they were exposed through their work. She subsequently joined the academic staff of the Department of Social Work at the University of the Witwatersrand where she retained her interest in trauma during the ensuing ten years through lecturing on this topic, among other lecture courses, and counselling traumatised clients via her private practice. This research study represents the fruits of that journey through the field of trauma.

1.4 ANTICIPATED VALUE OF THE STUDY

The potential significance of this research can be located within the following categories:

1.4.1 Development of Theory

It was envisaged that this research would enhance understanding of the extent and experience of secondary traumatic stress, vicarious trauma, compassion fatigue, compassion satisfaction, burnout, coping and the work environment among social workers employed in the South African Police Service (SAPS). Empirical data in respect of these theoretical constructs could potentially support or mitigate current theories and understandings. It was further anticipated that the findings from the study might lead to the formulation of a model which could potentially contribute to existing knowledge of secondary trauma particularly in traumatised and divided societies like South Africa.

1.4.2 Implications for Policy Development

The development of theory can assist and guide those who draft policy. It was hoped that this research would highlight the need for a specific policy to be drafted by SAPS in order to assist the social workers within the organisation in order to deal with the effects of secondary trauma exposure.

1.4.3 Implications for Social Work Education

As secondary trauma exposure is considered an occupational hazard of social work practice, social work educators have an obligation to educate and prepare social workers for the indirect effects of trauma exposure. Social work curricula need to sufficiently incorporate traumatology and equip students with the necessary knowledge and skills to ameliorate the negative effects of trauma. Students also need to learn about resilience and how positive professional growth can develop through primary and/or secondary trauma exposure.

1.4.4 Implications for Social Work Practice

Social workers need to understand the impact of secondary traumatic stress on their personal and professional lives, taking into particular consideration how their clients and client systems may be adversely affected. Moreover, it was expected that the research would have implications for practice by identifying the coping mechanisms utilised by therapists. The assumption was that SAPS would be able to utilise these findings and ensure that there are effective mechanisms available to social workers, thereby helping social workers cope more effectively with the trauma to which they are exposed during the course of their work, and ensuring that they offer high quality professional services.

1.4.5 Implications for Supervision and Support

If social work supervisors have a greater understanding of the impact that secondary trauma has on social workers, they are likely to be in a better position to be able to provide more appropriate and effective guidance and support to their supervisees.

1.4.6 Stimulation of Future Research

As this study explored and researched certain constructs, it is hoped that interest in this topic will be ignited and that further research studies in this area will be conducted. The longanimity of social workers needs to be acknowledged and opportunities created where their stories can be heard. Furthermore, the salience of the SAPS social workers' experiences needs to be recognised. Stories of resilience and posttraumatic growth also need to be told, so that social workers can learn from each other.

In summary, it was envisaged that the findings would have possible implications for theory, policy development, social work education, clinical practice, supervision and support as well as future research.

1.5 PRIMARY AIM, RESEARCH QUESTIONS AND OBJECTIVES

1.5.1 Primary Aim

To explore the nature and extent of secondary traumatic stress and coping experienced by social workers employed at the South African Police Service.

1.5.2 Research Questions

The following research questions were formulated:

1. What is the nature and extent of secondary traumatic stress, vicarious traumatisation, compassion satisfaction, burnout, coping and resilience in social workers employed by the South African Police Service, as measured by standardised scales?
2. Do marital status, work experience and type of work (occupational or forensic social work) affect the manner in which social workers experience and cope with secondary trauma?
3. What are participants' perceptions of the work environment as measured by Moos's (2008) Work Environment Scale?
4. Is there a relationship between secondary traumatic stress, vicarious traumatisation, compassion satisfaction, burnout, coping resources, resilience and the work environment as measured by standardised scales? If so, what is the nature of this relationship?
5. In what ways, if any, do social workers think they have changed, or their relationships with clients have changed as a result of the constant exposure to traumatic material?
6. How do the participants understand transference and counter-transference reactions in the counselling relationship?
7. What coping mechanisms do social workers identify within themselves and their environment which help them cope with the continual exposure to traumatic material?
8. What factors do social workers identify which contribute to resilience?
9. How does the work environment influence the manner in which social workers cope with secondary trauma?

10. What recommendations would these social workers make to (a) SAPS to improve the work environment; and to (b) social workers to limit or curtail the effects of secondary trauma?

1.5.3 Secondary Objectives

The research objectives emanated from the research questions:

1.5.3.1 Secondary objectives for the quantitative data collection phase

1. To determine the extent of secondary trauma exposure experienced by the social workers employed in the SAPS as measured by Norris's (1990) Traumatic Stress Schedule.
2. To measure the prevalence of secondary traumatic stress according to Bride, Robinson, Yegidis and Figley's (2004) Secondary Traumatic Stress Scale.
3. To ascertain levels of vicarious trauma experienced by practitioners, as determined by Pearlman's (2003) Traumatic Attachment and Belief Scale.
4. To measure levels of compassion satisfaction experienced by practitioners, and determined by Hudnall Stamm's (2010) Professional Quality of Life Scale (ProQOL).
5. To determine the levels of burnout as measured by Hudnall Stamm's (2010) Professional Quality of Life Scale (ProQOL).
6. To measure the ten work dimensions identified in Moos's (2008) Work Environment Scale.
7. To identify the levels of coping resources that practitioners utilise as assessed by Hammer and Marting's (2004) Coping Resources Inventory.
8. To ascertain levels of resilience as measured by Wagnild's (2009) Resilience Scale.
9. To determine the nature and extent (if any) of the relationships between secondary trauma exposure, secondary traumatic stress, vicarious traumatisation, compassion satisfaction, burnout, the work environment, coping resources and resilience as experienced by the social workers working for the South African Police Service.

1.5.3.2 Secondary objectives for the qualitative data collection phase

1. To understand the nature of the secondary trauma exposure experienced by the social workers employed at SAPS.
2. To explore the phenomenon of secondary traumatic stress among SAPS social workers.
3. To ascertain whether participants' worldviews have changed as a result of the secondary trauma exposure and to explore the phenomenon of vicarious trauma in the qualitative interviews.
4. To determine whether participants experience compassion satisfaction in their work.
5. To understand participants' experiences of burnout.
6. To explore participants' experiences of the SAPS work environment.
7. To identify practitioners' trauma coping mechanisms (formal and informal).

8. To explore the phenomenon of resilience with the interview participants.
9. To elicit information on practitioners' awareness of transference and counter-transference and whether they recognise the impact of these factors on the counselling relationship;
10. To obtain recommendations from participants (a) in order to improve the work environment and (b) to reduce the negative effects of the traumatic material encountered in their work.

1.6 OVERVIEW OF THE RESEARCH DESIGN AND METHODOLOGY

The research employed a mixed methods design involving a combination of exploratory, descriptive and correlational designs, which also incorporated both qualitative and quantitative paradigms. The unit of investigation was social workers working for the South African Police Service.

The stages of the research process are depicted in Figure 1.1. In the first phase the entire population of social workers (approximately 200) who were employed at SAPS at the time of the study, were invited to participate in the research. In the quantitative phase, seven standardised tools were administered which measured: exposure to secondary trauma, secondary traumatic stress, vicarious traumatisation, burnout, compassion satisfaction, resilience and the work environment.

Most of these scales were administered in group settings. Some, however were self-administered as the researcher posted the survey questionnaires to some of the provinces that could not accommodate her visits. In total 132 respondents completed the survey, 4 were unusable; hence 128 were incorporated in the study. The data collected in this phase were analysed using descriptive and inferential statistics. Specifically, correlations, multiple regression and structural equation modeling techniques were used.

In the second phase 30 qualitative interviews were conducted using a structured interview schedule. The schedule explored social workers' experiences of secondary traumatic stress and vicarious trauma. Various methods of data collection were employed, including telephonic, Skype and face-to-face interviews. The responses from these interviews were analysed using thematic content analysis. These qualitative findings were used to expand and explain the results obtained from the quantitative data collection phase. The data from both stages of the data collection phases were combined and presented in the thesis.

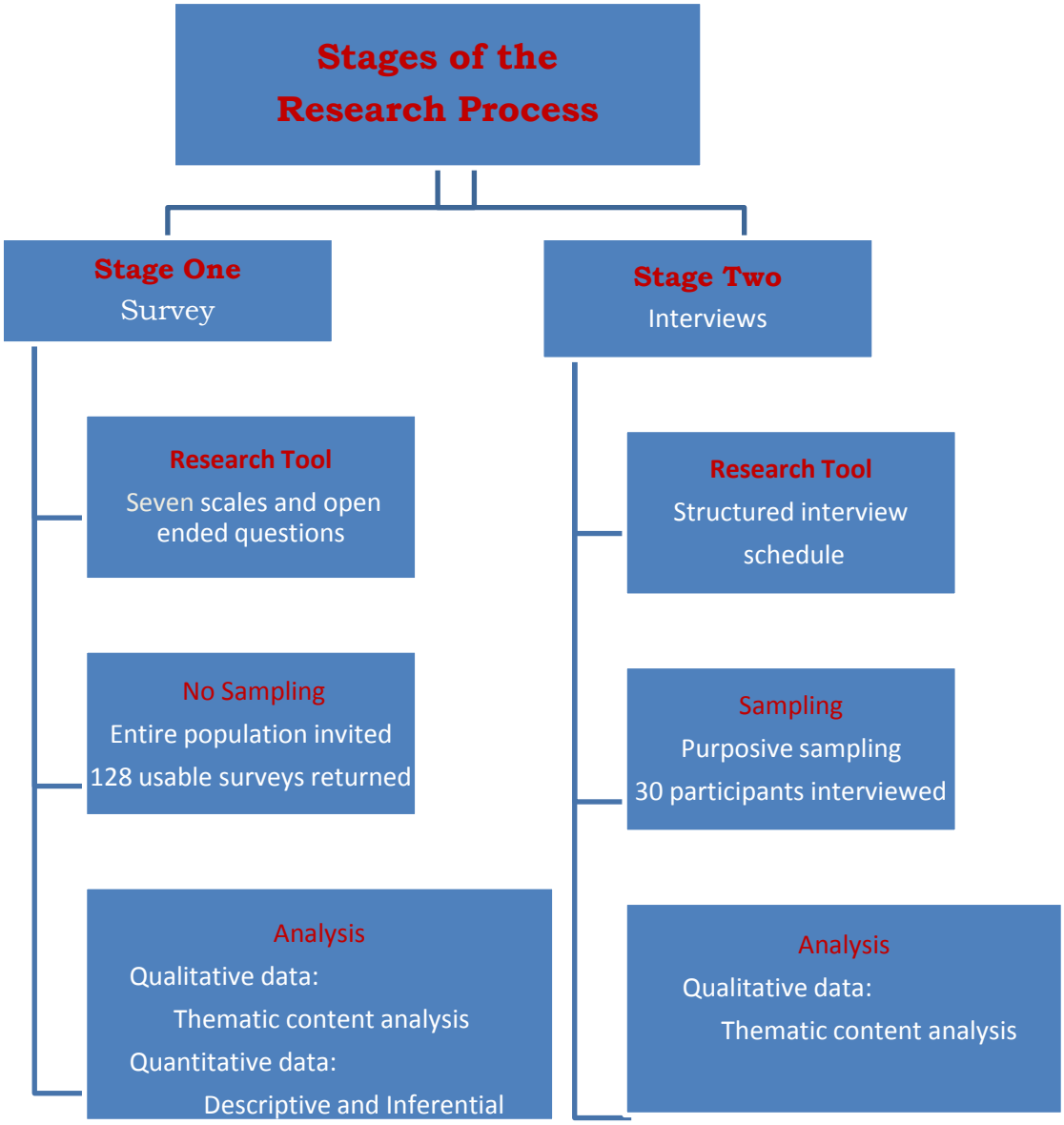


Figure 1.1: The Stages of the Research Process

1.7 THEORIES UNDERPINNING THE STUDY

Due to the complex and multi-faceted nature of trauma, various interrelated theories formed the theroretical lens for the study. The theories that underpin this study included theories relating to secondary or indirect traumatic exposure. In particular, Figley's (1995) conceptual understanding of secondary traumatic stress was used to guide and inform the study. This theory of secondary traumatic stress posits that an individual who may not directly have witnessed a traumatic event may experience the same symptoms of trauma as an individual who has experienced primary traumatisation.

Pearlman and Saakvitne's (1995a) understanding of vicarious trauma formed another important theoretical framework for the study. Their theory, which is based on constructivist self-development theory, postulates that the counsellor's inner beliefs and cognitive schema can be altered as a result of exposure to a client's traumatic story. The theories about secondary trauma and vicarious trauma also indicate factors that contribute to an individual's vulnerability to developing secondary and vicarious traumatisation. Moreover, theories on coping and resilience play an integral role in understanding the role of coping, both before and after the secondary traumatic exposure. Wagnild's theory of resilience was used to understand the characteristics of resilience in the social workers. In addition, Radney and Figley's (2007) understanding of how exposure to secondary trauma can result in the development of compassion fatigue and/or compassion satisfaction, highlighted the importance of exploring both positive and negative effects of secondary trauma exposure.

Maslach's (1986) understanding of burnout and how burnout is comprised of three dimensions namely, emotional exhaustion, depersonalisation and deteriorating work performance was another important theory incorporated within the study. Maslach and Leiter (1997) emphasise how a work environment can contribute to the burnout levels in employees. Accordingly, Moos's (2008) understanding of dimensions and factors that comprise the work environment were included as part of the theoretical framework of this study. Finally, Hudnall Stamm's (2010) conceptual framework of compassion fatigue helped to portray how compassion fatigue is comprised of both burnout and secondary trauma.

1.8 PRE-UNDERSTANDINGS UNDERPINNING THE STUDY

As a mixed methods research design, the study included both quantitative and qualitative components. With reference to the second component, qualitative researchers are encouraged to be aware of their subjective beliefs and understandings about the subject under study (Wolcott, 2009). The researcher's pre-understandings included the following:

- As the field of traumatology has developed in the last few decades, so have understandings of the impact of secondary trauma on mental health practitioners. Terms such as secondary traumatic stress and vicarious trauma have been developed to explain these effects. While some theorists maintain that these terms are synonymous, others believe there are differences in the concepts. The premise of the study is that despite the obvious overlaps there are conceptual differences between the terms. As such the researcher understands the terms in the following frames of reference: secondary traumatic stress is similar to that of posttraumatic stress with the nature of the stressor factor varying. Vicarious trauma refers to significant changes in cognitive schema and beliefs of the therapist as a result of prolonged exposure.

- South Africa is a country in transition as it has changed from an apartheid-dominated society to a constitutional democracy. Despite significant political change, more than twenty one years after the election of a democratic government, the socio-economic conditions of the country have not changed for the majority of the population. The levels of unemployment, poverty and violent crime are residual factors resulting from the apartheid system. The crime situation is exacerbated by ineffective and under resourced judicial and policing systems, easy access to weapons and corruption within government and private sectors.

- The South African Police Service has the insurmountable task of protecting citizens and maintaining law and order in one of the most violent countries in the world. The poor public image of the SAPS is reinforced by the constant change in SAPS leadership, the ongoing reports of police brutality and deviant police officials as well as the tragedy of the Marikana massacre. Significantly under resourced and constantly criticised by the public, police morale has been adversely affected by the events that have occurred in the past few years. The working conditions of the police officers are extremely precarious and their safety cannot be guaranteed as they put their lives on the line on a daily basis to serve the public. As a result of their occupational stress, the psycho-social functioning of many police officers is adversely affected, which is evident in the high police suicide rates and police family murders.

- The social work profession is in constant flux as the profession adjusts to meet the changing demands of society. Social work is a profession that is inherently stressful as social workers try to institute change and assist vulnerable individuals with limited resources and support. The poor image and status of the social work profession, low salaries and adverse working conditions all contribute to high levels of occupational stress within the profession.

- Social workers may experience secondary traumatic stress as they endeavor to assist clients who have experienced traumatic events (Bride, 2007a; Killian, 2008). For SAPS occupational social workers this exposure to traumatic material may occur through listening to the traumatic experiences of police officers and for the SAPS forensic social workers as a result of conducting forensic investigations into allegations of child abuse. Secondary traumatic stress may negatively impact on social workers at both personal and professional levels and result in poor service delivery to clients. As a result of their work, social workers may experience changes in their world views, their views on humanity and their own sense of meaning.

- With constant exposure to traumatic material social workers develop various coping strategies, strategies which may be adaptive or maladaptive, conscious or subconscious. Personality traits, levels of resilience and support structures are all factors that are likely to influence the extent of the

traumatisation of the social worker. Research has also indicated that there are gender differences in the styles and coping strategies employed by men and women (Aldwin, 1994; Friedman, 2006).

1.9 LIMITATIONS OF THE STUDY

The limitations of this study are mentioned appropriately in the discussion chapters as well as the research design and methodology chapter. In addition, the following limitations of the study are acknowledged:

- This study was designed prior to 2013; some of the research tools utilised were based on the diagnositic criteria of PTSD as determined by the Diagnostic and Statistical Manual of Psychiatric Disorders (DSM) Version IV-TR prior to the publication of Version 5. One of the most significant changes occurred in the identification of the trauma exposure (criterion A) (American Psychiatric Association, 2014). This study was planned utilising research tools that were developed on the DSM IV-TR understanding of PTSD and trauma classifications, although these changes may not have been particularly significant for this study. Furthermore, it is acknowledged that most of the research tools used in this study were designed in America and are based upon Western understandings of trauma and may not take into account the cultural understandings of trauma within an African context. However, understandings of trauma in South Africa are still predominantly based on Western conceptualisations and theories and there is a paucity of South African trauma measurement tools. In order to make the research tools more appropriate for the South African context, the wording of some of the items was adjusted in two of the scales. As a result the reliability and validity of these scales may have been affected, which is an acknowledged limitation of this study.

- Previous research has shown that a mental health practitioner's experiences of personal trauma may influence their levels of secondary and vicarious traumatisation. However, due to the already large scope of this study, exploration in this area was not included, which is acknowledged as a limitation of this study.

- The cross sectional design of the study meant that longitudinal inferences or conclusions could not be established. As such the research indicates the experiences of social workers at a specific time and in a specific space, and is a limitation of the study as the causal factors of secondary traumatic stress could not be determined.

- The researcher tried to understand the amount of secondary trauma to which participants were exposed through inquiring about two aspects: Firstly, the researcher asked the participants to indicate how much time they spent counselling in comparison to their other duties. However, most participants did not give the percentage breakdown that was required and instead simply indicated

that counselling was one of the tasks that they fulfilled in their work, in addition to facilitating training workshops and completing administrative requirements. Secondly, the researcher attempted to establish the number of traumatic cases that practitioners had dealt with in the previous six months through the use of the Traumatic Stress Schedule (TSS) which identifies different traumatic situations and then asks the respondent if they have been exposed to that traumatic stressor and how frequently in the last six months. However, more than half the survey participants did not complete the column that inquired about the frequency of the trauma and so for validity purposes, the researcher did not include the frequency of trauma exposure in her analysis, but instead explored the number of different traumatic stressors to which participants were exposed (the first column on the TSS). In order to establish the extent of the secondary trauma exposure, the researcher explored this aspect in the interviews and found that this exposure was substantially different from person to person. The lack of data on frequency of trauma exposure is considered a limitation of the study and the researcher recommends that further research be conducted in this area.

- In qualitative research the objectivity of the researcher can always be questioned. The objectivity of the researcher can be questioned not only in the manner in which data are collected but also in the manner in which the data are analysed. In order to limit possible research bias, the researcher kept an audit trail and incorporated reflexivity practices.

- As social workers are not always knowledgeable about secondary traumatic stress, they may have been reluctant to talk about difficulties they had experienced as a result of their work. They may also have been reluctant to acknowledge difficulties because the inability to cope as a social worker in the South African Police Service (SAPS) may be perceived as a vulnerability and weakness, contrary to the macho culture that is advanced in the SAPS.

- Although social workers in South Africa may be confronted by similar work challenges as the social workers in the study, the unique work environment of the South African Police Service, suggests that it may not be possible to generalise the findings beyond the social workers employed at SAPS.

- The researcher designed the study a few years ago in order to explore the effects of secondary trauma on SAPS social workers. Developments in the world of traumatology in the last decade or so have expanded significantly to focus greater attention on the positive aspects of trauma exposure. In particular, constructs such as ‘vicarious resilience’ and ‘shared resilience’ warrant further exploration. While the issue of posttraumatic growth of these social workers was explored, this construct was not the primary focus of this study. In hindsight, if the researcher were to redesign the study, she would shift the focus of this research accordingly. Consequently, one of the recommendations for further research encapsulates this notion.

1.10 DEFINITION OF KEY TERMS

Burnout: "According to the ecological paradigm, burnout is viewed as a form of ecological dysfunction or misfit between people and their ecosystems, representing the imbalance or misfit between environmental demands and stress-coping resources" (Ross, 2010, p. 403). Maslach (2003) emphasises the fact that burnout has three dimensions namely emotional exhaustion (feeling drained), depersonalisation (emotional hardening) and a sense of inefficiency (that work contributions are not effective).

Compassion Fatigue (CF): This term was first coined by Joinson in 1992 in discussing burnout among nurses. According to Figley (1999, p. 10), compassion fatigue is "the natural, consequent behaviours and emotions resulting from knowledge about a traumatising event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatised or suffering person".

Compassion Satisfaction (CS): Radney and Figley (2007) take an approach that is rooted in positive psychology and try to look for feelings of fulfillment in working with clients. They term this experience compassion satisfaction.

Coping is a multidimensional and multifaceted phenomenon that is mediated by many variables (Wilson, 1989). Lazarus and Folkman (1984, p. 210) define coping as "consisting of cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person".

Counter-transference (CT) refers to the therapist's own emotional reactions to the client or any disruption that may cause the therapist's attitude not to be neutral (Dryden, 1990).

Posttraumatic Stress Disorder (PTSD): The American Psychiatric Association's Diagnostic and Statistical Manual - Version 5 identifies PTSD as a trauma and stressor-related disorder that is comprised of an exposure category and criteria that include: re-experiencing the traumatic event, numbing and avoidance, and increased arousal and vigilance (Levin, Kleinman & Adler, 2014).

Resilience: Jacelon (1997, p.123) defines resilience as "a personality characteristic that moderates the negative effects of stress and promotes adaptation".

Secondary Traumatic Stress (STS) according to Figley (1999, p. 10) is "the natural, consequent behaviours and emotions resulting from knowledge about a traumatising event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatised or suffering person".

Transference: The term 'transference' refers to the feelings, thoughts and fantasies that patients have towards their therapists. Within the therapeutic relationship repressed aspects from childhood are often expressed (Smith, 1990).

Vicarious Trauma (VT) is a term that was first used by McCann and Pearlman (1990a, p. 217) and is defined as "an accumulation of memories of clients' traumatic material that affects and is affected by the therapists' perspective of the world".

1.11 ORGANISATION OF THE THESIS

This thesis is divided into six parts including the prologue; the theoretical lens framing the study; the context of the study; the empirical research; the findings and discussion section and the epilogue.

Part one comprises the prologue or introduction to the study. Chapter one provided an introduction to the research study; explained the motivation and rationale for the research; and clarified the research aims and objectives. A brief overview of the research design and methodology was provided; and the pre-understandings and limitations of the study were identified. Key concepts used in the study were defined and finally the organisation of the thesis was described.

Part two, comprising three chapters, locates the study within the theoretical lens that underpins the study. A synopsis of the history of the development of trauma is provided followed by an exploration of the understandings and effects of primary traumatisation. The effects of indirect traumatisation namely: secondary traumatic stress, compassion fatigue, compassion satisfaction, vicarious trauma and burnout are also clarified.

In the second theoretical chapter, theories of coping are discussed. The construct of resilience is also explored and strategies to ameliorate the effects of indirect trauma on a personal, professional and organisational level are identified. The last chapter in this section discusses theories of work and factors that influence employee stress as well as the development of employee wellness programmes.

Part three addresses the South African and professional contexts which are applicable to this study. The first of the two chapters in this section explores South Africa as a traumatogenic society. The socio-economic context of the country is discussed as it contributes to the levels of violent crime in society. The history of work during the apartheid era provides insight into the complex dynamics that preceded contemporary South African workforces. Models of occupational stress and work variables that influence occupational stress are tabled. Moreover, the work environment of SAPS is explored, as this organisation is the setting where participants in this study were employed. The second chapter discusses the nature and development of the social work profession internationally and in South Africa.

Part four incorporates the empirical aspect of this study and comprises one chapter. In this section, the research design is explicated. The type of research design that is utilised is explained as well as the triangulation of both qualitative and quantitative paradigms. The nature of sampling is clarified as well as the research procedures that were used. The research tools are each explained as well as the procedures used to analyse the relationship between the variables that the tools measured. Strengths and limitations of the study are highlighted and the ethical considerations are expounded upon.

Part five comprises four chapters in which the results and discussion are presented. In chapter seven, the demographics of the respondents are described and the findings and results of the traumatic stress schedule and the secondary traumatic stress scale are given. In chapter eight the results of the trauma and attachment belief scale, the burnout scale, the compassion satisfaction scale and the work environment scale are provided. Interview participants' understandings of transference and counter-transference are also analysed and discussed. In chapter ten, the coping dimensions and the resilience levels of participants are explored as well as participants' recommendations to reduce the effects of secondary trauma. In chapter eleven the quantitative findings from the different scales are integrated within various regression models and two structural equation models depicting the complex correlations of the variables used in this study.

In **part six** the epilogue, the summary of the main findings and the conclusions emanating from the findings are presented. The thesis culminates in recommendations for policy, social work education, social work practice and future research.

PART TWO

THE THEORETICAL LENS

FRAMING THE STUDY

CHAPTER TWO

TRAUMATOLOGY

> ***"When you open your life to the living (your clients, students or patients), all things come spilling in on you, and you're flowing like a river, the changer and the changed…it's an endless waterfall, like the rain falling in the ground, all around" (Williamson, 1975 as quoted by Skovholt, 2001, p. 124).***

2.1 INTRODUCTION

Today, the science of traumatology is a burgeoning field as there are numerous debates and interpretations that theorists have put forward to explain not only the effects of trauma but also the very concept of trauma, debates that are still ongoing today. The word trauma originates from the Greek word "traumat" which means "to tear" or "to puncture" (Courtois & Ford, 2009). While this understanding was generally associated with the medical world, psychological trauma "refers to psychological wounding and the penetration of unwanted thoughts, emotions and experiences into the psyche or being of the person" (Kaminer & Eagle, 2010, p. 2). In the past, there has been a tendency to discredit the victim rather than acknowledge the fragility and evil nature of humans (Joseph, Williams & Yule, 1997; Matsakis, 1998). However, through political movements and social contexts, social consciousness has grown and the disempowered have been given a voice. Herman (1997) postulates that the study of psychological trauma depends on the support of political movements. The history of trauma is therefore not a simple story that can be told in linear progression without understanding the social constructions of experience as well as the cultural and political ideologies that shape society.

Traumatic events have been called the ultimate or most severe stressors. Furthermore, traumatic stress is differentiated from other types of stress by the severity of both the event and the response (Hesse, 2002; Kaminer & Eagle, 2010; Kira, 2001). The ubiquitous nature of trauma shows how pervasive it is within every level of society. Even those who work with traumatised populations are themselves exposed indirectly to the trauma and can experience secondary traumatic stress (Figley, 1995; Hudnall Stamm, 1999).

This research study is located within the theoretical framework of secondary traumatic stress. As the dialect of traumatology has progressed, so the theoretical and empirical research into the area of secondary traumatic stress has advanced and formed the theoretical imperative for this study. While many of the concepts relating to working with trauma victims are used interchangeably there are significant differences in the meanings and interpretation of terms. Concepts such as "secondary

traumatic stress", "vicarious trauma", "compassion fatigue" and "burnout" are often used synonymously. An explanation of the terms trauma, posttraumatic stress, secondary trauma, vicarious trauma, compassion fatigue, compassion satisfaction, burnout and shared trauma is therefore provided in an effort to address the taxonomy of concepts related to indirect trauma and locate the theoretical underpinnings of this study.

This chapter explores the history and development of psychological trauma. Firstly, a brief overview of the history of trauma is presented, and then direct trauma is explained with specific emphasis on post-traumatic stress disorder. An explanation of indirect traumatisation follows, with efforts made to clarify concepts such as secondary traumatic stress, vicarious trauma, compassion fatigue and burnout. An overview of the different theoretical frameworks and treatment models of trauma as well as posttraumatic growth is provided. The chapter concludes with a discussion of trauma and culture.

2.2 OVERVIEW OF THE HISTORY OF TRAUMA

Evidence of trauma responses date as far back as the ancient Greeks. For example, during the Battle of Marathon in 490 BC the historian Herodotus wrote about an Athenian soldier who after witnessing the death of another soldier standing next to him became permanently blind even though he had no physical wounds (Matsakis, 1994). Political and theoretical influences have played a significant role in the history of understanding trauma and the impact on individuals and society alike (Everstine & Everstine, 1993; Wilson, 1989). In tracing this history, Herman (1997) identifies three specific types of trauma that have emerged in the last century, namely hysteria, war neurosis and neurosis of the sex wars.

In France in the late nineteenth century, Charlot, a neurologist, was one of the first persons to study trauma and name it as such. He postulated that hysteria had a psychological base but could not find a reasonable cure for the condition. In the 1890s, Janet in France and Freud and Breuer in Vienna furthered the belief that hysteria is a condition caused by psychological trauma. This altered state of consciousness occurred as a result of unbearable emotional responses to trauma. Freud initially posited that hysteria was a condition that emanated from an individual's experience of premature sexual experience. Freud later repudiated this claim and emphasised two important aspects, namely the effect of fright as well as the subjective nature of the trauma. Furthermore, he highlighted human vulnerability to trauma and the fact that no one was immune to its effects. However, by the turn of the century the study of hysteria had dissipated (Herman, 1997).

After the First World War the reality of psychological trauma was recognised due to soldiers' emotional responses to the war. Initially mental breakdowns were attributed to having physical causes and were treated from this position. However, it was later found that the emotional stress of

prolonged exposure to violent death was sufficient to produce a neurotic syndrome that resembled hysteria in women. This finding was again highlighted through studies on the impact of military combat such as the Franco-Prussian War and the two World Wars. In the late 19th century clinical attention became focused on the effects of war, including the cardiovascular effects (called soldier's heart, Da Costa's syndromes, neurocirculatory aesthenia) or psychiatric symptoms (shell shock, combat fatigue or war neurosis). What was particularly evident to physicians during this period was that survivors of military trauma often presented with both physiological and psychological symptoms (Friedman, 2006). In 1980 Posttraumatic stress disorder was officially recognised as a distinctive category in the Diagnostic and Statistical Manual III (DSM III) (American Psychiatric Association, 1980). Since then, there has been an explosive proliferation of research, theories, debates and understandings regarding the world of trauma.

The third type of trauma that Herman (1997) identified was the trauma of the gender wars, specifically gender and domestic violence. With the advent of the feminist movement in Western Europe and North America in the 1970s, recognition and acknowledgment of gender violence increased dramatically. The reality of women's lives was no longer as hidden as previously and instead it was realised that sexual assault against women was pervasive and endemic. The prevalence of violence in a particular society tends to coincide with the prevalence of domestic violence (McKendrick & Hoffman, 1990, p.9). This association is explained by these authors who refer to the family as the 'cradle of violence'. They emphasise that violence in society and violence in family life are inextricably linked. Psychological investigations into domestic violence and child abuse have also led to a rediscovery of the effects of psychological trauma (Nadelson, Notman, Zackson & Gornick, 1982).

While society initially struggled to acknowledge each type of trauma as it emerged, Herman (1997) posits that today's understanding of trauma is built upon a synthesis of each of these lines of investigation. The following section explains some of these understandings and provides a comprehensive taxonomy of trauma.

2.3 THE CONCEPTUALISATION OF TRAUMA

2.3.1 Defining Trauma and Traumatic Stress

According to Friedman (2006), when 'trauma' was first introduced in the DSM III criteria for PTSD more than thirty years ago, it referred to a catastrophic event that would evoke significant symptoms of stress in almost anyone. However, as understandings of trauma and PTSD developed, what became apparent was not only the exposure to a catastrophic event but also the intense emotional response of fear, helplessness or horror evoked in the person. Consequently, some authors, such as Kaminer and Eagle (2010, p. 2), refer to trauma as both a stimulus of a catastrophic nature and the severe distress that occurs from such an event. Trauma is defined by Bremner and Marmer (1998, p.98) as

"emotional shock (psychic trauma) with a lasting effect; a disordered psychic or behavioural state resulting from mental or physical injury". This definition emphasises the lasting effect or state that results from trauma. Pearlman and Saakvitne (1995a, p.60) define psychological trauma as "… the unique individual experience of an event or enduring conditions, in which: The individual's ability to integrate his/her emotional experience is overwhelmed, or the individual experiences (subjectively) a threat to life, bodily integrity or sanity". What is significant in this definition is that the subjectivity of the event is considered. As mentioned earlier, traumatic stress can be envisioned as part of the larger concept of stress. PTSD and Acute Stress Disorder would fall into the category of traumatic stress. Hudnall Stamm (1999, p.5) depicts the conceptualisation of traumatic stress in Figure 2.1.

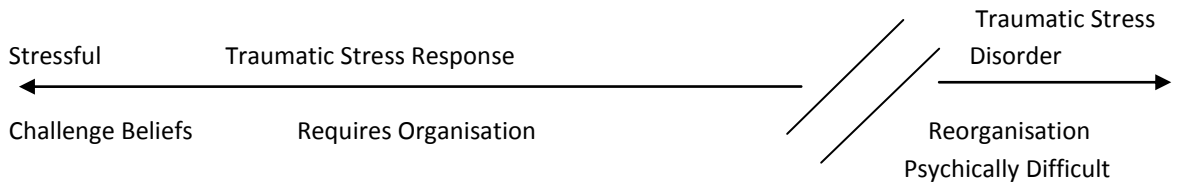


Figure 2.1: Hudnall Stamm's (1999) Conceptualisation of Traumatic Stress

Hudnall Stamm (1999) suggests that a traumatic event, in combination with a specific individual's response may be stressful as the individual's beliefs (of self, others and faith in life) are challenged. What differentiates a traumatically stressful experience from a stressful experience is the demand for reorientation. This demand requires change which, whether positive or negative, can be stressful but can also provide opportunities for growth. A traumatic stress response or reaction requires a demand for the reorganisation of one's belief systems. However, when the demands placed upon one's belief systems are so traumatically stressful and sufficiently challenge one's psychosocial resources, pathology can occur resulting in Traumatic Stress Disorder.

2.3.2 Classifications of Trauma

Trauma can also be classified according to similar associations. Early (1993) identifies seven different classes of trauma, namely:

Class A - Neonatal Trauma: This trauma refers not only to difficulties experienced during the birthing process but also to mistreatment issues that may occur in the first year of life such as abandonment; Class B - Loss Trauma: Included in this class of trauma are abandonment by parents or caregivers; traumatic parental death, unprepared loss of other significant attachments that significantly alter identity; Class C - Accident Trauma: This trauma arises from vehicle or domestic accidents. Factors that are important in this kind of trauma include whether any deaths occur as a result of the accident, the role the survivor had in the accident and whether the accident occurred due to carelessness and/or neglect; Class D - Sexual Trauma: This type of trauma includes rape, incest and general traumatic sexual mistreatment. This type of trauma often involves betrayal of trust, which forms an important

focus of psychotherapy; Class E - Interpersonal Violence: Included in this class are spousal battering, child abuse, life-threatening assaults, torture as well as witnessing acts of inter-personal violence. Anger is the common emotion associated with this kind of trauma; Class F - Natural Trauma: This trauma includes so-called Acts of God, floods, earthquakes, individual illnesses, multiple deaths and epidemics; and Class G - Combat Trauma: Traumatic events in this class are normally multiple and include collective violence and civil unrest. Psychological numbing is a common response to this type of trauma.

Trauma can also be classified into different types, depending on the duration of the event. **Type I trauma** refers to short term trauma or traumatic events that last a few minutes or a few hours. Examples here would include natural events (floods, tornadoes or earthquakes) or accidental occurrences (motor vehicle accidents, fires or explosions) as well as man-made disasters (bombings, robberies or assault). **Type II trauma** includes sustained or repeated traumatic events involving chronic or ongoing exposure. Examples of this type of trauma include combat, nuclear accidents, child sexual abuse and holocaust victimisation (Terr, 1991). Both types of trauma have been well researched over the years (Courtois, 2010; Wilson, Friedman & Lindy, 2001). **Type III trauma** occurs due to the cumulative effect of all traumatic events occurring across the lifespan that affects one or more areas of functioning (Kira, 2001). Classifying trauma assists practitioners to understand the kind of symptomology present and to intervene appropriately. The following sections explore primary and secondary traumatisation, and the conceptual developments that occurred through time.

2.4 PRIMARY TRAUMATISATION

Primary traumatisation refers to the reactions or experience a victim may endure as a result of exposure to an event, where the victim is the direct target of the stressor. Posttraumatic stress disorder has dominated the framework and studies of primary traumatisation (Eagle & Kaminer, 2013).

2.4.1 Posttraumatic Stress Disorder Classification

In 1952 in the Diagnostic and Statistical Manual Version 1 (DSM-I), trauma was initially included under the broad category of “gross stress reactions”. However this categorization was replaced with “adjustment reactions of adult life” in the later version, DSM-II (Figley, 1978 cited in Esprey, 1996). When hundreds of severely traumatised veterans returned from their combat experience in Vietnam, the phenomenon of war neurosis re-emerged and the interest in the field of trauma developed. Prior to this period government propaganda had effectively promoted the idea that the experience of battle and being a soldier was a maturing process for men (Bracken, 2002).

PTSD was first included in the American Psychiatric Association's Diagnostic and Statistical Manual III, and then later refined in the DSMIV-TR. There was great reluctance from the DSM III task force to creating a diagnostic entity that related to a highly politised event (Herbert & Forman, 2006). While Posttraumatic Stress Disorder (PTSD) was primarily used in the past to describe experiences of combat soldiers and war veterans, the term is currently used to understand a wider range of trauma survivors including: crime victims, refugees, abused women and children, and survivors of natural disasters and accidents. Moreover, people who work with trauma victims, rescue and medical personnel, are also acknowledged as being at high risk of developing PTSD (American Psychiatric Association, 2000). One can discern the development in understanding of this disorder through the changes in classification from the DSM III to DSM IV. Initially PTSD was diagnosed as 'a result of an event experienced outside the range of human experience', that could 'evoke signs and symptoms of distress in almost everyone'. In the DSM IV this definition changed significantly to include anyone who had witnessed an event. This change shows recognition of traumatisation as far broader than was initially conceptualised (Kaminer & Eagle, 2010). There are six criteria that need to be met in order for the classification of Posttraumatic Stress Disorder as stipulated by the DSM IV-TR, to be made. These include the factors listed in Table 2.1.

In 2013, the DSM-5 brought about significant changes in the classification of PTSD. Significantly, PTSD and Acute Stress Disorder (ASD) were removed from the anxiety disorders category and a new section called "Trauma and Stressor-Related Disorders" was created. Additional changes included; specific elaborations about Criterion A, the nature of exposure to the traumatic event; the inclusion of a new category of stressor; an expansion in the number of symptoms and the formation of a new subtype of PTSD. Some researchers have raised concerns about these changes, feeling that the new classification does not encapsulate the centrality of fear and avoidance that is prevalent in PTSD (Levin, Kleinman, & Adler, 2014).

Since PTSD was first classified in the DSM III there have been numerous debates about the classification of this condition. Kira (2001) argues that the event criterion for PTSD limits the type of trauma to survival trauma and that the range of trauma is far more complex than only survival trauma.

Table 2.1: Levin, Kleinman and Adler's (2014, pp.147-148) Table of PTSD Criteria in DSM-IV-TR versus DSM-5

(A1) The person must have experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or threat to the physical integrity of self or others.	(A1) Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: 1. Directly experiencing the traumatic event(s). 2. Witnessing, in person, the event(s) as it occurred to others. 3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental. 4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.
(2) The person's response involved intense fear, helplessness, or horror.	(A2) Eliminated
(B) The traumatic event is persistently re-experienced in one (or more) of the following ways: (B1) Recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions (B2) Recurrent distressing dreams of the event (B3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes) (B4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event (B5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the trauma	(B) Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred: (B1) Recurrent and intrusive distressing memories of the traumatic event(s) (B2) Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). (B3) Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings). (B4) Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s). (B5) Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
(C) Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three or more of the following: (C1) Efforts to avoid thoughts, feelings, or conversations associated with the trauma. (C2) efforts to avoid activities, places, or people that arouse recollections of the trauma (C3) inability to recall an important aspect of the	(C) Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following: (C1) Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s). (C2) Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories,

trauma (C4) markedly diminished interest in or participation in significant activities (C5) feelings of detachment or estrangement from others (C6) restricted range of affect (C7) sense of foreshortened future	thoughts, or feelings about or closely associated with the traumatic event(s).
(D) Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more of the following): (1) difficulty falling asleep (2) irritability or outbursts of anger (3) difficulty concentrating (4) hypervigilance (5) exaggerated hyperalertness, and other symptoms (alternates with criterion C);	(D) Negative alterations in cognitions and mood that are associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two or more of the following: (D1) Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs). (D2) Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined"). (D3) Persistent distorted cognitions about the cause or consequence of the traumatic event(s) that lead the individual to blame himself/herself or others. (D4) Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame). (D5) Markedly diminished interest or participation in significant activities.
(E) Duration of the disturbance is at least one month: Acute–when the duration of symptoms is less than three months. Chronic–when symptoms last three months or more.	(E)Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following: (E1) Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects. (E2) Reckless or self-destructive behavior. (E3) Hypervigilance. (E4) Exaggerated startle response. (E5) Problems with concentration. (E6) Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).
(F) Requires significant distress or functional impairment.	(F) Duration of the disturbance (criteria B, C, D, and E) is more than 1 month. "Acute" and "chronic" eliminated
Specifiers: With delayed onset: if onset of symptoms is at	(G)The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. (H) The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition. With dissociative symptoms (with either depersonalization or derealization).

least six months after the stressor.	With delayed expression: if the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate)

Some theorists such as Van der Kolk and Saporta (1991) argue that PTSD has been understood to be a mental disorder rather than a normal response to a traumatic event. Other theorists (Bracken, 2002; Edwards, 2009) argue that PTSD is a social construction and that PTSD in essence pathologises normal reactions to human experiences, therefore equating normal human suffering with mental illness. However, as Herbert and Forman (2006) argue, most traumatologists reject this view and insist that PTSD is a natural phenomenon that represents a universal concept that is applicable across time and different social and cultural contexts. The complexity of this phenomenon can be seen, by the many models of PTSD that have been developed in order to understand this phenomenon.

There has also been much debate regarding the nature of the complex relationship between the stressors, the subjective appraisal of the stressors and the psychological responses to the stressful event/s. Another discourse suggests that the PTSD trajectory over time is more reflective of PTSD symptomology than a simple diagnositic status at one time. This argument is supported when one considers the possibility of delayed onset trajectory which is often present in the longitudinal course of PTSD and may not be ascertained in an initial assessment. Yehuda, Schmeidler, Labinsky, Bell, Morris Zemelman and Grossman (2008) conducted a longitudinal study of PTSD diagnosis and symptom severity and found that longitudinal information over time provides a more powerful indicator of symptom severity than cross-sectional evaluations.

Taylor and Asmundson (2008) identify six major controversies concerning PTSD. These include: what constitutes traumatic stress; the question whether traumatic stress causes brain damage; the validity of the concept of delayed-onset PTSD; the recovered memory controversy; the question whether PTSD can arise when the person has no memory of the trauma; and the concept of malingering PTSD. Many of these aforementioned debates are still ongoing and despite all the controversy surrounding the PTSD diagnosis, what has consequently occurred is that the diagnostic criteria have been refined and the debates about PTSD's existence have subsided. Concomitantly, other traumatic terms have been developed such as complex trauma, secondary trauma and continuous trauma, to mention but a few (Eagle & Kaminer, 2013; Suvak & Barrett, 2011).

Many studies have assessed what constitutes the predictors of PTSD and explored the question why some people are more susceptible to developing PTSD than others. Numerous factors can be attributed to this phenomenon and when assessing risk factors for PTSD three aspects need to be considered: pre-traumatic; traumatic; and post-traumatic factors. Friedman (2006, p. 16) identifies numerous risk factors associated with each phase. These factors are shown in Table 2.2.

Table 2.2: Risk Factors for Posttraumatic Stress Disorder (Friedman, 2006, p. 16)

Pre-Traumatic	**Gender –** Women are twice as likely as men to develop PTSD at some point in their lives, particularly due to the likelihood of experiencing interpersonal violence (e.g. rape). **Age** – Adults younger than 25 are at most risk. Education – Those with less than a colleague education are more at risk. Childhood Trauma – Child abuse, rape, war or motor vehicle accidents can increase risk. **Childhood Adversity** – Economic deprivation or parental separation/divorce before the child is age 10 can be a factor. Adverse Life Events – Divorce, loss of job, failure at school, financial problems, or poor physical health can increase risk. Psychiatric Disorders – Those diagnosed with a childhood conduct disorder or those with any prior psychiatric disorders are most at risk, as are those with personality pathology. **Genetics** - Family history of any psychiatric disorder or possible genetic differences in regulating pre-synaptic uptake of serotonin can increase risk.
Traumatic	**Severity (dose) of the Trauma** – The greater the magnitude of trauma exposure, the greater the likelihood of developing PTSD. **Nature of the Trauma** - Interpersonal violence (e.g. rape; physical attack; torture; war-zone trauma), in which there is a human perpetrator, is much more likely to produce PTSD than an impersonal event (e.g. natural disaster). **Betrayal** – When a parent or caregiver on whom the victim is completely dependent perpetrates interpersonal violence; as in childhood sexual abuse, the trauma is more likely to produce PTSD than when the perpetrator is a stranger. **Peritraumatic Dissociation** – This symptom, as seen in Acute Stress Disorder, is more likely to predict the later development of PTSD than if the trauma survivor did not experience dissociative symptoms at the time of the trauma. **Participation in Atrocities** – Being either a perpetrator or witness of atrocities has proven to be a risk factor for Vietnam and other military veterans.
Post-Traumatic	**Poor Social Support** – After exposure to trauma, lack of social support is a risk factor for the onset of PTSD. **Development of Acute Stress Disorder (ASD)** – ASD is a strong indication of post-traumatic symptom severity and predicts the later development of PTSD among 80 percent of affected individuals. **Access to Acute, Post-traumatic Clinical Intervention** – Timely treatment of ASD can prevent the later development of PTSD.

Kaminer and Eagle (2010) emphasise that PTSD is far more likely to develop in individuals after they have experienced a violent assault as opposed to experiencing other traumatic incidents or a natural disaster. These authors also highlight the fact that research has shown different responses to different types of trauma for men and women. The lifetime prevalence rate of PTSD for women is twice that for men (Butterfield, Becker & Marx, 2002). In a study conducted in South Africa, women were found to be more likely to experience PTSD after rape as opposed to other forms of assault such as domestic abuse or criminal violence, while for men the strongest predictor of PTSD was torture (Kaminer & Eagle, 2010).

Risk factors are not only important when considering the propensity for developing PTSD, but are often also an indicator whether victims are likely to seek treatment after a traumatic event. Gavrilovic, Schutzwohl, Fazel and Priebe (2005) reviewed findings from 24 articles on mental health utilisation following a traumatic event. While many of the findings were inconsistent, they found that the most important factors associated with treatment seeking appeared to be higher levels of psychopathology, the type and level of traumatic event, socio-demographic characteristics and gender (women).

2.4.2 Acute Stress Disorder (ASD)

Prior to the publication of the DSM III (1980), the term 'posttraumatic stress' was not officially used and instead, terms like 'combat stress reaction' and 'battle fatigue' were used to describe the symptoms that people would exhibit soon after a traumatic event. The DSM-IVTR provides specific criteria for a diagnosis of ASD. These criteria are similar to PTSD in terms of the re-experiencing, hyperarousal and avoidant symptoms (there are differences in the number of symptoms) as well as in understanding of functional impairment. Further differences include the fact that the emphasis with ASD is on dissociative symptoms, whereas with PTSD it is on Avoidant and Numbing Symptoms. Most people (70 – 80 per cent) who are diagnosed with ASD will develop PTSD (Friedman, 2006).

2.4.3 Complex Posttraumatic Disorder

Herman (1997) refers to complex posttraumatic stress disorder or disorders of extreme stress not otherwise specified that may occur when repetitive trauma amplifies the PTSD symptoms. She believes that Complex Posttraumatic Stress Syndrome can co-exist with simple PTSD, but it extends beyond PTSD (Herman, 1997). One may be particularly vulnerable to complex PTSD if the traumatisation occurred early in life, was prolonged and was interpersonal. Wilson (1989) identifies prisoners of war, concentration camp survivors, cult survivors, battered women, domestic violence survivors, sexual abuse survivors and children who have suffered years of trauma as being vulnerable to suffering from Complex Posttraumatic Stress Disorder. Yet some people who are exposed to prolonged trauma have a better chance than others of not developing posttraumatic stress disorder. This phenomenon can be explained through understanding the concept of resilience, which will be

further elaborated upon in the following chapter. Symptoms which are generally present with complex PTSD include:

- Behavioural difficulties (Self-destructive actions, impulsivity, sexual acting out, eating disorders and substance abuse);
- Emotional difficulties (Rage, depression and panic);
- Cognitive Difficulties (Fragmented thoughts; Dissociation and Amnesia);
- Somatisation; (Physical symptoms and pain); and
- Identity confusion (Friedman, 2006, p.27).

2.4.4 Posttraumatic Stress Disorder and Comorbid Disorders

Individuals with lifetime PTSD generally have been diagnosed with another psychiatric disorder as well. Disorders that commonly exist alongside PTSD include: Major Depressive Disorder; Generalised Anxiety Disorder; Simple Phobia; Social Phobia; Panic Disorders as well as Substance Abuse or Dependency (Friedman, 2006; Konner, 2007). Furthermore, DSM – IVTR Axis II disorders are common among PTSD patients, especially borderline, obsessive-compulsive, avoidant, paranoid and self-defeating personality disorders. Butterfield et al. (2002) found that nearly 80% of women with PTSD have a history of at least one other psychiatric disorder and that at least 40% of women with PTSD meet criteria for three or more other psychiatric disorders. However, differential diagnosis of PTSD and these disorders is difficult as often symptoms are only clearly evident after a traumatic incident has occurred and trauma specific symptoms are presented. It is difficult to distinguish whether the underlying disorder was unmasked by the trauma or whether the trauma caused the disorder. The presence of a comorbid disorder has also predicted worse outcomes two years after for patients who received a PTSD diagnosis than for those patients where no comorbid disorder was evident (Konner, 2007).

Norman (2000) argues that historically therapeutic assessments and interventions have focused on symptoms of depression, anxiety, eating disorders and substance abuse alone. These medical conditions have often been viewed in isolation and further assessments of a prior or underlying PTSD that may have generated other diagnoses are often forgotten.

2.5 SECONDARY TRAUMATISATION

In **secondary traumatisation** the traumatisation occurs as a result of assisting or being associated with the victim of the stressor event. Those experiencing secondary traumatisation would include people who have a close relationship with the traumatised person or persons, for example - a husband, friend or colleague as well as those assisting the victims such as mental health practitioners (Ortlepp & Friedman, 2002). Secondary trauma occurs as a result of indirect traumatisation, as the person was

indirectly exposed to an event (through witnessing or listening to an event) where another person was the direct victim (Collins, 2003; Figley, 1995).

A significant modification of the classification of PTSD that occurred in DSM-IV was that if a person witnessed or experienced a trauma he or she could be diagnosed with PTSD. Therefore according to the DSM-IVTR criteria, a traumatic stressor is defined as "an event in which the person experiences, witnesses, or is confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of self or others" (Taylor & Asmundson, 2008). In his study of social workers, Bride (2007b) showed that as a result of their work social workers were twice as likely as the general population to develop PTSD.

In the past few decades, there has been an exponential increase in research about the conceptual and anecdotal effects of indirect trauma. The terms 'secondary trauma', 'vicarious trauma' and 'compassion fatigue' and 'burnout' are often used synonymously and interchangeably by researchers, suggesting that the constructs are not conceptually distinct (Bercier & Maynard, 2015; Hudnall Stamm, 2010). Hudnall Stamm (2010) believes that while each construct has a particular meaning, there is little difference between these terms. However, some authors (Meadors, Lamson, Swanson, White & Sira, 2009; Sansbury, Graves & Scott, 2015), believe that these concepts may in fact be phenomenologically different. While acknowledging that there are significant conceptual similarities between these terms, it is possible to understand each concept to be a slightly varied phenomenon on the same continuum. In the next section the origins of these terms are explored and discussed. The concept of 'shared trauma', a more recent construct to emerge in the trauma literature, which acknowledges that counsellors may be traumatised by the same event as their clients, is also explored as well as strategies for the reduction of the negative effects of indirect trauma.

In Table 2.3 Newell, Nelson-Gardell and MacNeil (2015) recorded the chronological development of the trauma terms associated with the effects of trauma on the therapist, which is useful for clarity and coherence. The concept, shared trauma is missing from the timeline, and would be important to incorporate as well as the concept vicarious resilience and consequently have been added to the table by the researcher. The terms that are further elaborated upon in this chapter are printed in bold type.

2.5.1 Secondary Traumatic Stress (STS)

2.5.1.1 Conceptual understanding of secondary traumatic stress

Secondary traumatisation occurs when an individual is indirectly exposed to trauma through hearing a narrative of a traumatic experience (Zimering, Munroe & Gulliver, 2003). Blumberg (2000) emphasises that secondary traumatisation can occur through identification with others that may also occur through a common social context which incorporates the common geographical or work environment.

This context could include family members, colleagues, emergency workers as well as counsellors (professionally qualified or lay counsellors).

Table 2.3: Newell, Nelson-Gardell and MacNeil's (2015, p. 2) Amended Terminology and Construct Timeline

Year	Trauma term
1889	Shellshock
1916	**Transference**
1924	Emotional Contagion
1946	Projective Identification
1970	Empathic Identification
1974	**Burnout**
1987	Empathic Attunement
1988	Emotional Contagion
	Secondary Victimisation
1990	**Vicarious Traumatisation**
1991	Co-vicimitisation
1994	**Compassion Fatigue**
1995	**Secondary Traumatic Stress**
1998	**Compassion Satisfaction**
	Vicarious Resilience
1999	**Posttraumatic Growth**
2001	**Compassion Satisfaction**
2002	Shared Trauma
2004	Traumatoid Stress
2008	Vicarious Resilience

Figley (1995) adopted the term "secondary traumatic stress" as he felt this term encompassed what therapists/helpers of PTSD victims tend to experience. The diagnostic criteria for PTSD are almost identical to that of secondary traumatic stress disorder except that PTSD occurs as a result of direct trauma exposure and secondary traumatic stress occurs as a result of indirect trauma exposure. Thus secondary trauma is based upon the diagnostic conceptualisation of Posttraumatic Stress Disorder and is a syndrome of symptoms characteristic of intrusion, avoidance and arousal symptoms (Phipps & Byrne, 2003). Figley's (1995, p. 8) table clearly depicts the similarities of primary trauma and secondary trauma. If symptoms are experienced within one month of a traumatic event, they are considered acute and appropriate responses. When an individual only experiences the symptoms six months or longer after an event, this experience is considered delayed PTSD or STS (Figley, 1995).

Table 2.4: Figley's (1995, p.8) Comparison Between Primary and Secondary Trauma

Primary Trauma	Secondary Trauma
A. Stressor: **Experienced an event outside of usual human experiences that would be markedly distressing to almost anyone; an event such as:** 1. **Serious threat to *self*** 2. **Sudden destruction of one's environment**	A. Stressor: **Experienced an event outside of usual human experiences that would be markedly distressing to almost anyone; an event such as:** **1. Serious threat to *traumatised person* (TP)** **2. Sudden destruction of *TP's* environment**
B. Experiencing trauma event 1. **Recollection of event** 2. **Dreams of event** 3. **Sudden re-experiencing of event** 4. **Distress of reminders of event**	B. Experiencing trauma event **1. Recollection of event/TP** **2. Dreams of event/TP** 3. **Sudden re-experiencing of event/TP** 4. **Distress of TP/ event distressing**
C. Avoidance/numbing of reminders of event 1. **Efforts to avoid thoughts/feelings** 2. **Efforts to avoid activities/situations** 3. **Psychogenic amnesia** 4. **Diminished interest in activities** 5. **Detachment/estrangement from others** 6. **Diminished affect** 7. **Sense of foreshortened future**	C. Avoidance/numbing of reminders of event 1. **Efforts to avoid thoughts/feelings** 2. **Efforts to avoid activities/situations** 3. **Psychogenic amnesia** 4. **Diminished interest in activities** 5. **Detachment/estrangement from others** 6. **Diminished affect** 7. **Sense of foreshortened future**
D. Persistent Arousal 1. **Difficulty falling/staying asleep** 2. **Irritability or outbursts of anger** 3. **Difficulty concentrating** 4. **Hyper vigilance for self** 5. **Exaggerated startled response** 6. **Physiologic reactivity to cues**	D. Persistent Arousal 1. **Difficulty falling/staying asleep** 2. **Irritability or outbursts of anger** 3. **Difficulty concentrating** 4. **Hyper vigilance for TP** 5. **Exaggerated startled response** 6. **Physiologic reactivity to cues**

In addition to Figley's (1995) model of stress there are numerous other models that describe secondary traumatic stress, including among others the models of Dutton and Rubinstein (1995) and two South African models, Friedman (1996) and Ortlepp (1998) which are discussed. Distinguishing features of secondary traumatic stress include a sense of helplessness and confusion, feelings of isolation from others and the fact that symptoms may be disconnected from the actual issue. Munroe (1999) found that therapists who treated clients with PTSD who had been in combat also suffered from intrusion and withdrawal symptoms.

Dutton and Rubinstein (1995) proposed a model of four components to explain traumatic stress reactions in trauma counsellors. This model included the traumatic event to which the worker has been exposed, the post traumatic stress (PTS) reactions of the trauma worker, the coping strategies of the trauma worker and the personal and environmental characteristics in which the STS occurred. Although the four categories identified by the authors provided a conceptual understanding of factors influencing the development of STS, the nature of the connection between these components needs to be articulated (Ortlepp, 1998).

Instead, Ortlepp (1998) proposed a systemic model explaining the nature and experience of trauma work which includes the relation of the incident, the individual, and the environment. The first aspect that is considered relates to the trauma counselling material - the nature and frequency of exposure to traumatic material. The second aspect is the appraisal process – the meaning attached to this event. Factors that impact on the meaning include the nature of the traumatic event that the client experienced; individual factors relating to the trauma counsellor (age, gender, previous and current life stressors, personality traits, training and trauma counselling experience); characteristics of the client which may lead to over-identification on the part of the therapist; characteristics of the environment and the organisation where the therapist operates (incorporating social support, role aspects, cultural norms of the organisation and the broader community); and finally the secondary traumatic stress reactions of the therapist, which could incorporate both positive and negative consequences. Moreover, there is a feedback loop from the outcomes to the initial trauma experience. Ortlepp (1998) shows how her model complements the Twin Peaks Model of Traumatic stress developed by Friedman (1996), a South African psychologist and researcher.

The Twin Peaks model depicts the natural attempts made by people or professionals who are frequently exposed to trauma to cope with the trauma. Friedman (1996) explains how emergency personnel are likely to experience traumatic stress reactions quite markedly even if they have not had previous exposure to trauma. This experience may be followed by a period of disillusionment with work and some natural attrition may occur. A period will subsequently follow where the intensity and frequency of the trauma continues so that the individual develops negative resilience, as distress is experienced but is often not acknowledged. The defences of denial and numbing help to dissociate the individual from the actual magnitude of the trauma. At a significant point the resilience will be broken down and the trauma personnel will either burn out and/or experience PTSD (Friedman, 1996).

2.5.1.2 Vulnerability to secondary trauma

Theorists have argued that exposure to the traumatic material alone will not cause STS (Adams, Boscarino & Figley, 2006), and that both individual and environmental factors play an important role

in the development of STS. There has been an extensive debate as to whether therapists' personal history of trauma makes them more susceptible to developing secondary traumatic stress, while secondary traumatic stress theory would advocate that workers with a personal history of trauma have experienced prolonged exposure and therefore these therapists are at a higher risk of developing secondary traumatic stress (Figley, 1995; Pearlman & Saakvitne, 1995b). Alternatively, Collins and Long (2003) take a different position advocating that social workers, who have worked through their own traumatic events, may come to the therapeutic relationship being less naive and having developed positive coping strategies. Accordingly, it is not only the therapist's personal trauma exposure that one needs to consider but also whether or not they have successfully worked through these traumas as these aspects will influence a therapist's susceptibility to developing secondary traumatic stress.

Naturale (2007) argues that practitioners who have previously experienced a mental disorder are at a higher risk for developing secondary traumatic stress. Ortlepp and Friedman (2002) identify additional variables that are significantly related to the development of STS, including: coping styles; level of social support; professional experience and the number and type of trauma cases in the counsellor's workload. Similarly, Creamer and Liddle (2005) found that therapist characteristics influenced the levels of STS. For example, higher levels of STS were found in mental health workers responding to the September 11 attacks that had heavy trauma caseloads, were young, and had less professional experience. However, these authors point out that finding in the direction of relationships have not always been consistent.

2.5.1.3 The impact of secondary traumatic stress

Yassen (1995) specifies the various categories or systems of an individual and identifies symptoms within each category, namely the cognitive, emotional, behavioural, spiritual, interpersonal and physical. These categories are reflected in Table 2.5.

Table 2.5: The Personal Impact of Secondary Traumatic Stress (Yassen, 1995, p. 184)

COGNITIVE	EMOTIONAL	BEHAVIOURAL	SPIRITUAL	INTERPERSONAL	PHYSICAL
Diminished concentration Confusion Loss of meaning Decreased self esteem Preoccupation with trauma Trauma imagery Apathy Rigidity Disorientation Whirling thoughts Thoughts of self harm or harm towards others Self doubt Perfectionism Minimization	Powerlessness Anxiety Guilt Anger / rage Survivor guilt Shutdown Numbness Fear Helplessness Sadness Depression Hypersensitivity Emotional roller coaster Overwhelmed Depleted	Clingy Impatient Irritable Withdrawn Moody Regression Sleep disturbances Appetite changes Hyper vigilance Elevated startled response Use of negative coping (smoking; alcohol or other substance misuse) Accident proneness Self–harm behaviours	Questioning the meaning of life Loss of purpose Lack of self satisfaction Pervasive hopelessness Ennui (listlessness and dissatisfaction) Anger at God Questioning of prior religious beliefs	Withdrawal Decreased interest in intimacy or sex Mistrust Isolation from friends Impact on parenting (protectiveness, concern about aggression) Projection of anger or blame Intolerance Loneliness	Shock Sweating Rapid heartbeat Breathing difficulties Somatic reactions Aches and Pains Impaired immune system

Dutton and Rubinstein (1995) identify three primary areas in which trauma workers may experience secondary traumatic stress. Firstly, *psychological distress or function* – refers to distressing emotions, intrusive imagery, numbing and avoidance of work with traumatic material, somatic complaints, addictive or compulsive behaviours, physiological arousal and impairment of day-to-day functions in social and personal roles. Secondly, *cognitive shifts* – this idea refers to changes in beliefs, expectations and assumptions that therapists may have. In particular this construct refers to aspects such as trust, intimacy, dependence, power, self esteem and frame of reference. Lastly, *relational disturbances* – relationships, both personal and professional can be adversely affected by work with a trauma victim. Issues of trust, safety and power are threatened and can lead to detachment, over identification or distancing (Dutton & Rubinstein, 1995).

High levels of STS in mental health therapists have been significantly associated with lower relationship satisfaction, lower social intimacy and greater use of negative communication patterns, such as avoidance and withdrawal patterns (Robinson-Keilig, 2014). Bride's (2007b) study with social workers also found that almost a quarter of the social workers sampled felt detached from others and they attributed their detachment to their exposure to secondary trauma. What is also of particular concern is the impact of STS on professional functioning. Performance in job tasks can deteriorate, on a quantitative and qualitative level as the helper may avoid certain job tasks. Increased absenteeism, faulty judgment, irritability, irresponsibility or overwork may be evident in behavioural performance. Demoralisation, lack of interest, apathy and detachment can also occur. Yassen (1995) elaborates upon each of these aspects in Table 2.6.

A significant consequence is that the therapeutic relationship can be affected if the therapist is suffering from secondary trauma. Clients can be aware of the effects of their trauma story on others including the therapist. Hence, the therapist needs to be sensitive to this aspect and ensure that the client does not become concerned about the therapist's well-being and in doing so only reveals certain aspects of the trauma. If this scenario occurs the client is in essence taking care of the therapist and thus the roles have been reversed, which can be considered an ethical violation. Munroe (1999) raises the question as to whether therapists should inform the client from the outset that they may personally be affected by the trauma as well. One argument is that if the therapist implies that he/she is not affected by the client's story this response could be interpreted by the client as if their traumatic experience would not have affected the therapist and that the client is making a big issue over nothing.

Others argue that to inform the client that one may be affected may raise concerns with the client whether the therapist is strong enough to deal with their case. However, if therapists explain that they have specific coping strategies in order to ameliorate these effects, this approach would provide a

model to the client for effective coping. Furthermore, from an ethical perspective, therapists should explain to the client about the limits of confidentiality and that they are likely to discuss the case with their supervisor or at a case conference. Not to offer this explanation to the client could be considered highly unethical as the bounds of confidentiality were not truthfully explained and disclosed.

Table 2.6: The Impact of Secondary Traumatic Stress on the Work Environment

Performance of Job Tasks	Morale	Interpersonal	Behavioural
- Decrease in quality - Decrease in quantity - Low motivation - Avoidance of job tasks - Increase in mistakes - Setting perfectionist standards - Obsession about detail	- Decrease in confidence - Loss of interest - Dissatisfaction - Negative attitude - Apathy - Demoralization - Lack of appreciation - Detachment -Feeling of incompleteness	- Withdrawal from colleagues - Impatience - Decrease in quality of relationships - Poor communication - Subsume own needs - Staff conflicts	- Absenteeism - Exhaustion - Faulty judgment - Irritability - Tardiness - Irresponsibility - Overload -Frequent job changes

(Yassen, 1995, p.184)

2.5.1.4 Secondary traumatic stress and social workers

Bride (2007b) found that social workers were frequently exposed to client trauma, with 89 percent acknowledging that they addressed trauma related concerns with their clients. He found that 15.2 percent of social workers in his study met the criteria for a formal diagnosis of PTSD, five percent met the criteria for at least one of the core symptom clusters (avoidance, re-experiencing and hyperarousal) while about 20 percent met two of the core symptom clusters.

Munlo (2009) conducted a study of secondary traumatic stress with therapists (both psychologists and social workers) who counselled Zimbabwean torture victims. She found that most (seven of eight participants) experienced secondary traumatic stress and presented with some of the following symptoms: sleepless nights, hypervigilance, fear, lack of safety, loss of appetite, intrusive thoughts and bad dreams.

The terms secondary trauma and vicarious trauma are often inappropriately referred to as the same phenomenon. This confusion can be attributed in part to the conceptual understanding of the word 'vicarious'. The Oxford Advanced Learner's Dictionary (2005, p.1639) defines the word vicarious as, "felt or experienced by watching or reading about somebody doing something, rather than by doing it

yourself". One would understand that secondary trauma is therefore experienced vicariously and so the terms are often used synonymously. However, the conceptual understanding of vicarious trauma is explained in the following section.

2.5.2 Vicarious Trauma (VT)

2.5.2.1 Conceptual understanding of vicarious trauma

Jenkins and Baird (2002) explain that while secondary traumatic stress and vicarious trauma are similar; they differ conceptually in their relative emphasis on emotional/social versus cognitive symptomology. McCann and Pearlman (1990a) explain the concept "vicarious traumatisation**"** to describe a transformation in the therapist's inner experience occurring from empathic engagement with clients' trauma material. Pervasive changes can occur within clinicians over time, due to counselling clients who have experienced trauma. Vicarious traumatisation, therefore refers to alterations in the cognitive schemas of trauma counsellors' identity, memory system and belief systems (Robinson-Keilig, 2014; Trippany, White Kress & Wilcoxon, 2004).

Through their empathic openness therapists are vulnerable to both emotional and spiritual effects of vicarious traumatisation, which can be evident in both the therapist's personal and professional lives (Saakvitne & Pearlman, 1996). These authors state that while there is an overlap between secondary and vicarious trauma, they differ in focus and emphasis (Ortlepp, 1998). Vicarious traumatisation occurs as a result of the cumulative effect upon a therapist who counsels trauma victims. "Vicarious traumatisation can have an impact on the helper's sense of self, world view, spirituality, affect tolerance, interpersonal relationships, and imagery system of memory" (Pearlman, 1999, p. 52).

Courtois (2010) posits that vicarious trauma overlaps to some degree with burnout and counter-transference. However, vicarious trauma differs from burnout in that it specifically involves patterns of re-experiencing clients' trauma, avoidance, numbing and persistent arousal. Vicarious trauma could be considered a special type of counter-transference; however, there are not necessarily pre-existing characteristics or unresolved psychological conflicts to explain therapists' reactions (Figley, 1995).

2.5.2.2 Constructivist self-development theory and the effects of vicarious trauma

Vicarious Trauma is based upon constructivist self-development theory, which views the therapist's unique response to client material as shaped by two dimensions, namely, characteristics of the situation and the therapist's unique psychological needs and cognitive schema. This response has the potential to affect all realms of the therapist's life; it is cumulative and can gradually reinforce changing schemas of the therapists that may alter permanently. The underlying premise of constructivist self-development theory is that through the development of complex cognitive structures which are used to interpret events, human beings construct their own personal realities

(Pearlman & Saakvitne, 1995a). This theory compliments Piaget's (1971) Cognitive Developmental Theory, which posits that people construct beliefs, values and assumptions into cognitive schema (Tehrani, 2007). Trauma can disrupt these schemas (Janoff-Bulman, 1989); moreover, working with trauma survivors can disrupt the therapist's schema about self and the world. McCann and Pearlman (1990a, pp.39-43) identify the following schemata that may be disrupted in the helper:

-***Dependency/Trust:*** Therapists may become cynical, suspicious of other people's motives or distrustful as they constantly hear how victims are betrayed, deceived, or violated often in a very cruel manner by the perpetrator(s). As Hesse (2002) explains, this experience can cause therapists to view intimate partners, friends and family with the same mistrust and thus affect their personal relationships;

-***Safety:*** Therapists may experience a heightened sense of vulnerability and awareness of the fragility of life due to constantly hearing about how people's safety is violated. "They in turn may become hypervigilant, expect to be victimized or lose trust in their instincts" (Hesse, 2002, p. 299).

-***Power:*** Therapists' own sense of power or efficacy can be challenged through constantly hearing about the helplessness and vulnerability of victims. Therapists may also feel that they have no control over their clients' recovery and so give advice to clients instead of helping them understand their own reactions to traumatic situations. In the face of helplessness therapists may feel that they need to control their own personal relationships. This response can cause problems in their own personal relationships;

-***Independence:*** Therapists often identify with clients as their need for independence may be reduced due to the trauma that the client has experienced. Thus therapists feel a diminished sense of autonomy and a restriction in their personal movements.

-***Esteem:*** Therapists may experience their view of human nature becoming cynical and pessimistic just as their clients experienced diminished esteem for others due to the cruel and malicious harm that they have experienced at the hands of others. Their own self esteem may also be affected as they feel that they are doing more harm than good when helping trauma survivors.

-***Intimacy:*** Due to exposure to gruesome imagery, therapists may feel alienated from others and from the world. These feelings are often compounded and can lead to a growing sense of alienation as therapists are bound by confidentiality and cannot discuss client material with others. This sense of estrangement can adversely affect personal relationships.

-***Frame of reference:*** It is a fundamental human need to develop a meaningful frame of reference. Therapists can experience a sense of disorientation as they continually listen to client's traumatic experiences.

The therapist's spirituality can also be affected due to the emotional numbing that occurs as a result of feeling grief, shock, anger or terror. Furthermore, an awareness of oneself and one's spiritual beliefs can become stunted as the individual loses hope in the self and the world around the self

(Hesse, 2002). Therapists' memory systems can also be altered as they internalize memories of their clients. In vicarious traumatisation the imagery system of memory is likely to be altered. McCann and Pearlman (1990b) believe that the imagery most painful to therapists is often centered around the schemas related to the therapist's need areas. These traumatic memories can become permanently incorporated into therapists' memory systems, particularly when material relates closely to their life experience and if therapists do not talk about their experience of the traumatic material.

In the process of understanding constructivist self-development theory, it becomes evident that the way helpers are influenced by vicarious trauma is also influenced and guided by the individual belief system which emanates from the therapist's own history (Rosenbloom, Pratt & Pearlman, 1999). Therefore the conceptualisation of vicarious trauma depends on both the traumatic material as well as the helper's personality.

2.5.2.3 The impact of vicarious trauma on the helping relationship

With vicarious trauma therapists may question their own identity, role and self worth. They may often question their competency to be a therapist. Dissociation from the self and creating distance from others may result as therapists are pre-occupied with client's traumatic material. The therapists' view of the world and their values may change as they hear tales of horrific events. They may lose a sense of hope and optimism in humanity and become cynical. Even the therapists' spirituality may be affected as they may become emotionally numb due to the constant feelings of grief, anger, shock or terror that they experience. Self awareness can become diminished as therapists close off and lose hope in themselves and the world (McCann & Pearlman, 1990a).

Matsakis (1994) believes that trauma therapists must either bear the anxiety of knowing that they may be the next victim or they can build defences against their clients and what they represent. Defences that therapists employ include denial, intellectualization, dissociation, numbing and projection in order to protect themselves from the harmful material. These responses can seriously alter a therapist's identity, worldview and spirituality (McCann & Pearlman, 1990b). Furthermore, behaviours that promote numbing may include alcohol consumption, over-eating, over-spending or over-working. As the therapist's self capacity is challenged, it can lead to the therapist over working or becoming over involved in trauma cases. Moreover, it may also lead to a lack of insight into processes in therapeutic relationships (Hesse, 2002).

If a therapist is suffering from vicarious trauma, it will naturally start to impact upon the helping relationship. Hesse (2002) argues that even well trained and skilled therapists may struggle to remain empathic towards clients. As clients can possibly be harmed or even retraumatised by such reactions this behavior can become an ethical dilemma for the therapist. Therapists who doubt their own ability

due to vicarious trauma may have potentially harmful counter-transference reactions. The therapists may then inappropriately seek praise or affirmation from the client in order to boost their own self esteem and feel like competent therapists. Alternatively if the client idealises the therapist whose self esteem is impaired, the therapist may not pick up this response and work through it. In addition, therapists who feel incompetent and ineffective may try new treatment strategies without fully understanding them; which can be harmful for the client.

Pearlman and Mac Ian's (1995) study found that therapists who were also survivors were at much higher risk of developing vicarious trauma than those who were not trauma survivors. They found that in 60% of survivor therapists there were much higher rates of psychological disturbances than with those who had not experienced their own trauma. Personal trauma can also influence the therapeutic relationship as with therapists who are also trauma survivors there may be potential risks of over identifying with clients or confusing their own healing with the clients' healing. Moreover, serious disruption in the therapeutic process could occur as therapists who have gone through the same experience as their clients may dissociate during the sessions (Pearlman & Saakvitne, 1995a).

A therapist who over identifies with the client's experience may either express too much rage for the perpetrator or blame the victim or join together to avoid talking about the traumatic event. A therapist may try to avoid feelings or topics that produce anxiety, anger, fear or any other negative emotion. Furthermore, if a therapist cannot be empathic towards the client, the client can be retraumatised. This lack of empathy may be evident as the therapist may cancel sessions, not return calls, respond irritably or not be focused during the session (Pearlman & Saakvitne, 1995b). Another area where vicarious trauma can affect therapists is when therapists may professionally isolate themselves due to mistrusting others. They may refrain from referring clients to other professionals when it is necessary, or utilizing supervision or consultation services that are available. If therapists who are experiencing vicarious trauma feel that their sense of control has been compromised, they may be too directive with clients or establish unreasonable and extremely rigid boundaries in an attempt to re-establish control.

What is clearly evident is that the effects of vicarious trauma can have a profound impact on the helping relationship, yet therapists often do not realise how potentially destructive and harmful these traumatic effects can be upon the helping relationship and subsequently the client who is already a victim. Hesse (2002) goes so far as to say that social workers who are experiencing vicarious trauma have a moral and ethical responsibility to address these effects before they inflict any harm upon clients.

2.5.2.4 Empirical research on vicarious trauma

In a study examining vicarious trauma with criminal law and non-criminal law solicitors, one hundred solicitors completed numerous standardised tests, one of which measured vicarious trauma. What the findings showed was that the level of vicarious trauma was higher in the criminal law solicitors. In particular, levels of subjective distress, vicarious trauma, depression, stress and cognitive changes relating to safety and intimacy were higher in the criminal solicitors. Almost twice as many criminal law solicitors reported seeking professional help in order to cope with work related distress than non-criminal law solicitors (Vrklevski & Franklin, 2008).

A South African study conducted on vicarious trauma was conducted by Blumberg (2000) and assessed students both directly and indirectly exposed to trauma. Results showed that cognitive disruptions were evident in both groups. In particular, participants showed an inability to control their own feelings as well as diminished trust in others (MacRitchie, 2006).

2.5.2.5 Criticism of vicarious trauma

A phenomenological study of vicarious trauma with psychologists and professional counsellors working in the field of sexual abuse found that many therapists experienced positive changes in their sense of identity and their beliefs about the self, others and the world (Steed & Downing, 1998). However, the concept of vicarious trauma does not incorporate positive changes that may occur but only focuses on negative changes. Steed and Downing find this focus limiting and suggest that there should be a more comprehensive and holistic approach to this phenomenon.

What vicarious trauma has highlighted is how the helping relationship can be adversely affected by the trauma that the therapist experiences. As Hesse (2002) explains, some researchers believe that vicarious trauma is a special form of counter-transference. The concepts of transference and counter-transference are therefore examined more closely later in this chapter.

2.5.3 Compassion Fatigue (CF)

2.5.3.1 Conceptual understandings of compassion fatigue

The concept of ‘compassion fatigue’ first emerged in 1992 when Joinson first used the term in a study on nurses. One can understand the term compassion fatigue to mean a ‘fatigue’ or exhaustion of compassion. Figley (1995) then expanded on this understanding by identifying compassion fatigue as a natural consequence of working with secondary traumatic stress. His understanding further expanded as he explored how trauma workers and mental health professionals appeared to vicariously experience the effects of trauma. Some of the common signs associated with compassion fatigue are decreased self-esteem, apathy, rigidity, perfectionism, disorientation, thoughts of harm to self and others, disorientation, differences in cognitive abilities. Common emotional reactions include anxiety,

guilt, anger, powerlessness, depression, fear and over sensitivity. Behavioural symptoms include sleep disturbances, withdrawal from others, disengagement/detachment; irritability and appetite changes (Huggard, 2003; Tyson, 2007; Valent, 2002). Compassion fatigue can be sudden in onset, unlike burnout which is a gradual slow process as helpers feel overwhelmed by their work. However, burnout may be an important precursor to compassion fatigue (Figley, 1995).

Figley (2002a) developed a ten-component theoretical model that identifies factors that contribute to compassion fatigue as well as the management of compassion fatigue. This model is based upon the two following premises:

- For effective service delivery, empathy is essential in order to establish an effective therapeutic relationship; and
- Empathy also makes the therapist vulnerable.

Table 2.7 presents compassion fatigue in a linear format, however all components reciprocally influence each other (Udipi, McCarthy Veach, Kao & LeRoy, 2008, p.460). The model is conceptualised in a linear process, along with a binary understanding of compassion fatigue, which has received some criticism from theorists like Sabo (2011) who argue for a more integrative approach premised on the belief that individuals' responses may be expressed in varying degrees.

2.5.3.2 Vulnerability to compassion fatigue

Figley (1995) identifies four factors that make trauma counsellors particularly susceptible to compassion fatigue. These include: Firstly, *empathy* - While empathy is a core and necessary component of the therapeutic relationship, being empathic can also have detrimental consequences for therapists. In the transferring of traumatic material from the primary victim to the secondary victim empathy is identified as the predominant medium through which this process occurs.Secondly, *trauma workers' own traumatic events* - It is inevitable that at some point in their careers therapists will be presented with a traumatic experience similar to what they would have experienced. In such instances the therapists may over-identify and share or promote their own coping strategies with the client, which limits the amount of objectivity that is required to make the therapeutic relationship effective. Thirdly, *unresolved trauma* - If therapists have unresolved trauma aspects in their lives these memories and feelings can be provoked and reignited through listening to the story of a client. Fourthly, *children's trauma* - Because children represent innocence and vulnerability, when children are exposed to traumatic situations it triggers many emotions as it highlights the cruelty and injustice of the world. Consequently it is understandable that working with children who are traumatised may be very traumatic for many therapists.

Table 2.7: Figley's (2002a) Ten Component Model of Compassion Fatigue (Udipi et al., 2008, p. 459)

Component	Description
1. Empathic ability	The caregiver experiences patients' emotional energy and suffering through face-to-face interactions.
2. Empathic concern	The caregiver desires to respond to patients' needs with genuine empathy.
3. Empathic ability	The caregiver's potential for recognizing a patient's pain.
4. Empathic response	Effort exerted to understand a patient's thoughts, emotions and actions with the aim of empathically responding. The caregiver may experience negative emotions (e.g. fear and anger).
5. Residual compassion stress	Lingering emotional energy from empathic responses and from persistent demands to relieve patient suffering.
6. Sense of achievement/ Sense of dissatisfaction	Having a realistic awareness of one's professional responsibilities fosters greater satisfaction which can reduce or prevent compassion stress.
7. Disengagement/Detachment	Extent of which the caregiver emotionally lets go of residual effects of empathic connection to patient suffering. Deliberate and conscious efforts can reduce compassion stress.
8. Prolonged exposure to Suffering	Long periods of empathic caring for suffering individuals without periodic breaks increase compassion fatigue risk.
9. Traumatic recollections/ Traumatic memories	Memories of past experiences with patients and/or traumatic events from one's own life may trigger symptoms such as depression and anxiety.
10. Degree of life disruption/ other life demands	Crises or unanticipated changes in caregiver's daily routine that demand attention combined with the other components in the model can increase the risk of compassion fatigue.

Valent (2002) suggested that compassion fatigue may emerge as the result of unsuccessful or maladaptive survival strategies of the therapist. Compassion fatigue can be ameliorated by work satisfaction and appropriate detachment strategies, while it can be exacerbated by personal life demands. Compassion Fatigue can challenge the helper's ability to maintain professional therapeutic relationships as well as personal relationships, which ultimately affects the therapist's ability to provide effective services (Collins & Long, 2003).

2.5.3.3 Compassion fatigue studies

In a study of 222 genetic counsellors regarding their compassion fatigue and factors that predict its occurrence, findings revealed that 26% were at high risk for compassion fatigue and 57% for moderate risk. Multiple regression analysis identified seven significant predictors which accounted for 53.7% of the variance in compassion fatigue. These predictors included: feeling burnt out; being self critical; experiencing a greater variety of distressing clinical events; having higher caseloads; relying on religion as a coping strategy; having no children; and not seeking support to manage stress (Udipi et al., 2008).

Current research (Figley, 2002b; Geoffrion, Morselli, & Guay, 2015; Killian, 2008) has assisted in the acknowledgement and identification of compassion fatigue in social workers. Yet some theorists maintain that compassion fatigue is now too loosely associated with social work. Tyson (2007) proposes that there are five factors that determine how a social worker will respond to a client's suffering. These include: the social worker's lack of skills; unrealistic professional expectations of rescuing and fixing in a short period of time; the social worker's temperament and prior life experience; counter-transference reactions that are not dealt with and particular clients that can push buttons. In order to ameliorate compassion fatigue symptoms therapists have a professional (and personal) responsibility to address their vulnerabilities, ensuring that the focus is not only on the reduction of compassion fatigue symptoms but also on appropriately addressing the root causes of vulnerabilities. Concomitantly, appropriate selection criteria should be used to select appropriate practitioners to intervene in trauma work (Killian, 2008).

2.5.4 Compassion Satisfaction (CS)

The negative effects of working with trauma have for too long dominated the secondary trauma trajectory. As has already been alluded to in the literature, there are also many positive outcomes for the trauma therapist. In fact, Radney and Figley (2007) take an approach that is rooted in positive psychology and try to look for feelings of fulfillment in working with clients. They call this term compassion satisfaction. They call for a paradigm shift from focusing on negative aspects to exploring what makes social workers flourish in the field. This approach is adopted by Hudnall Stamm (1999) who argues that some workers develop a protective mechanism that helps maintain their well-being and prevents some workers from succumbing to secondary traumatic stress.

Radney and Figley (2007) have developed a model explaining compassion satisfaction among clinical social workers. Energy from compassion stress can lead to a feeling of positivity and a sense of flourishing. Quoting Fredrickson and Losada (2005, p. 678), they concur with the understanding of positivity as the ability "to live within an optimal range of human functioning, one that connotes goodness, generatively, growth and resilience". Flourishing within a work context would mean that

workers exude goodness, flexibility, learning, growth, and resilience in order to provide highly competent and compassionate care whilst retaining high morale and work satisfaction.

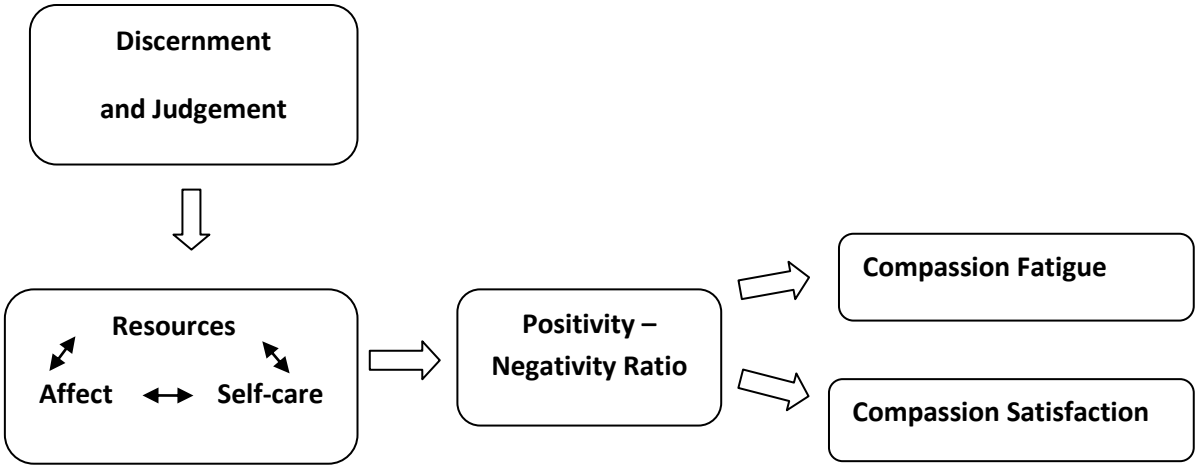


Figure 2.2: Creation of Compassion Satisfaction or Compassion Fatigue (Radney & Figley, 2007, p. 208)

The model depicted in Figure 2.2 draws on the work of Fredrickson (1998) who emphasises maximizing positivity, which will then maximise compassion satisfaction. This model highlights a reciprocal relationship between affect and resources whilst emphasizing the concept of self-care. Resource building is grounded in altruism and consists of an individual's inner resources and capabilities, resilience and accumulated wisdom. Self-care refers to clinicians' positive affect and physical, intellectual and social resources. Individual self care strategies include eating correctly, taking time off, exercising, self-reflection, attending own counselling and allowing time for friends and family. Organisational self-care strategies would include adequate benefits, appropriate supervision, diverse caseloads and staff development opportunities. Collegial support and a warm encouraging work environment cannot be underestimated. These factors Radney and Figley (2007) believe will promote an optimal environment for compassion satisfaction.

Discernment and judgment are key variables in a social worker as the latter needs to discern and judge the appropriate amount of altruistic behavior he/she needs to display. Over or under responding may break the cycle and produce apathy or burnout which can then result in compassion fatigue. This model suggests that if one is influenced by judgment and discernment, physical, intellectual, and social resources and self-care will impact upon each other reciprocally. Self-care is influenced and influences resources and affect alike. These variables affect self-care and resources and together contribute to clinician's positivity-negativity ratio, which in turn results in the absence or presence of compassion satisfaction or compassion fatigue. When the ratio of positive experiences is greater than the negative experiences clinicians have higher morale and consequently the services that they deliver will be of a higher quality. Moreover, practitioners can increase their positivity ratio by shifting their

focus from negativity and what is not working (Radney & Figley, 2007) to what is working. This model suggests that an increase in compassion satisfaction mitigates secondary traumatic stress. Hudnall Stamm (2010) understands compassion fatigue to be comprised of two specific components namely, secondary trauma and burnout, as depicted in Figure 2.3.

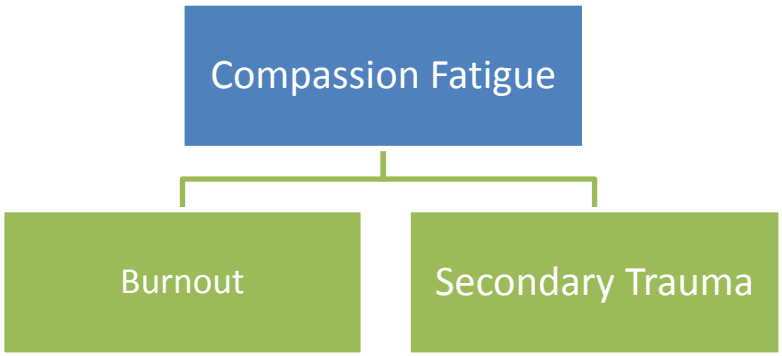


Figure 2.3: Hudnall Stamm's (2010) Conceptual Framework of Compassion Fatigue

Acknowledging the role that the work environment contributes to the development of compassion fatigue, Hudnall Stamm (2010) incorporates burnout as an integral component of compassion fatigue. This conceptualisation of compassion fatigue served to guide the current research and underpins the theoretical framework of this study. A closer examination of the concept of burnout is therefore required, in the analysis of concepts related to indirect traumatisation.

2.5.5 Burnout

2.5.5.1 Conceptual understandings of burnout

One of the important consequences of ongoing and unmitigated job stress is burnout. While many people confuse the term 'burnout' with that of 'occupational stress', burnout can be understood to be one of the consequences of ongoing stress. Specifically, "burnout is the exhaustion or breakdown phase after long-term or intense stress, when the body's reserves are depleted and physical and emotional breakdown happens" (Van Zyl-Edling, 2006, p. 168).

Research on burnout has shown that burnout rates differ according to professions and the field of work (Adballah, 2009). Ross and Altmaier (1994) note that professionals that are particularly vulnerable to burnout are teachers and counsellors. Due to the emotional intensity of trauma work, burnout is an inherent concern particularly in the helping professions such as social work. The symptoms of burnout are similar to those of compassion fatigue but burnout occurs more gradually and can be more difficult to treat (Jacobson, 2012; Wagner, 2003). Similarly, secondary traumatic stress can emerge suddenly and without any warning while burnout is a process. In addition, with secondary traumatic stress there is a sense of hopelessness, confusion, and isolation from supporters,

and symptoms are often disconnected from real causes and yet recovery generally occurs at a faster rate than burnout (Figley, 1995).

2.5.5.2 Predictors of burnout

A multi-dimensional approach needs to be adopted when understanding the variables that impact on burnout. These include client character, worker character and organisational factors. Furthermore, certain variables are correlated to higher susceptibility to burnout, which include:

- Marital status - due to less familial support single persons are more vulnerable;
- Age - younger people tend to experience more burnout, which could be attributed to being idealistic and having a lack of experience;
- Gender - women are generally more susceptible to burnout as they tend to be more emotionally involved;
- Education levels - a lower level of education and less experience make one more vulnerable to burnout;
- Belonging to a minority ethnic group;
- Personality type - those who are particularly committed and enthusiastic are at greater risk of burnout;
- Employer type - particularly government employees are more susceptible to burnout, due to excessive structures and bureaucracy;
- High case or workload;
- Lower positions or salary grade - the less remuneration one receives the less one feels like participating;
- The work environment - factors in the work environment can also contribute to burnout, for example, powerlessness where employees are placed in conditions where they cannot control events (Adbullah, 2009, p.52; Rowe, 2000).

2.5.5.3 Effects of burnout

A review of the literature on burnout shows that while there is inconsistency in understanding the cause of burnout, there has been consistent agreement about the effects of this phenomenon. Maslach (2003) emphasises the fact that burnout has three dimensions, namely emotional exhaustion (feeling drained), depersonalisation (emotional hardening) and a sense of inefficiency (that work contributions are not effective). Figley (1995) identifies three specific criteria that are associated with burnout. Firstly, burnout is a process that begins gradually and gets worse. Secondly, during the process there is gradual exposure to job strain, with a reduction in idealism and a lowered sense of achievement. Thirdly, there is an accumulation of intensive contact with clients.

Ross (2011, p.5) divides the signs and symptoms associated with burnout into three categories, namely:

- *"Physical symptoms* which include: chronic fatigue, increased susceptibility to illness and infections, frequent headaches, shortness of breath, backaches, stomach aches, gastrointestinal disturbances and insomnia;
- *Affective-cognitive symptoms* include the development of a negative self-concept, suspicion, rigidity, depersonalization, cynicism, emotional lability, meaninglessness and alienation, depression, lack of motivation, the feeling that work is drudgery, the belief that one is losing one's professional effectiveness, and a sense of emotional and spiritual depletion; and
- *Behavioural symptoms* which include displays of anger, impatience and irritation, overuse of food, tobacco, alcohol, tranquillizers or sleeping tablets, difficulty in finishing tasks, reluctance to get up in the morning for work, problematic interpersonal relationships at home and at work, finding it increasingly difficult to empathise with clients, reluctance to socialize, impaired concentration and job performance, increased errors and accidents, absenteeism, and staff turnover".

What is evident is that not only are these symptoms evident at work but these negative attitudes tend to spill over into the employee's personal life. Hence burnout can hold severe consequences for the social worker on a personal level and it can also be costly for the organisation or institution where he/she works as well as the client system (Abdallah, 2009). The costs are far reaching; not only is burnout a cost to the hospital administration and an added strain on the nursing staff, but also to the quality of care that patients receive and the nurse's ability to provide consistent care to patients. Often workers who are burnt out leave not only their jobs but also their profession. The same can be said of social workers when working with clients, where the potential for quality of services to be affected is extremely high. Furthermore, as Stevens and Higgins (2002) explain, burned out workers may be neglectful of important aspects of their jobs and, they may demonstrate faulty judgment. Burned out counsellors may distance themselves from their clients' problems as the issues may be too overwhelming for them to deal with or too close for comfort (DeLahunta & Tulsky, 1996 cited by Stevens & Higgins, 2002).

In order to cope with the burnout, some workers move into other positions in their organisations, while others will seek job advancement, often where posts are more administrative in nature. Whilst this move may help the burnt out individual it is not always the best option for the organisation. Sometimes the burnt out employees can bring negative attitudes with them into the new position. Other workers who are burnt out and remain in their jobs, often lose any enthusiasm for their own development, both personal and professional. These workers may be considered as the 'dead wood' of the organisation (Ross & Altmaier, 1994).

The relationship between burnout and job absenteeism is another aspect that needs to be considered. Firth and Brotton (1989, as cited by Parker & Kulik, 1995) examined this relationship by studying employee records. They found that emotional exhaustion in nurses was found to be positively associated with the total sick time taken. Another area that may be affected by burnout is that of job turnover. Lazaro (1984, as cited by Parker & Kulik, 1995) found that the higher the burnout rate the greater the probability that the individual would leave his/her job. What these variables indicate is a lower quality of services to patients and possibly also lowers morale amongst colleagues. If nurses are exhausted it will ultimately reduce the amount of warmth and concern that they are likely to show in treating patients.

2.5.5.4 Burnout and social workers

In the last few decades there have been many studies exploring burnout in social work (Abdallah, 2009; Geoffrion, Morselli & Guay, 2015; Ross, 1997). In particular the role of personal characteristics of the social worker in relation to burnout rates has been explored. Findings have revealed that the personal trauma history of the social worker was not positively correlated with burnout (Steven & Higgins, 2002). When exploring the extent of burnout among 180 Palestinian social workers working in the west bank Abdallah (2009) found that 20% experienced emotional exhaustion, 47% experienced depersonalisation and 53% reported a lack of personal accomplishment. Moreover, findings indicated that 20% found that they could no longer dedicate themselves to the work that they intended to do and almost half (46.7%) had negative feelings towards their clients. Age was also revealed to be a significant predictor of burnout as younger social workers tended to experience higher levels of burnout than older social workers. It is possible that younger social workers were more idealistic whilst older social workers who tended to be married with children may have invested less of themselves in their work. Another significant finding was the effect of self esteem on burnout, where increased burnout rates were correlated with low self-esteem. This finding has implications for employing organisations to improve efforts to promote social workers' sense of self worth, particularly when they are working with highly stressed client populations.

Calitz, Roux and Strydom (2014, p. 164) attribute high burnout rates among South African social workers to the less than optimal working conditions, and believe that social workers are "pushed to their limits" in trying to fulfil work requirements which results in their impaired work performance and poor mental and physical health.

2.5.6 Transference and Counter-transference

2.5.6.1 Conceptual understandings of transference and counter-transference

Understanding transference has become a central component of psychoanalytic therapy. The term 'transference' refers to the feelings, thoughts and fantasies that patients have towards their

therapists. Within the therapeutic relationship repressed aspects from childhood are often expressed (Smith, 1990). **Trauma-specific transference (TST)** refers to the unresolved and unassimilated aspects of the traumatic event and how the client unconsciously relates these aspects to the therapist. These reactions can present themselves through "affective states, behavioural tendencies and symbolic role relationships" (Wilson & Lindy, 1994, p. 9). Kluft (1994) posits that in dealing with trauma survivors one not only encounters normal transference issues but also traumatic transference. He maintains that when one is counselling a trauma victim one inevitably retraumatises the client as one helps the client retrieve painful memories. As a result some clients may come to associate the therapist with emotional pain as well as the shattered view that their lives are not as ideal as they may have wanted to believe. Conversely, clients may treat therapists as their 'magical helpers' and when therapists fail to live up to their expectations they may feel betrayed and disappointed.

Counter-transference refers to the therapist's own emotional reactions to the client or any disruption that may cause the therapist's attitude not to be neutral (Smith, 1990). Corey (2005) expounds on the concept of counter-transference and refers to it as a process of seeing oneself in the client, meeting one's own needs through the client or over identification with the client. In the initial stages of intervention with a traumatised client, a safe holding environment needs to be created in order to establish trust and openness so that the 'trauma story' is explored. In order to be empathic Wilson and Lindy (1994) explain that one is required to project oneself into the phenomenological world being experienced by the client. However, the complexities of an empathetic relationship should not be minimised, as it is difficult to sustain the 'empathic inquiry' and counter-transference will invariably also have prolific effects. Slatker (1997, p.203 cited in Wilson & Lindy, 1994) refers to 'counter-identification' and explains that "through the process of counter identification the analyst identifies with the patient and at the same time pulls back from that identification so as to view the patient's conflict with objectivity". One can see that the phenomenon of counter-transference is complex; Wilson and Lindy (1994) identify four aspects that need to be considered in counter-transference. Firstly, the context within which the therapeutic relationship occurs is crucial as the therapist may be responding to the initial reaction. Secondly, these reactions can be harmful or beneficial to the therapeutic relationship. Thirdly, counter-transference may be complimentary or concordant. Complimentary counter-transference occurs when the therapist identifies with some aspect of the client's situation. Conversely, in concordant counter-transference the therapist may identify with another perspective or role other than that of the client. Lastly, it is important to note that counter-transference is a reactive process that may ignite reactions from both the therapist and the client.

However, Tehrani (2007) questions the universatility and value of the term 'counter-transference'. Furthermore, Danieli (as cited in Tehrani, 2007) believes that the use of the term counter-transference

is not helpful as it has perpetuated psychodynamic attitudes and inhibited professionals from studying, adequately diagnosing and treating the effects of secondary trauma.

2.5.6.2 Counter-transference in relation to PTSD

Wilson and Lindy (1994) propose that the primary cause of treatment failure with PTSD is counter-transference reactions. They identify two types of counter-transference. Type I is characterised by avoidance, distancing, denial and detachment responses. Type II is characterised by over identification, overrealisation and enmeshment. Furthermore, they identify four types of empathic strain that occur, namely, empathic withdrawal, empathic repression, empathic enmeshment and empathic disequilibrium. Empathic withdrawal occurs when a therapist who is predisposed to a defensive Type I style of personality, experiences affective and cognitive responses. Empathic repression occurs when the therapist's own concerns and unresolved issues are brought to the fore. They also have a tendency to Type 1 counter-transference and will either deny the intensity of the client's issues or transfer the client to another therapist. In empathic enmeshment the therapist has a tendency towards Type II counter-transference and becomes over involved and over identified with the client. Therapists, who are particularly vulnerable to this mode of empathy, generally have a personal history of victimisation themselves. Empathic disequilibrium is identified by feelings of insecurity, discomfort, and uncertainty in dealing with the client. It is characterised by a predisposition to Type II counter-transference.

2.5.6.3 Counter-transference in relation to secondary stress

Counter-transference not only refers to the emotional reactions of the therapist to the client but also includes what the therapist absorbs from the traumatic information expressed by the client (Figley, 1995). In order to manage counter-transference effectively therapists need five essential qualities. These include anxiety management, conceptualisation of skills, empathic ability, self-insight, and self-integration. The last two qualities were identified as being the most significant (Hayes, Gelso, Von Wagoner & Diemer, 1991 cited in Figley, 1995). In essence the argument that Figley puts forward is that secondary traumatic stress in therapists includes counter-transference dimensions. One therefore needs to acknowledge this phenomenon and deal with the counter-transference appropriately in order to remain effective in the therapeutic relationship.

2.5.7 Shared Trauma (ST)

Possibly one of the most recent constructs to have emerged in the field of traumatology is that of **shared trauma**. Tosone, Nuttman-Schwartz and Stephens (2012) argue that in traumatogenic environments, the phenomenon of secondary trauma does not adequately reflect the enormity of the impact of a traumatic event on mental health practitioners. The profound effects on the clinician are

more appropriately encapsulated and described by the concept of shared traumatic stress (Tyson, 2007).

Mental health personnel who assist in international relief or disaster situations are particularly vulnerable to shared trauma. A study conducted with international relief and development personnel found that respondents reported high rates of direct and indirect exposure to life-threatening events. Multiple regression analysis revealed that both direct and indirect trauma exposure to life threatening events as well as social support and life threat accounted for a significant variance in PTSD severity. Almost a third of those surveyed reported significant symptoms of PTSD (Eriksson, Van de Kemp, Gorsuch, Hoke & Foy, 2001).

The concept of shared trauma became particularly relevant after the September 11 terrorist attacks which occurred in the United States of America in 2001. Therapists, who were involved in counselling victims and family members of those who had died in the attack, were also affected by virtue of the event. Tosone reflects on the September 11 event with MSW students, most of whom were first-hand witnesses of the event. They highlight the complexity of working in a profession such as social work that requires one to assist clients who are experiencing similar feelings and difficulties and trying to cope with the same event (Tosone et al., 2003). Saakvitne (2002) maintains that shared trauma also increases the therapists' vulnerability to developing changes in cognitive schema. Exploring and understanding the notion of shared trauma is an imperative trajectory for the field of traumatology, as it not only incorporates the context in which the social worker or therapist works but provides a holistic understanding of the effect of trauma on the social worker.

Recent studies concerning shared trauma have explored both the positive and negative experiences of practitioners. The Shared Traumatic and Professional Posttraumatic Growth Inventory (STPPG) has consequently been developed in order to measure shared trauma, personal trauma and professional posttraumatic growth (Tosone, Bauwens & Glassman, 2014). While this measure has not yet been extensively used, developers of the STPPG emphasise the need to explore both positive and negative experiences of secondary trauma exposure. In a country like South Africa which has an extensive traumatic past, the concept of shared trauma is extremely relevant as many mental health practitioners are more than likely to have been exposed to traumatic situations similar to their clients. Currently there is no evidence that this construct has been researched in South Africa; hence conducting empirical studies would be a necessary step in contributing to the South African trauma trajectory.

2.6 THE OTHER SIDE OF THE COIN - POST TRAUMATIC GROWTH

In Jung's (1943) work 'On the Psychology of the Unconscious', the hero must go underground to find renewal and direction (Early, 1993). This theme of victory following difficulty is a common premise throughout history. While most of the research into trauma has focused on the debilitating effects of trauma, the potential for growth and positive change should not be under-estimated or disregarded. Calhoun and Tedeshci (1998, as cited by Ben-Porat & Itzhaky, 2009) formulated the term posttraumatic growth to refer to an individual's experience of growth following a traumatic incident.

Victor Frankl is possibly one of the greatest stalwarts in the area of psychological growth occurring as a result of trauma. Frankl, a psychiatrist who survived the Holocaust, analysed how some people survived the atrocities of the Holocaust and the concentration camps, while many did not. He suggested that the human psyche is challenged through crisis situations and that hope and meaning can be deepened through difficult situations. An inner strength can develop if these qualities are nurtured and meaningfulness can be found through adversity (Frankl, 1984). According to Polkinghorne (1998 as cited by Jenmorri, 2006) we imbue our lives with meaning through creating, telling and re-creating stories about our place in the world.

Positive and negative changes after trauma should possibly be considered as independent constructs instead of being on opposite ends of a continuum. For example, Linley, Joseph, Cooper, Harris and Meyer (2003) found in a study of vicarious exposure to the terrorist attacks of September 11 that participants experienced both positive and negative changes. Furthermore, they found that positive and negative changes were positively associated, indicating that positive and negative changes occur alongside each other. Their results revealed that respondents who perceived terrorist attacks to be attacks on their own values and beliefs, were more likely to report positive changes. However, negative changes also occurred and were positively associated with positive change.

For the therapist experiencing vicarious trauma, this experience can become a crisis of opportunity as practitioners' spiritual frameworks may be challenged, but also through reflection and a search for meaning, deeper levels of spirituality may be the result (Jenmorri, 2006). Baum and Ramon (2010) found that most Jewish social workers working with victims of political violence in Israel, reported professional growth, through increased knowledge and skills, improved professional identity and greater team cohesion. In another study in Israel, Ben–Porat and Itzhaky (2009) found that therapists not only reported growth in their professional lives but also in their personal lives and the lives of their families as a result of their work. Specifically, these therapists reported positive changes and development of assertiveness skills, greater control over their anger, more constructive communication skills as well as positive changes in their spousal relations and parenting skills.

Despite optimistic views about posttraumatic growth, some authors (Danieli, Rodley & Weisaeth, 1996) caution about being overly optimistic about traumatic growth. They believe that even survivors, who feel that they have made it, still experience difficulties as a result of their trauma and that perhaps the survival stories are more of a defence than effective coping. What is apparent from a literature search on the topic of posttraumatic growth is that it is an area that has not yet been researched extensively and still requires significant exploration (Ben–Porat & Itzhaky, 2009).

2.7 TRAUMA AND CULTURE

While many critics claim that the classification of PTSD is predominantly Western based and perhaps not necessarily suitable for all cultures, authors such as Herbert and Forman (2006) discuss how the research in this area has yielded mixed results. They argue that whilst studies have shown the legitimacy of the concept of PTSD as a concept across historical contexts and cultures, it would seem that these studies have not sufficiently explored a wider range of traumatic experiences across cultures both in terms of what is considered traumatic as well as the responses to the trauma. Briere and Scott (2006) indicate that often traumatised people from non-Anglo-Saxon cultures, who present with re-experiencing and arousal symptoms, lack avoidance or numbing symptoms and so fail to meet the diagnostic requirements of PTSD.

What is apparent is that the notion of PTSD is dependent upon prevailing cultural conceptualisations of psychopathology as psychobiological, cross-cultural and historical studies have shown (Herbert & Forman, 2006). Bracken (2002, p. 20) argues how historically psychiatry emerged to label those who had already been rejected and thus its diagnoses became symbols of rejection in themselves. Bracken (2002) records how Foucault (1980) questioned whether the emergence of institutions in which to place 'unreasonable people' was progressive, or whether it was rather an act of social exclusion. Furthermore, he strenuously objected to the positivist nature upon which psychiatry was built. Two important aspects about the positivist position include the notion that firstly, the history of psychiatry is seen as a progressive identification of the true nature of mental illness and secondly, the belief that psychological problems have the same basic form cross-culturally. The positivist approach attempts to delineate universal aspects of mental illnesses, through the use of standardised questionnaires and operational variables. As these methods are 'scientifically' based they are interpreted as value-free and neutral. However, the ethnic, cultural and class bias is not sufficiently considered (Bracken, 2002).

Western ideology advocates that one should seek counselling and assistance from mental health professionals if one experiences traumatic stress. However, in African cultures if something detrimental or traumatic occurs, it usually means that either the ancestors are upset about something or that someone has put a curse upon the victim (Kaminer & Eagle, 2010). Many African people consult traditional healers to assist them to overcome the trauma. While the two paradigms are

distinctively different there are areas of overlap. For example, in many Western approaches to therapy dreams are very significant and symbolic. Theorists such as Freud and Jung clearly emphasise the importance of analysing dreams. African healing practices also use dreams for diagnostic purposes but also believe that they are a form of communication from the ancestors (Straker, 1994).

Different cultures have religious and ritualistic practices to address and treat various illnesses whether they are physical or psychological (Wilson, 1989). A classic example includes the rituals and practices that surround death and bereavement. In Zulu culture it is considered important that the body is buried with the ancestral spirits, 'the amadlozi'. If the body cannot be returned home for burial, someone is sent from the family to fetch the soul. Many Zulu people believe that this process is made possible with a branch of buffalo thorn tree, which draws the spirit from the dead into the branch (Ross & Deverell, 2010).

Straker (1994) advocates that practitioners need to be more culturally sensitive and need to combine Western and African paradigms and understandings when assisting victims. She emphasises that there are many similarities between an African and Western understanding of symptoms of PTSD. Both systems acknowledge these symptoms to be a function of breaching the stimulus boundaries, the existence of survivor guilt and the phenomenon of incomplete mourning. Furthermore, certain aspects of Western psychotherapy, such as: catharsis after a traumatic event; re-ordering of perceptions following insight; and establishing hope following trauma whilst promoting continuity with the past; may be promoted alongside interpreting dreams with African traditional meanings. Edwards (2009) calls for Western trauma treatment approaches to be modified so as to align with cultural contexts. Appropriate evidence based practice would be more likely to occur if grounded clinical theory allowing for personality and cultural differences, is developed and adapted in order for trauma interventions to be applicable in the South African context.

2.8 CONCLUSION

Traumatology, has in the past two decades seen a proliferation of research into the impact of indirect trauma on therapists. What is clearly evident is that the terms secondary trauma, vicarious trauma, compassion fatigue, and burnout may all be closely related. While some authors tend to juxtapose these terms as the same concept, and one cannot dispute the similarities, this chapter has tried to differentiate between these concepts. Perhaps the best way of understanding this differentiation is in Hudnall Stamm's (2010) explication, namely that secondary trauma is the broad term and that compassion fatigue, vicarious trauma and some types of counter-transference should be viewed as specific types of secondary traumatic stress. It is upon this understanding that this research has been framed.

What is clear is that the therapist who counsels a victim of trauma is vulnerable to being affected by the trauma. What these numerous terms convey is that trauma work is difficult, challenging and frequently exhausting for those who are involved in it (Williams & Sommer, 1999). Ultimately this understanding helps one to realise that the response to trauma is possibly far more complex than was initially conceptualised. When analysing secondary traumatic stress, it is imperative to understand the context within which trauma practitioners work. The third part of this thesis endeavours to provide understanding of the South African context and the functioning of the social work profession within that context.

CHAPTER THREE

COPING, RESILIENCE AND TRAUMA

"***Healing from trauma requires a reverence for life. Reverence requires a state of meditative reflection on life's goodness. Meditative reverence is a consciousness of ultimate being and daily presence. Transformation of trauma is spiritual reverence. Spiritual reverence is the embodiment of soul and the sanctity of life" (Wilson in Wilson, Friedman & Lindy, 2001, p.2).***

3.1 INTRODUCTION

Exposure to indirect trauma has the potential to impact every area of the therapist's life. The effects of a traumatic event are determined not only by the extent of the trauma exposure but also by the coping methods that one utilizes in order to deal with stress and trauma. The coping strategies utilised may ameliorate or further exacerbate the individual's overall functioning. Effective coping helps to reduce traumatic stress, whereas ineffective coping can exacerbate the trauma response (Davies, 2001; Figley, 1995). Interventions in the treatment of trauma have focused primarily upon primary trauma survivors while not as much attention has been given to ensuring effective treatment for secondary victims. Bercier and Maynard (2015) assert that more outcome research is required to assess effective strategies in the treatment of secondary traumatisation. Furthermore, clinicians often acknowledge that their professional training has not adequately prepared them for how to cope with their personal responses that may arise when working with trauma victims (Jacobson, 2012; Salston & Figley, 2003).

Coping strategies may be considered protective factors as they help to alter or modify the individual's response to stress or trauma and in turn help to develop resilience (Stevens & Higgins, 2002). Consequently, it is imperative to explore and understand the concept of resilience. Understanding the risk factors for STS as well as enhancing protective factors such as creating an optimal work environment and encouraging personal and professional supports are imperative when addressing the effects of indirect trauma exposure. This chapter focuses on the relationship between coping and trauma; risk factors for STS; factors that enhance resilience; and theoretical approaches to understanding coping and trauma. In addition, strategies to address the effects of indirect trauma are discussed in relation to organisational, professional and personal dimensions.

3.2 COPING AND TRAUMA

3.2.1 The Relationship of Coping and Trauma

Coping is a multidimensional and multifaceted phenomenon that is mediated by many variables, and can be understood to be a rubric or metaconstruct within which a number of phenomena are embedded (Wilson, 1989). Lazarus and Folkman (1984, p. 210) define coping as "consisting of cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person". This understanding of coping has three important features: Firstly, it implies that coping is process- orientated and highlights the manner in which the person changes in order to adjust to the changing situation. Secondly, the definition is contextual and refers to the person's appraisal of the demands of a particular situation. Thirdly, coping refers to the efforts in managing demands but it does not refer to the success of these efforts.

Other authors such as Aldwin (1994) understand coping to be divided into two components: **active efforts directed towards the environment** and the use of **defence mechanisms** directed towards protecting the self. Thompson, Murphy and Stradling (1994) explain that coping occurs in four dimensions, namely removing the stressors from one's life; not allowing neutral events to become stressors; developing a proficiency in dealing with situations which we do not wish to avoid; and through relaxation and seeking diversion from the pressures. Research by Kirby, Shakespeare-Finch and Palk (2011) has shown that there are gender differences in coping as the expressive types of coping appear to be employed more by women than men. Whilst conceptualisations of coping appear quite different, it is evident from the variety of definitions that coping involves either active problem-solving techniques or adjustments on the part of the individual. One must acknowledge that coping can lead to positive adaptation or maladaptation. It is not stress alone that causes distress but also how people manage, or cope with the stress and trauma. The practitioner's ability to adjust to the traumatic stress is highly dependent upon his/her individual coping strategies and resources (Gil & Weinberg, 2015). Figley (1995) displays this understanding in Figure 3.1.

Figley's (1995) model shows how individuals' appraisal of a stressful situation is dependent on their past learning, views of themselves, sensory perceptions as well as physiological responses. Aldwin (1994) referred to this idea as differentiation function and dysfunctional coping. A traumatic response occurs when the coping strategies do not adequately assist the individual to obtain equilibrium. Psychological defences then help to minimise the effects of the trauma or physiological changes can occur as a result of trauma adaptation, which can result in physical illness or trauma related psychiatric disorders such as PTSD, dissociative disorders and depression (Figley, 1995).

People may resort to desperate measures in order to cope temporarily and relieve the negative emotions that are often experienced with trauma. In an attempt to self-regulate the negative effect of

anxiety, fear, guilt and sadness, people often engage in self-destructive behaviours. These behaviours may include an increase in addictive or abusive activities such as substance abuse, sex addiction, eating disorders, intentional self-harm and sometimes even suicide (Allen, 2005). These harmful behaviours may provide temporary emotional relief from a traumatic state and provide an opportunity for immediate emotional release but often result in complications and delay in healing from the trauma.

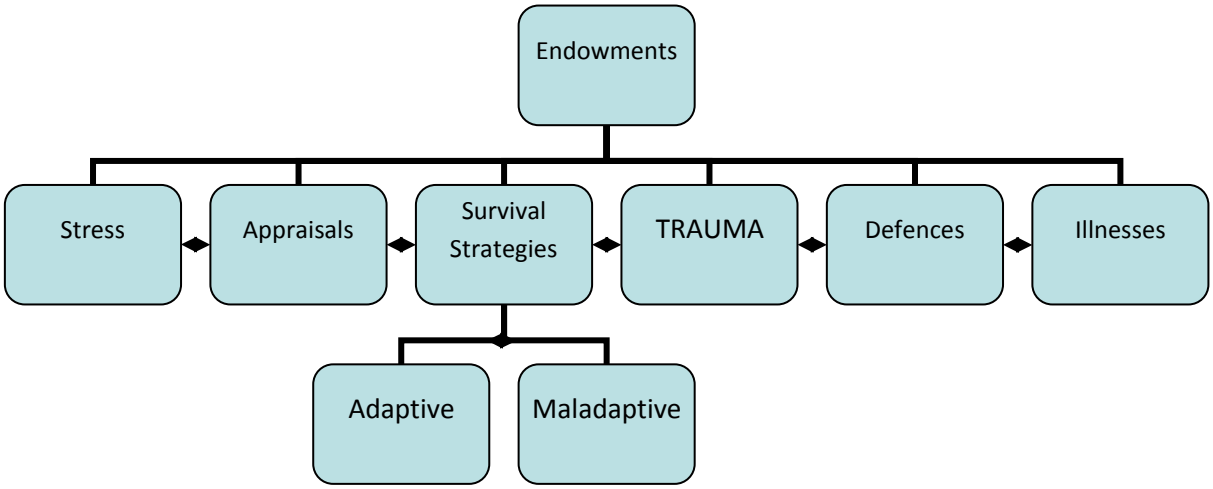


Figure 3.1: Figley's (1995) Model of Coping and Trauma Transmission

However, Kirby et al. (2011) caution against understanding coping as a dichotomous construct as certain strategies may be essential in ensuring that the individual copes with a specific situation. For example, these authors view the emotional detachment that paramedics may display as a necessary factor which enables them to fulfill their duties when treating patients. In a similar vein, Huggard (2003) explains that caring professionals may detach themselves rather than emotionally engage with clients in order to prevent burnout. Detachment can help practitioners to maintain impartiality, improve concentration and ration time to maintain objectivity. While these defences may be appropriate in work situations, the question arises whether practitioners are able to lower these defences in their personal lives with their partners and families.

3.2.2 Determinants of Trauma and Coping

The question that has puzzled traumatologists for decades is why some people develop PTSD from traumatic exposure while others do not. Similarly, the question can be asked why some mental health professionals are affected by the indirect exposure to trauma, while others do not appear to be affected. Extensive research has also been undertaken in trying to answer this question (Bride, 2007b; Figley, 1999; Hudnall Stamm, 1999; Killian 2008) and while there is general consensus around vulnerable factors, these factors appear to be subject to change in different contexts, cultures and time periods.

Table 3.1: Elements for a Theory of Traumatic Stress Reactions (Wilson & Lindy, 1994, p. 21)

I	**The Nature of the stressor Dimensions Present in the Trauma and the Trauma Story**	• **Complexity and type of stressor (natural vs. human origin)** • **Grotesqueness, death, injury, mutilation and abuse** • **Stage in life cycle at exposure** • **Roles (in event)** • **Moral dilemmas during event** • **Degree of psychological ensnarement by perpetrator or events** • **Personal role relations in event** • **Duration, severity, frequency of exposure or victimisation** • **Degree of community involvement**
II	Personal Factors in the Therapist/ Helper	• Personal beliefs, religious values, ideological systems and preconceptions • Defensive styles and dispositions • Personal 'historical' data from own life experiences • Degree of training and experience with trauma and victimisation • Motivation to work in trauma field • Theoretical assumptions about personality and life cycle development
III	Factors in Client Relevant to Understanding Counter Transference Reactions/	• Age, race, gender, ethnicity, and cultural dimensions • Role in traumatic event (e.g. perpetrator, victim witness) • Personality characteristics • Defensive and coping styles • Level of traumatisation • Cultural differences affecting the cognitive process of trauma • Pre-trauma ego strength or pre-morbidity • Type of traumatic event • Family dynamics and background factors
IV	Institutional/Organisational Factors relevant to Therapeutic Process	• Political context: supportive versus oppositional • Attitudes toward client population • Adequacy of resources that help or hinder treatment • Availability of 'network' affiliations and resources to aid in treatment • Internal or external mechanisms to provide necessary support for helpers • Flexibility versus rigidity to change existing organisational health care structures

Friedman's Table (Table 2.2 in Chapter Two) shows how various individual characteristics in conjunction with the nature of the traumatic event are likely to play a role in the development of traumatic symptoms. All these factors listed in Table 3.1 are relevant and need to be considered when trying to understand the variables that influencing trauma development in the therapist. In addition to personal factors in relation to the therapist (such as age, gender, race, religion and personality), Wilson and Lindy (1994) identify three key areas which are likely to influence the manner in which the therapist is affected and how a client's trauma may evoke counter-transference reactions in the therapist. These areas include the nature of the stressor dimensions present in the trauma and the trauma story; relevant factors in the client; and institutional and organisational factors relevant to the therapeutic process. Table 3.1 depicts the four factors and numerous variables that these authors identify as influencing relevant dynamics and how trauma therapists are likely to respond to their clients' traumatic material. While some of these factors have been explored in Chapter Two, this chapter explores the influences of factor three and four of this table, namely factors relevant to the therapist's interpretation of the trauma – specifically coping – and factors relevant to the organisational context. As previously acknowledged, one of the inherent difficulties in being a social worker is the exposure to client suffering and exposure to traumatic material. However, as Tyson (2007) points out, it is how the suffering is experienced and responded to by the social worker which impacts upon whether listening to the trauma is bearable. This factor will determine whether the experience is a growth-enhancing one or a destructive one for the social worker.

3.3 DIFFERENT THEORETICAL APPROACHES TO UNDERSTANDING COPING WITH TRAUMA

Numerous theorists and different schools of thought have various interpretations and understandings of trauma and which approaches should be used to reduce the effects of trauma. Hence the next section provides a brief explanation in respect of some of the most prevalent theories including the psychoanalytic understanding, the cognitive approach, the narrative approach, neurobiology and the neoteric therapies as well as trait theories.

3.3.1 Psychoanalytical Understanding and Treatment Approaches

Clinicians have used psychodynamic psychotherapy in the treatment of trauma for more than 100 years (Friedman, 2006). The psychoanalytic understanding is grounded in the frameworks of Freud and Klein, who contended that the impact of a traumatic event on an individual can only be understood once the meaning of that event for the client is explored. Therefore, the therapist needs to pay particular attention to the client's childhood and developmental experiences which have shaped the client's internal world. When psychic wounding occurs in the client's external world, the psychoanalytic approach tries to shift the internal object relations and the corresponding internal world (Garland, 1998). Psychodynamic theories focus on how individuals maintain their psychic balance through the use of unconscious defences.

Clients may, through the psychological defence of repression, force intolerable thoughts and feelings from conscious awareness. Unconscious traumatic memories are often expressed as symptoms, which include intrusive, avoidant or hyperarousal symptoms. As trauma overwhelms existing defences against anxiety the mind is then flooded with stimulation which is disruptive to existing mental structures. Primitive fears, anxieties and impulses are then expressed. Rather than focusing strictly on trauma symptomology the analyst brings out the unresolved pain and conflicts of childhood. In order for a traumatic event to be successfully worked through the survivor needs to be able to mourn. As the therapist helps the client to confront unconscious processes which have repressed the memories and produced maladaptive symptoms, so clients gain insight into how their repressed memories are transformed into their symptoms. Ideally through improved understanding and enhancing ego strength, the client can reduce the severity of symptoms (Friedman, 2006; Garland, 1998).

While psychodynamic approaches to therapy are usually long term interventions, a brief psychodynamic psychotherapy (BPP) has been developed, which is trauma focused and lasts for 12-15 sessions. This approach, which can be located within the ego psychology tradition, has been developed from the work of Horowitz and Lindy. This approach does not focus on character change and catharsis; instead it aims to help the client develop a sense of self-cohesion, and develop more adaptive defences and coping strategies. This goal is achieved through the client retelling the trauma story to a therapist who is calm, empathic, non-judgmental and compassionate. From an object relational perspective, the counselling experience provides the client with an opportunity to internalize a 'good object' experience (Friedman, 2006; Kaminer & Eagle, 2010).

3.3.2 Cognitive Theories and Interventions

The cognitive behavioural understanding of traumatic stress is based upon the understanding that symptoms of trauma occur as a result of maladaptive learning and conditioning that occurs in response to traumatic stimuli. According to Zayfert, DeViva, Becker, Pike, Gillock and Hayes (2005), Cognitive Behaviour Therapy (CBT), in particular Exposure Therapy (ET) and Cognitive Restructuring (CR), are the most systematically studied psychosocial interventions for the treatment of PTSD. It is understandable that these approaches would be popular in the treatment of trauma as trauma exposure is understood to make people feel helpless and exposed, and to evoke negative automatic thoughts in which the environment is both threatening and dangerous. Cognitive Behaviour Therapy would directly confront these distortions in thinking and is the most popular method of intervention in trauma counselling (Friedman, 2006; Kaminer & Eagle, 2010).

One of the first most influential cognitive models was Horowitz's (1974) Model of Information Processing, which was built on classical and contemporary theories of emotion and which identifies numerous phases of the trauma response. It is based upon the approach that individuals have mental

schemas of themselves and the world which they use to interpret incoming information. When a traumatic event occurs, information is presented which does not correlate with existing schema. The response to the traumatic event requires reappraisal and revision of the schema. Over time cognitive processing and integration occurs. The flow of information is regulated through processes of facilitation and habituation (a process where an individual reduces responses to a stimulus through constant presentation of the stimulus) in order to prevent emotional exhaustion. When inhibitory control is not strong enough, denial and intrusion may occur or it could even result in avoidance. When the individual is unable to process beyond the oscillation and intrusion phases, posttraumatic stress may occur (Horowitz, 1999).

3.3.3 Narrative Therapy

Narrative therapy although not as commonly used as some of the other approaches, has been employed in assisting trauma victims. The essence of narrative therapy is to help clients re-author their lives, and increase the sense of personal agency through addressing the meaning of significant events in their lives. The therapist emphasises that the client is a survivor and not the victim of an event. The client's traumatic experience becomes a story of resilience and survival (Kaminer & Eagle, 2010). Meichenbaum (1997) encourages therapists to assist clients to reconstruct the traumatic event so that they are then able to integrate the traumatic experience in their lives and move on beyond the event. In essence in Meichenbaum's later writings on trauma, he incorporates a narrative approach and refers to it as 'narrative constructivism' (Kaminer & Eagle, 2010).

Whilst social work has historically recognised a strengths perspective when working with clients, incorporating a narrative constructivist approach includes both a strengths as well as a constructivist perspective. Norman (2000) maintains that adopting a narrative constructivist approach when assisting trauma victims not only helps clients to reflect on pre-traumatic support such as available support, effective coping abilities, and healthy family functioning but also to help reframe the traumatic experience and derive meaning from the event. During this stage the therapist needs to model the language of striving and thriving and facilitate narrative construction. As the story is shared by the clients themselves this sharing allows clients to tell their stories in ways unique to their own cultures and communities (Norman, 2000). This kind of intervention provides a space for the collective and individual story of a trauma survivor.

3.3.4 Existential Therapy

Trauma is also conceptualised as a transformational opportunity and the existential approach to understanding trauma emphasises finding meaning and purpose in life. Existentialism holds that people are neither good nor evil. How one behaves is based upon the choices that one makes. These choices are grounded in constraints, influences and lessons from social and political interactions

(Thompson et al., 1994). Existentialism does not advocate that people are primarily good, but instead existentialists believe our behavior results from the choices we make. Existentialism places significant emphasis on the socio-political context in which individuals live and themes of freedom, choice, responsibility and courage are essential tenets of this approach (Meyer, Moore & Viljoen, 1989; Van Deurzen-Smith, 1990).

Therefore important ways in which one deals with pressure and stress would be to seek meaning and purpose in one's life. Furthermore, existentialists aver that one should seek authentic existence, so that one can come to terms with personal responsibility for one's actions and the realization that there is little certainty in life. Fosha (2008) describes how Lindermann (1944) explained the symptomology of grief after counselling hundreds of survivors of a fire in Boston, where hundreds died. He emphasised that crisis creates psychic fluidity as defences are loosened and previously entrenched defence patterns are challenged and derailed. Hence the opportunity for growth and healthier coping strategies develop. Growth after trauma has often been associated with the individual's search for meaning. Victor Frankl (1984) believed that people could survive and endure trauma if they had a deep understanding of the meaning of their existence. Frankl grounded his work in the words of Nietzsche "He who has a why to live can bear almost any how" (Frankl, 1984, p.36).

3.3.5 Neurobiological Theories

During the last 20 - 30 years there has been an increased understanding of the biological effects of trauma ensuant upon the development of brain imaging techniques and new bio-chemical approaches. What is apparent is that trauma disrupts homeostasis and there may be short and long-term effects on many organs and systems in the body. Concomitantly, as brain imaging techniques developed so the complexities of the relationships among experience, neurophysiology, endocrinology and behaviour have become evident (Solomon & Heide, 2005). The brain functioning of those who develop PTSD has been found to differ from those who do not develop PTSD (Kaminer & Eagle, 2010). Three important areas of the brain (the amygdala, medial prefrontal cortex and hippocampus) have been implicated in dysregulations through neuroimaging research. Hyperarousal symptoms may occur as a result of heightened activity of the amygdala. Symptoms such as flashbacks can also be attributed to insufficient inhibition of the amygdala.

The hippocampus of trauma survivors who develop PTSD also appears to be significantly smaller. Androgenic HPA, serotonergic systems as well as corticotropin-releasing factor (CRF) function abnormally in people with PTSD (Friedman, 2006). These changes in brain structure and physiology are thought to affect numerous areas of functioning including memory, learning, ability to regulate affect, social development and even moral development (Solomon & Heide, 2005). Immediate and long-term endocrine changes affecting metabolism and neurophysiology can result from traumatic experiences.

These changes in turn may affect other body systems including the cardiovascular system, respiratory system and muscular system. Cortisol concentrations are also lower in PTSD sufferers. This finding suggests that there is failure of cortisol to shut down the stress response (Solomon & Heide, 2005). The debate about whether these neurobiological features develop after the trauma as a result of the trauma exposure or whether these neurobiological features are inherited vulnerabilities that existed prior to the trauma exposure is still ongoing (Kaminer & Eagle, 2010).

The neurobiology of trauma is a complex issue and the debate about PTSD is important. However, a polarized treatment approach between the psychiatric and social perspectives does not adequately address posttraumatic stress. The recent findings concerning the biology of trauma challenge therapists to embrace holistic treatment approaches in the treatment of trauma and accept its dichotomous nature. Treatment needs to comprise both affective and somatic elements and therefore a multi-disciplinary approach is most suitable (Kaminer & Eagle, 2010; Solomon & Heide, 2005).

3.3.6 The Neoterics or Power Therapies

Whilst these therapeutic approaches still need extensive empirical research in order to ascertain their scientific validity, they tend to result in rapid alleviation of symptoms and are used by trauma therapists, especially in the United States of America (Kaminer & Eagle, 2010). The most well known of these is Francine Shapiro's Eye Movement Desensitisation and Reprocessing (EMDR), which involves elements of desensitization and cognitive restructuring but also includes neurological processing. The essence of this procedure is the generation of rhythmic, multi saccadic eye movements while the client focuses on the memory to be sensitized. The patient is then asked to articulate a positive memory (Shapiro, 1989). Despite limited scientific evidence to support this technique (Watson, Friedman, Ruzek & Norris, 2002), the efficacy of this approach has been widely accepted. For example, in a study of traumatised women, Scheck, Schaeffer and Gillette (1998) found that women who received EMDR experienced a greater reduction in trauma symptoms than those who did not.

Traumatic Incident Reduction (TIR), Visual Kinaesthetic Dissociation (VKD) which is based on Neurolinguistic Programming (NLP) and Thought Field Therapy (TFT) which has its origins in kinesiology, are additional therapies that can be considered as power therapies. A criticism of these approaches is that they tend to focus on symptom reduction and do not focus on the meaning or integration of an event into the client's life. Kaminer and Eagle (2010) note that due to the inherent limitation of these approaches, therapists in South Africa tend to include these approaches as part of their skills repertoire but do not rely exclusively on these techniques in the treatment of trauma. The lack of empirical studies and scientific understanding of these approaches raises the question whether it is ethical for professional practitioners to incorporate these techniques in their practice (Masson, Graham & Langa, 2016).

3.3.7 Trait Theories

Trait theorists believe that we have certain stable characteristics within our personality which help us to deal with pressure and stress. These patterns or traits, are constant through time and across various situations. One refers to a particular personality type where certain traits are clustered together. Thompson et al. (1994) identify the following specific traits: personality type, hardiness, locus of control and neurotic anxiety, as having specific roles in the manner in which an individual copes with stress and trauma in a situation.

3.3.7.1 Personality type

People can generally be classified as either Type A or Type B personality types. Type A personalities are characterised by a high level of ambition, a preoccupation with work and deadlines, competitiveness, and a low tolerance for stress and frustration. Type B personalities are the opposite and lack the sense of urgency on which type A thrive. Understandably type A personalities are far more prone to experiencing stress and burnout (Schafer, 2000; Seaward, 2002). Thompson et al. (1994) also cite Freudenberger (1965) who identifies three particular helping personality types that are vulnerable to experiencing stress and burnout: firstly, the dedicated personality - while people with this personality type tend to be very committed to their work, they tend to take on too much and get over involved; secondly, the overcommitted personality - individuals with this type of personality tend to live for work and have very few interests outside of the work realm and thirdly, the authoritarian personality - persons with this type of personality believe that they need to be in control all the time as no-one can do the job as well as they can. Pross (2006) postulates that those in the helping professions do not do so entirely for altruistic reasons. For many in the helping profession, there is a deep need to be needed by others. The 'darkside' of helping satisfies unconscious (or conscious) narcissistic desires for power and glory and helps the helper to avoid their own sense of helplessness. These very attributes, if not dealt with by the helper, are likely to result in burnout, confusion and despair (Pross, 2006).

3.3.7.2 Hardiness

People with what is termed a hardy personality are likely to experience less stress. Characteristics of a hardy personality include a high level of commitment, an internal locus of control and a tendency to be challenged. Specifically, hardy people see challenges not as a threat but as an opportunity for growth (Thompson et al., 1994).

3.3.7.3 Locus of control

Locus of control can have a significant influence on the way individuals cope with stress and trauma. Those with an internal locus of control believe that they have control over what happens in their lives. Conversely, those with an external locus of control believe that they have little control and attribute

events to factors outside of their control. One can attribute the existence of an external locus of control to learned helplessness. Externals are more likely to give up and withdraw from stressful situations while internals will attempt to cope (Thompson et al., 1994).

3.3.7.4 Neurotic anxiety

People with excessive levels of anxiety, may have neurotic anxiety which is characterised by: establishing high level goals and being very punitive when these goals are not accomplished; being emotionally unstable; having a low self-esteem and being over concerned about pleasing others. If someone is prone to neurotic anxiety it is likely to have negative implications on how he/she manages stress (Thompson et al., 1994). Neuroticism and previous psychiatric problems have been linked to an increased development of post-traumatic stress (Kleber & Brom, 1992). Critics of the trait approach emphasise that traits are not fixed and that there is the possibility of change, which is not taken into account by trait theorists (Thompson et al., 1994). When one takes this factor into account, the concept of resilience, which may be seen by some theorists as a trait, has become an important concept to emerge within the traumatology genre.

3.4 RESILIENCE

3.4.1 Defining Resilience

Just as constructs such as PTSD are continually refined and developed, so the construct of resilience has changed in its meaning over time. There have been many debates and disputes about an exact understanding of what the term 'resilience' means. Some authors emphasise ego control, others refer to self-esteem and self-efficacy, some to hardiness and yet others to internal and external risk and protective processes (Wagnild, 2009). Jacelon (1997, p.123) defines resilience as "a personality characteristic that moderates the negative effects of stress and promotes adaptation".

Folke (2006) explains that the study of resilience has focused on an individual's capacity to absorb shock and still function and that more emphasis should be placed upon the process of resilience that concerns the individual's capacity for renewal, reorganisation and development. Garmezy's eloquent explanation (cited in Jacelon, 1997, p.129) of resilience encapsulates both aspects of resilience when he most states,

> The central element in the study of resilience lies in the power of recovery and in the ability to return once again to those patterns of adaptation and competence that characterize the individual prior to the pre-stress period… 'to spring back' does not suggest that one is incapable of being wounded or injured… a (resilient) individual can bend…yet subsequently recover.

3.4.2 Understanding Resilience

Research into resilience began in the 1970s, when researchers studied children who, despite living in highly stressful environments managed to progress through normal development. In the 1980s and 1990s studies then focused more on adults who had experienced adversity or endured traumatic situations (Wagnild, 2009). Antonovsky's work on salutogenesis in 1979 influenced the study of resilience as salutogenesis offers a paradigm for understanding resilience, illness and health, which contrasted with the dominant pathogenic paradigm. The fundamental question that salutogenesis asks is why some people become ill while others remain healthy when they are exposed to the same stress? He then went on to develop a salutogenic model of health, which illustrates an individual's position on the ease or disease continuum. Central to Antonovsky's salutogenic theory is the concept, 'sense of coherence' (SOC). This sense of coherence comprises three components, namely; comprehensibility – a primarily cognitive dimension, which explains how an individual makes sense of internal stimuli or situations; manageability – which refers to the understanding one has of the problem as well as having the resources to address the problem at one's disposal and meaningfulness – which is the emotional face of comprehensibility. Antonovsky believed that SOC was established in a person by about the age of 30. Persons with a strong SOC who experience catastrophic life events are more likely to survive with their SOC intact. Furthermore, Antonovsky's research found that people who draw boundaries within the objective world tend to have a strong SOC as long as these aspects which fall within the boundaries are considered coherent (Van Breda, 2001). Antonovsky's theory has been fundamental in understanding how important an individual's SOC impacts on coping with adversity, which contributed to understanding resilience in individuals. However, understandings of resilience have subsequently moved towards a system concept and away from an intrapsychic concept (Van Breda, 2011a).

Clark and Clark (2003) believe that there are significant differences in the way people show their resilience. They believe that resilience is formulated from three particular influences, namely, personal characteristics, external support and the duration of such support. Personal characteristics or inner resources include sociability, problem-solving ability and the development of self-esteem. People with strong resilience appear to have personal qualities and interact with strong external support for a long duration. This classification of resilience should not be regarded as static for an individual because if any of the variables change, so will the complex interaction of all the other variables and functioning change. These authors explain that successful adaptation to adversity strengthens resilience whereas unsuccessful adaption leads to greater vulnerability.

As previously mentioned, the exploration of resilience has had two distinctive discourses, namely the outcome of resilience and the processes that produce resilience (Ungar, 2004). While there appears to be a general understanding and consensus regarding the outcome of resilient behaviour, Jacelon

(1997) highlights the controversy surrounding the mechanism of resilience. Whereas some theorists identify resilience as a trait inherent in individuals, others view resilience as a process which may be learnt. From a developmental perspective, Flach (1998) understands resilience to be a cyclical process. It begins with a divergent stress point which disturbs the homeostasis of the individual and which then results in chaos. Resilience, at this point is initiated leading to reintegration and a new homeostatic structure at a higher level of functioning. Flach's understanding of resilience has two phases: disintegration and reintegration. Milner and Palmer (1998) maintain that resilience is a combination of an individual's physiology and personality factors that predispose individuals to different degrees of resilience.

Ungar (2004) descibes the social construction aspects of the theory of resilience and views resilience from a post-modern perspective. Adapting Foucault's understanding of inquiry he explores the notions of power that explain social interactions. Understanding mental health depends on one's notion of health and ill health and how society perceives and defines acceptable behaviour. This perspective shows how the understanding of what constitutes resilience changes over time and in different contexts. While achieving resilience may appear to promote optimal functioning, developing resilience in one domain (e.g. mental health) can be at the expense of resilience in another domain (e.g. physical health). Pole, Kulkarni, Bernstein and Kaufmann (2006) illustrate this understanding by explaining that if police officers repress fear and sadness which they feel as a result of their work, they may experience physical health problems as a result of the emotional suppression, such as high blood pressure. The environmental and personal factors that have been studied and identified as barriers to health and well-being are often referred to as risk factors. Environmental risk factors include low socio-economic status, sub-optimal academic achievements, poor family functioning as well as chronic and profound stressors. Personal risk factors include constitutional traits like temperament, sensory-motor deficits, unusual sensitivities, inability to bear frustration or maintain relationships, low self-esteem and feelings of incompetence (Ungar, 2004). Like different sides of the same coin resilience only develops when there is risk.

3.4.3 Family and Cultural Resilience

Carlton, Gorbert, Miyamoto, Andrade, Hishinuma and Makini (2006) explain that resilience indicators have moved beyond focusing only on individual aspects, to include family and community aspects. Family factors that influence well-being include family support, family caring, relationship formation, and maintenance of parental/self-expectations. In addition, Moss (2010) who studied resilience amongst South African social work client families, incorporates family strengths, adaptability, communication processes, belief systems, navigation of family risks and the protective buffer systems consequently established as important characteristics contributing to family resilience. Community

factors that promote resilience include extracurricular activities, peer support, religion and community involvement.

Cultural identity is an important component of resilience in individuals, especially in those from oppressed or minority cultures. In order to have a healthy cultural identity, individuals need to identity with the cultural strengths inherent in that culture. Van Breda (2001) cites Heavyrunner and Morris (1997) who maintain that children develop natural resilience when they are taught cultural values, which are then cherished and nurtured. This resilience emanates from a healthy and respectful cultural identity.

3.4.4 Resilience and Trauma

Trauma researchers in the last few decades appear to have had a specific interest in understanding why individuals differ in their vulnerability to symptom development and the onset of traumatic symptoms, which have resulted in trauma researchers exploring the concept of resilience.

In Holland, it has been found that with police officers, the following aspects contributed to resilience: marriage, an absence of psychopathology in the family history; active rather than passive coping, and posttraumatic growth. Furthermore, in their study of 21 retired police officers, Pole et al. (2006) found that resilience was best predicted by less distancing coping and fewer tendencies to keep their lives secret from family and friends. A regression analysis showed that less distance coping and less withholding from family and friends, which are both passive coping strategies, were the best predictors of post-retirement resilience. Moreover, keeping work-related matters and stressors secret from family and friends, as many do, can undermine resilience and increase social isolation. This finding contradicts the notion that one should keep work and family domains separate and reinforces the systemic understanding of human behavior, where one system in an individual's life impacts and influences every system in an individual's life.

In a study of resilience with 87 volunteer Israeli body handlers, Solomon, Berger and Ginzberg (2007) assessed how coping styles affected resilience. They understood resilience to be an absence of symptoms in the face of traumatic experiences. They found that body handlers who engaged in a repressive coping style reported lower levels of psychiatric symptomology and greater resilience than non-repressors. Repressive coping styles referred to the tendency to avoid negative thoughts and emotions or threatening experiences. Findings showed that repressive coping styles contributed to the reduction of psychiatric symptomology. The fact that these body handlers all had strong religious beliefs, mutual support and group cohesion were found to be resilience-bolstering factors. What this study highlights is that repressive coping can have positive effects and may be a necessary coping

strategy in certain situations, therefore repressive coping can be viewed as having both positive and negative consequences.

The individualistic interpretations and the subjective manner in which people experience the nature, intensity and duration of symptoms are indicative of the complexity of trauma. Harvey (2007) identifies demographic factors (age, race, class and gender); neurobiological mediators of hardiness and vulnerability; social, cultural and political contexts as well as access to supports and professional assistance. In addition, a key issue is why some individuals exposed to trauma are not at risk of symptom development. Some individuals (irrespective of whether or not they received professional assistance after the traumatic event) do not develop persistent PTSD. In fact, some appear to thrive in response to trauma. This response has been termed 'positive' or 'adversarial' growth posttrauma and was discussed in the previous chapter. Nuttman-Schwartz (2014) identifies two competing discourses explaining resilience and posttraumatic growth – one that says posttraumatic growth (PTG) is superior to resilience and another that says resilience is inversely associated with PTG.

While the construct of resilience may still be contentious, social workers need to familiarize themselves with this concept, not only in their interactions with clients but also in order to enhance their own growth. Fosha (2008) reiterates the need for social workers to consciously promote resilience and self-awareness in their work. In particular, social workers need to develop and enhance their self-esteem; cultural sensitivity; empathy; respect for others; a sense of ethics and professionalism; awareness and expression of personal style; and the ability to delay gratification of needs and expression of affect.

'Vicarious resilience' is a recent construct to emerge in the traumatology literature and refers to the resilience processes that occur within therapists as a result of their work (Engstrom, Hernandez & Gangsei, 2008). Vicarious trauma theory predicts that counsellors are likely to be profoundly affected by their work. Pack (2014) found that as a result of experiencing vicarious traumatisation and the resultant search for meaning, counsellors fostered personal and professional resilience strategies which enhanced their ability to 'bounce back'. Ironically this growth emanated from the immersion in trauma work, alongside the adoption of effective coping strategies by counsellors.

3.5 COPING AND SELF-CARE STRATEGIES

3.5.1 Coping Strategies

From an ecological understanding of human behaviour, one aspect of a person's life impacts upon all other areas of that person's life. As such, coping occurs in all dimensions of a person's existence, namely physical, emotional, behavioural, cognitive, social and spiritual. What is apparent is that not all coping strategies are helpful and an individual can develop coping strategies which are harmful. Self-care refers to the proactive strategies that professionals working with trauma survivors employ in

order to enhance their own well-being and to counteract the negative aspects of their work (Wasco & Campbell, 2002). In addition, self-care can promote appropriate opportunities for the enhancement of awareness and introspection, and enrichment of the professional's personal and professional life.

For this reason, the following section considers strategies on various levels, namely: personal, professional and organisational strategies that can promote or enhance social workers' ability to cope with indirect trauma. Professionals need to determine what particular self-care and coping strategies they find to be effective and individualise their self-care routines. Various factors may influence a person's preference for selecting and responding to different self-care strategies, such as personality, culture, religion, life experiences, and professional orientation (Kuo, 2011).

3.5.2 Individual Self-Care Strategies

In order to perform effectively on a professional level, individuals need to ensure that they maintain and nurture their personal selves. Adopting personal self-care strategies, might at times feel selfish for practitioners who often find caring for others a more natural process than caring for themselves. However, self-care is imperative in order to be an effective and responsive trauma counsellor. Coping strategies can exist on numerous dimensions of the individual, namely bio-physical, intrapersonal, interpersonal, and spiritual-cultural.

3.5.2.1 The Bio-physical dimension

(i) Physical exercise and nutrition

The advantages of physical exercise are far-reaching. Not only does exercise help to stabilize stress hormones, increase the metabolic rate, relieve anxiety, and improve sleep but it also increases energy levels. Exercise has been well documented as contributing to the attainment and maintenance of physiological and psychological vitality. Moreover, specific anaerobic exercises are understood to be stress antidotes, namely jogging, brisk walking, swimming and aerobic dancing (Thompson et al., 1994). Other physical strategies include sleep and rest, massage therapy, yoga, a hot bath or sauna as well as timeout (Ross, 2011). It is also important to combine a healthy diet with physical exercise in order to achieve maximum benefit (Van Zyl-Edeling, 2006).

(ii) Adequate sleep

Insufficient sleep can lead to mental and physical fatigue which impact every area of an individual's life. Relationships can become strained and work performance can be reduced as the individual's levels of alertness and attention are reduced (Schafer, 2000). Sleep is also important in the appropriate processing of traumatic memories and enabling an individual to view the world from a more balanced and holistic perspective.

(iii) Medication

When individuals are compliant, pharmacotherapy can be extremely effective in the treatment of trauma and anxiety (Friedman, 2006). Medications often prescribed in the treatment of PTSD include anti-depressants such as Selective Serotonin Reuptake Inhibitors (SSRIs) and **Serotonin–norepinephrine reuptake inhibitors** (SNRIs) as well as anxiolytics as they can improve sleep and reduce general anxiety (Friedman, 2006). Medications can help to reduce the intrusive and arousal symptoms of PTSD and are necessary when therapy cannot proceed due to the intensity of the symptoms (Schiraldi, 2000).

3.5.2.2 The Emotional intrapersonal dimension

Coping strategies on this dimension include emotional expressiveness, emotional regulation and increased self-awareness.

(i) Emotional nurturance and expressiveness

Developing the counsellor's ability to nurture him/herself, is one of the most important self-care principles. Nurturing activities include having a bath with oils, meditating, attending reiki and engaging in yoga (Hunter & Schofield, 2006). Skovholt (2001, p.152) believes that nurturing oneself is a 'sacred responsibility' and is a critical element for practitioner success. Nurturing the playful self and recreational self through hobbies, interests and recreational activities help to provide opportunities for counsellors to renew their energy and promote a healthier outlook on life.

(ii) Engaging in activities which promote emotion regulation

Instead of suppressing traumatic emotional responses, Allen (2005, p. 221) believes one needs to "make use of all the wisdom of our emotions…we must listen to them". One should allow for appropriate emotional response and expression. Allen (2005) suggests that response modulation allows for more adaptive responses as the individual learns to self-regulate. Through the development of self-regulation strategies, arousal levels can be lowered or emotional responses to trauma can be reduced as individuals learn appropriate containment. Often the tensions between the personal and professional self are difficult to manage and unrealistic expectations of professional invulnerability fail to acknowledge the humanness of professionals (Sweifach, Linzer & Heft LaPorte, 2012). Appropriate emotional regulation may seem to contradict repressive coping, but these constructs could be understood in conjunction with one another, as emotional repression needs to be appropriate and may initially require that an individual adopts a repressive coping style until a more appropriate time and space allow for emotional expression. Whereas developing competence in self-regulation is a lifelong process, some self-regulation strategies include relaxation techniques, imagery, meditation, and biofeedback. Art and music therapy have been proposed by Jansen van Rensburg (2006) as

possible intervention strategies as these forms of therapy promote self-discovery, ignite creativity, explore imagery and develop imagination.

(iii) Increasing self-awareness

Many trauma counsellors may select to be helpers, not only for altruistic reasons but also as a result of their own experiences of a personal trauma. Rothschild and Rand (2006) believe counsellors should not delude themselves about their motivational choices in becoming a helper but instead counsellors should assess their own vulnerabilities and implement strategies to increase self awareness and self-control. Ross (2011) recommends that mental health practitioners keep a 'stress diary' and conduct regular audits in order to assess their strengths and weaknesses, analyse the levels and intensity of stress and then prioritise specific intervention strategies to reduce the stress. Using this self-awareness strategy the counsellor could keep a 'stress and trauma diary', recording both stress and trauma responses and then formulating appropriate intervention strategies.

Counter-transference reactions are natural and the therapist needs to be able to use these reactions in an appropriate manner so that they are not disruptive or harmful to the helping relationship. Supervision can be an important catalyst in this process. Therapists also need to take time to increase their own self-awareness, reflect on their feelings and decide on the most appropriate course of action. At times the most appropriate response might be to discontinue working with an individual (McDonald, 2011; Wilson & Lindy, 1994).

3.5.2.3 The Cognitive intra-personal dimension

(i) Assumptions underpinning cognitive approaches

According to Aldwin (1994, p.104), cognitive approaches to coping are based on four assumptions, namely:

- *"How individuals cope with stress and trauma is largely dependent upon their appraisal of the event"*. If the situation is seen as threatening or challenging then the individual is likely to attempt to solve or ward off the problem using problem-focused coping. No coping is needed if the situation is assessed by the individual as benign. Palliative coping is needed when a situation occurs that involves harm or loss. The implication is that cognitive coping is conscious as individuals assess the severity of the situation and then decide how to cope.
- *"Cognitive approaches assume that individuals are flexible in their choice of coping strategies and modify their strategies according to the demands of the particular problem".* As individuals are not consistent in how they approach situations, one must therefore incorporate environmental contingencies. The term 'coping style' implies that coping is consistent, and that it is a function of personality. However, cognitive theorists believe that coping is a blend of personal preferences and environmental demands and that coping strategies are linked to a particular problem.

- *"Coping efforts include both problem and emotional-focused strategies that are directed at the problem and at the emotions, respectively".* While controlling emotions may facilitate the management of a problem, if a problem is resolved successfully, emotions will naturally be managed.
- *"Cognitive theorists do not assume a hierarchy of adaptiveness"*- Coping strategies used in different situations may promote either positive or negative adaptation.

One could argue that not all these assumptions are absolute, for example are all coping strategies conscious choices? It is possible that some strategies are unconscious. Others may argue that coping styles are intrinsically linked to personality. Moreover, some coping strategies could straddle a continuum from positive to negative rather than being either positive or negative. Defence mechanisms are a case in point as most defences are subconscious strategies for dealing with stress and trauma.

(ii) Defence mechanisms

Whilst defence mechanisms are a means of coping they may be maladaptive in that they distort reality. Valliant (1977 as cited by Aldwin, 1994) attempts to categorise this method of coping by defining defence mechanisms in terms of adaptation styles, understanding that some defence mechanisms can be healthy and adaptive:

Level I: **Projective Mechanisms -** Denial, Distortion and Delusional projection;

Level II: **Immature mechanisms -** Fantasy, Projection, Hypochondriasis, Passive- Aggression and Acting out behavior;

Level III: **Neurotic mechanisms -** Intellectualisation (isolation, obsessive behaviour, rationalisation), Repression, Reaction formation, Displacement and Dissociation;

Level IV: **Mature mechanisms -** Sublimation, Altruism, Suppression, Anticipation and Humour.

Valliant's hierarchy is arranged from projective to mature mechanisms. He understood the use of defence mechanisms not to be inherently pathological but useful in that defences serve to maintain ego integrity under difficult conditions. The hierarchy is based on the extent of distortion of reality involved in each mechanism. The lower mechanisms involve more distortion and thus more pathology (Aldwin, 1994). In a study of South African social workers Vermeulen (2008) compared the coping strategies of newly qualified social workers versus social workers who had more than five years' social work experience. She found that the experienced social workers appeared to have more highly developed defences than the newly qualified social workers. These defences helped the social workers to be less affected by their work stressors, thus showing the use of defence mechanisms to be beneficial and necessary in coping with work stress.

(iii) Cognitive reframing and humour

Some stressors cannot be removed or avoided as they are inherent aspects of the job and therefore one has to 're-evaluate' them or try to reframe them. Thompson et al. (1994) cite Taylor (1983) who identifies three aspects to re-evaluation, namely: to find meaning, to regain control over the event and to restore self-esteem. Since cognitive reframing has gained popularity as a technique used to reduce stress and anxiety, so too has the therapeutic value of humour as it helps people to reduce tension and reinterpret events (Moran, 2002). Davies (2001) found that paramedics in South Africa used humour as a coping strategy to deal with the continual exposure to trauma and violence. Humour as a coping mechanism facilitates emotional insulation as it forestalls excessive identification with victims. Humour can also encourage group bonding and support among colleagues. However, humour is appropriate within certain boundaries – if humour becomes callous, cynical or ridiculing (referred to as 'gallows humour') it may be a manifestation of burnout (Skovholt, 2001; Thompson et al., 1994). Snodgrass (2016, p. 13) maintains that that type of humour has numerous benefits in societies which are deeply divided like South Africa, as humour creates "the opportunity to laugh, providing a Freudian catharsis - a release of emotional stress and tension - with therapeutic benefits. This comic release is beneficial in activating coping mechanisms to deal with the anxiety and insecurity of deeply divided societies".

(iv) Maintaining a positive outlook

Self-talk is a critical factor in determining how we feel. Self-talk influences how we behave and feel about ourselves. Positive self-dialogue boosts self-esteem, promotes confidence, and enhances personal resources to cope with pressure and fend off stress, whilst negative self-talk exacerbates the harmful effects of stress. Therefore, an invaluable asset when working in the trauma field is having a positive outlook on life. Not only is it essential to convey a positive outlook when working with clients, especially children, but being able to see the greater good emanating from negative situations is a powerful way of coping with trauma (Hunter & Schofield, 2006; Thompson et al., 1994).

(v) Mindfulness-based stress reduction (MBSR)

Mindfulness-based stress reduction programmes teach an individual to be 'mindful' and to make the most of each moment and encourage an individual to live in the present moment. MBSR was initially established as an intervention programme to help patients deal with chronic stress; however, mindfulness has become a popular stress reduction strategy of benefit to anyone. There are numerous modalities through which one can learn and practise mindfulness including meditation, guided awareness and hatha yoga. Counsellors who practise mindfulness report positive changes in their roles as counsellors, in the ways they clinically practise and in their therapeutic relationships (Chambers, Chrisman, Trotter-Mathison, Schure, Dahlen & Christopher, 2011).

(vi) Maintaining a balanced life

It is imperative for counsellors to balance the work and personal aspects of their lives, as this approach can help to restore a sense of perspective and maintain emotional stability. As Hunter and Schofield describe it (2006. p. 126), 'self care is about balancing the intensity of the ugly aspects of counselling with the relaxivity of the world outside'. Facilitating a lifestyle that nurtures and sustains the personal self in areas of life requires effective time management and the ability to prioritise appropriately.

3.5.2.4 The Inter-personal dimension

(i) Attending personal therapy

Personal therapy is a significant source of personal support from which counsellors themselves can benefit. Just as trauma counsellors debrief their clients who have experienced a traumatic event, they themselves may require debriefing or the opportunity to talk through the impact that their work is having on them. It is of interest that over half the counsellors which Hunter and Schofield (2006) interviewed, used therapy as a coping strategy. Counsellors acknowledged that attending therapy helped them to have more empathy for their clients. It is particularly important for therapists to be able to select their own independent therapist rather than one prescribed by the organisation as this approach is likely to help them feel more in control and secure, as the sense of control and security are the very aspects that trauma takes away from one.

Authors such as Phipps and Byrne (2003) suggest that counsellors should also attend their own trauma counselling when necessary and recommend the following specific brief interventions for trauma therapists: critical incident stress debriefing; critical incident stress management, stress inoculation training (where key techniques include muscle relaxation training, thought stopping, and covert self dialogue) and traumatic incident reduction. In particular, if therapists have unresolved trauma histories, they should attend their own therapy in order to work through these issues so as to ensure that they do not have an adverse influence on their counselling.

(ii) Family and social support

The understanding that family support is essential in helping the therapist overcome secondary traumatic stress is not new. Families can provide emotional support, encouragement, advice, companionship and practical assistance (Catherall, 1999). Figley (1999) explains that essential ways in which families help the therapist include: providing resources as well as social support skills; helping to clarify insights; assisting affected members to correct distortions; and supporting reframing.

Of crucial support to therapists are their families, particularly their spouses or significant others. As therapists should ideally be highly skilled relationship builders, one would assume that they are able

to establish nurturing and challenging connections with family and friends. Relationships with others provide consistent, ongoing support and help practitioners to have a realistic perspective of themselves. Such relationships are essential not only on a day-to-day basis but especially in times of crisis (Skovholt, 2001). A good marriage or significant relationship can help to reduce the negative impact of emotional work stress. The role that effective social support plays in reducing the effects of secondary trauma and compassion fatigue have been well documented (Figley, 2002a; Hudnall Stamm, 1999; Sansbury et al., 2015).

The absence of positive social supports such as marital relationships, close friends and relatives, religious, group or community associations can lead to social isolation. Social isolation and loneliness have been associated not only with emotional distress but also physical ailments (Spruill, 2010). Developing friendships outside of work, can also help practitioners to be able to see the world more holistically as they engage with others who may not deal with traumatic aspects of life. Skovholt (2001) cautions practitioners not to have too many one-way caring relationships in their personal lives, as the helper also needs nurturing relationships.

3.5.2.5 The Spiritual-cultural dimension

(i) Spiritual

Meisenhelder and Marcum (2009) explain how one should assess non-spiritual and spiritual coping strategies when trying to cope with trauma as spiritual coping strategies can be either positive or negative.



Figure 3.2: Meisenhelder and Marcum's (2009) Relationship of Stress, Trauma and Spiritual Outcomes

Non spiritual coping refers to behaviours other than spiritual that are adopted to cope with trauma exposure, for example increasing physical exercise. Positive spiritual coping refers to seeking comfort and strength from God, and acquiring a positive concept of God. This type of coping is reinforced through the following behaviours, namely, praying, attending a place of worship and prayer meetings; and seeking time with friends and family. Positive coping strategies sometimes result in post traumatic growth, which often encompasses positive spiritual aspects, while negative spiritual coping is reflected

through expressions of confusion, doubts about, and anger towards God. Higher levels of depression and poorer mental health are associated with negative spiritual coping in victims of terrorism.

(ii) Religion

The counsellor's constant exposure to life threatening events and psychological trauma can prompt spiritual questioning and a search for meaningful answers. Religious and spiritual beliefs and practices can assist practitioners in their own search for meaning and help them to sustain themselves (Skovholt, 2001; Davies, 2001). Sigmund (2003) explains that this search for answers may not always be found in religion but rather in a spiritual process in which the individual extracts meaning from a traumatic event and integrates positive growth from the suffering.

South Africa is a multicultural society, which is highly evident by the fact that it has eleven official languages. There are also many different religions that are practised in South Africa, namely Christianity, Judaism, Islam, Hinduism, Buddhism as well as traditional African religions. Religion remains a key cultural element in people's lives and they may find comfort and purpose in religious beliefs and practices (Ross & Deverell, 2010). In African culture, the traditional healer or sangoma seeks guidance and direction from the ancestors when helping people cope with either physical or emotional problems.

(iii) Culture and community

Culture can be broadly defined as "…a dynamic system of rules, explicit and implicit, established by groups in order to ensure their survival, involving attitudes, values, beliefs, norms and behaviours, shared by a group and harboured differently by each specific unit within the group, communicated across generations, relatively stable but with the potential to change across time" (Matsumoto, 2000, p. 24, cited in Smith, 2005)**.** Just like spirituality, culture can be expressed in family life through roles, rituals and practices. Rituals can be assimilated as part of cultural practices and have particular power when they are reinforced in cultural groups that emphasise the meaning of various rituals. It is often through the practice of these rituals that people can derive meaning from events and begin to heal. An example of an African ritual is that after a highly traumatic event, a cleansing ceremony is held at the place where the event occurred. This ritual provides the opportunity for people from the affected community to give support, acknowledge their pain and begin to move forward (Oppong, 1992 as cited by Smith, 2005).

Involvement with the community is an essential aspect for the practitioner in order to promote a sense of connection and belonging. The sense of community is of tremendous importance in the African world view, which is very different from Western understanding. African community solidarity is further explained by the concept 'ubuntu'. This African word captures the humanistic,

interconnection and participatory democratic values that are built upon mutual respect, care and support for one another (Elechi, Morris & Schauer, 2010). As a result there is strong sibling group solidarity and a lack of personal individualisation (Smith, 2005). This approach is different from Western ideologies which promote individualism, materialism and capitalism. Therefore in African culture the community may be seen as a support system to a much greater extent than in Western cultures. During the apartheid years the spirit of ubuntu was particularly prevalent in Black communities as people stood together in the fight for democracy and human rights. With the advent of neo-liberalism and globalisation, many South Africans have adopted more western and individualistic values. Traditional African values, such as ubuntu, while still maintained, may not be as internalised in the younger South African generations as previously. However, community practices and rituals can assist and help in the trauma recovery process. Holding public memorial activities can help a traumatised community to recover. The people of Marikana want the koppie (hill) where the 34 miners were shot to be made a public memorial site as they maintain that this act would help bring about healing to a traumatised community (Langa, Papola & Vilakazi, 2014).

3.5.3 Professional strategies

Professional strategies are often effective in providing support for trauma counsellors and may even be considered as mandatory requirements by various professional bodies in order to practise. The benefits of supervision and case consultations are multifaceted, as counsellors are provided with supportive and educational opportunities in dealing with traumatised clients. Killian (2008), not negating the importance of individual coping strategies, found that professional strategies such as supervision and peer consultation were more influential in reducing compassion fatigue and burnout than individual coping skills.

3.5.3.1 Supervision

(i) The professional need for supervision

The practice of supervision is a well accepted indirect practice of social work. Due to the shortage of social workers in South Africa in 2003, the National Department of Social Development formulated a Recruitment and Retention Strategy document for the social work profession. Supervision was one of the critical areas identified in this document as a strategy to ensure service quality and promote the competency of social workers (Department of Social Development, 2006). The benefits of supervision should not be underestimated as the most salient aspects of supervision include providing direction and constructive feedback, building supervisee confidence and skills repertoire and helping supervisees to assess their own strengths and growth areas. Tsui (2005) identifies three prominent aspects to supervision: *personal supervision* - which addresses the emotional requirements of counsellors in the work setting; *professional supervision* - focuses on the problem solving ability and professional growth of the social worker which occurs through enhancing professional values,

knowledge and skills; and *organisational supervision* - which addresses the efficiency of the intervention as well as the quality of service delivery and incorporates the administrative aspects of the job.

Supervision may be provided in an individual or a group context. While there are distinctive advantages to each approach, one needs to consider the most appropriate modality for the individual and the organisation. Group supervision affords supervisees the opportunity to learn from other people's successes and failures; offers a wider variety of learning experiences; and helps to normalize supervisees' anxieties or reactions to trauma (Brink, 2006).

While group supervision can be a valuable and rewarding experience, supervision is often provided in this format as a default mechanism as it appears to be the most practical and least time consuming method of supervision. Munson (2002) cautions that group supervision should not be entered into simply to relieve time pressures of the supervisor. One needs to carefully consider and be aware of the advantages and disadvantages of group supervision. Kaduvettoor, O'Shaughnesy, Mori, Beverly, Weatherford, and Ladany (2009, p.788) caution that the hindering effects of group supervision include problems with supervisors, problems between members, supervisee negative effects, logistical problems and poor group time management. All these factors can negatively influence the group climate and supervisee learning. In particular, traumatised supervisees may feel uncomfortable revealing how affected they are by their work as they may feel they have to keep up a front before their colleagues.

In essence supervision provides supervisees with essential feedback about their performance in counselling, provides a secure base for supervisees by offering guidance during periods of confusion, and allows the supervisee to express alternative views (Watkins, 1997 as cited by Jen Der Pan, Deng & Tsai, 2008). However, Noble and Irwin (2009) argue that the current fiscally restrictive environment has affected the social work landscape and consequently practice supervision has become more focused on efficiency, accountability and worker performance. This scenario is often to the detriment of professional and practice development as the supervisory priority shifts to performance evaluation and accountability. These authors are concerned that the changing context of supervision has meant that supervision has become a priority of management rather than a priority of the profession. More specifically, their concern is that with this change has come a loss for the integrity and independence of supervision as a process for improving the practice knowledge and skills as well as providing a space for reflection and growth. Whilst the underlying premise of supervision may be developmental, the actual practice of supervision was not always perceived as such by many social workers who regard the process as an insult to their own professionalism. Engelbrecht (2010, p.329) further reiterates this viewpoint by asserting that

supervision is often viewed as "a paternalistic control mechanism to impose neo-liberal productivity standards, based on an imperialist worldview".

(ii) Cultural sensitivity in supervision

As South Africa is such a diverse nation, with eleven official languages, it is more than likely that supervisors will supervise someone from a cultural group different from their own. Engelbrecht (2006) explains that due to South Africa's history of apartheid most people have not integrated with persons from different cultures on a social level. It is therefore important that social workers learn about multicultural beliefs and practices in order to better understand their clients. Cultural sensitivity is also applicable to supervisors when relating to their supervisees. Moreover, group supervision could be utilised as a valuable medium through which learning about multicultural aspects can occur. Not only would the group comprise social workers from different cultures, each of whom bring different levels of multicultural awareness, knowledge and skills, but the group could also be an ideal setting where theoretical discussions about cultural groups or appropriate interventions with diverse clients could be debated. Such an approach is especially relevant when discussing how clients from different cultural groups deal and cope with trauma. Kaduvettoor et al. (2009) identify four multicultural experiences that occur through group supervision. These include: multicultural learning and conceptualisation; peer vicarious learning; extra-group activities and supervisor direct influence. Aspects that hinder multicultural experiences include supervisor multicultural conflicts, peer multicultural conflicts and misapplication of multicultural theory. Suggestions for improving multicultural events included more supervisor involvement in such events; better integration of multicultural issues and greater interpersonal sensitivity from the supervisor.

Engelbrecht (2006) believes that cultural sensitivity requires a supervisor to have a good knowledge base, values and skills. He advocates that supervisors should aspire not only to be culturally sensitive but also to be culturally friendly. He explains cultural friendliness to comprise the following: being accepting, accommodating, sincere, open, respectful, comfortable, spontaneous and warm. If a supervisor has a culturally friendly approach to supervision it enhances the supportive function of the supervisory process. It is essential that the supervisor addresses cultural aspects with the supervisee, so that the supervisor and supervisee can work within the boundaries and perspectives of their respective cultures.

(iii) Supervision and trauma counselling

Supervision in trauma counselling is an essential part of the process, not only to address administrative and educational aspects, but more importantly, to provide support. Therefore the supervisor has a fundamental role to play in providing support and creating awareness about the effects of trauma counselling. Tsui (2005) indicates that supervision has been identified as one of the most important

factors not only in ensuring the quality of service to clients but also in determining the job satisfaction levels of social workers. Furthermore, reflective learning is dependent on the quality of the supervisory relationship, which significantly influences whether active learning occurs. The supervisory relationship becomes the space to review a counsellor's intentionality, belief and assumptions about disorientating professional events (Jen Der Pan et al., 2008). As the essence of vicarious trauma is about the disrupted beliefs due to trauma exposure, supervision can play a pivotal role in helping to identify and challenge distorted beliefs. Most social workers can adapt positively to the trauma they experience provided they have the necessary supports, of which supervision is one of the more significant.

(ii)The supervisor's needs

It is also important not to ignore the subsequent effects and consequences that dealing with trauma has on the supervisors. Often the supervisors themselves may be too stressed to notice the stress that a supervisee is experiencing. It is often only when something catastrophic happens that all the unseen factors begin to unravel and are then acknowledged, often with dire consequences for the supervisee or clients. It is therefore imperative that supervisors themselves receive support and are aware of their own stressors (Brown & Bourne, 2002). What is apparent is that supervision fulfills an essential need in assisting social workers, particularly those who work with trauma, to cope with work demands and develop into more skilled and competent practitioners. Noble and Irwin (2009) maintain that regular good supervision is essential for all social workers and should be incorporated as agency policy. In addition, there should be a well-resourced comprehensive training programme for all supervisors in order to equip them in providing appropriate supervision to their supervisees.

3.5.3.2 Learning the limits of the professional role and establishing appropriate boundaries

Often mental health practitioners are presented with a variety of problems and concerns by clients, some of which may overwhelm the counsellor. Certain cases may be out of the professional's scope of practice and the counsellor should know when to refer to other professionals. Often with experience and maturity the professional may begin to understand human suffering on a profound level (Skovholt, 2001) along with realistic expectations of how counselling can influence or assist the client. Establishing appropriate boundaries with clients and employers is imperative not only for professional reasons but also to ensure that the counsellor does not experience burn out. It is important to establish boundaries from the onset and to ensure that they are maintained.

Counsellors also need to learn not to take on board their clients' problems and over-identify with them. This process does not happen instantaneously but is a gradual process as counsellors learn to detach from their clients and their problems. This goal can be achieved by compartmentalising and by keeping private and personal lives separate from work lives (Hunter & Schofield, 2006).

3.5.5.3 Becoming more experienced and recognising patterns

In their study of counsellors' perceptions of coping strategies, Hunter and Schofield (2006) studied how counsellors developed personal and professional coping strategies when counselling trauma victims. They found that all participants identified increased experience as a coping strategy. Hence as the practitioners gained more experience they tended to feel less overwhelmed by traumatic material. Practitioners also need to maximise professional successes no matter how small they may be. Often experience teaches one to reduce expectations and become more realistic about situations (Skovholt, 2001). Young practitioners are often very enthusiastic and have great expectations about the level of change they can expedite. Bearing in mind that this factor can be a precursor for burnout, learning to celebrate small successes and to adjust unrealistic expectations can be very empowering for the practitioner. Furthermore, part of gaining experience means that in the process of actively searching for knowledge therapists learn to better understand their clients.

3.5.3.4 Utilising educational opportunities

Williams and Sommer (1999) highlight the particular vulnerability that counsellors may experience if they lack a strong foundation in trauma theory. As the empirical and knowledge base of trauma therapy is constantly developing, clinicians need to keep abreast of these developments through education, research and networking. In particular, inexperienced trauma counsellors should be closely supervised and mentored and they should make a conscious effort to increase their knowledge competency. Effective intervention with traumatised clients often requires therapists to be flexible in the strategies and approaches they employ. Having sufficient knowledge and training in different trauma approaches can help the therapist to individualise treatment options to best suit the client. Attending educational courses also creates opportunities to meet other professionals working in the same field. Moreover, peer relationships can be a vital source of support for the counsellor and provide opportunities to enhance self-awareness. This aspect is elaborated upon in the following section.

3.5.3.5 Peer support and professional networking

The notion of support is an essential factor for any therapist who works with survivors of trauma. Whilst support on a personal level is important, support on a professional level also fulfils a crucial role for the counsellor. Contact with professional peers could occur in the form of a consultation group, treatment team, case conference or a clinical seminar. The impact of secondary traumatic stress can be diluted as the therapist's professional peers are able to help normalise disturbing trauma reactions and help the therapist to reconnect with others. Discussions with professional peers can help counsellors to remain objective in their work and to develop appropriate boundaries with clients, as well as provide opportunities for emotional outlets for practitioners (Catherall, 1999; Trippany et al., 2004).

There have been different research findings about the role of professional and peer support amongst social workers. In Jansen van Rensburg's (2006) study social workers identified staff support groups and supervision as the most important sources of support. Pearlman and Mac Ian (1995) also found that practitioners identified discussions with colleagues as the most important way to reduce vicarious trauma. However, other researchers (Rafferty, Friend & Landsbergis, 2001) found that social support from supervisors and co-workers could not be directly correlated with lower levels of burnout.

Alternatively the therapist's professional peers can also exacerbate the situation if they are judgemental and not supportive. Catherall (1999) cautions that peer support needs to be handled in a very sensitive manner as it can also negatively affect the therapist who may be in dire need of support. If a therapist is traumatised by his or her work, this response may remind other therapists of their own vulnerability which is often difficult to handle. Colleagues may instead blame the therapist and attribute their traumatisation to the therapist's own inadequacies, thereby allowing the other therapists to disown their own vulnerability and feelings of insecurity. The traumatised therapist may feel even more traumatised, shattered and personally damaged if this defensive view gains prominence within the group. In order to counteract these dynamics and group cohesiveness, group confidentiality needs to be encouraged and all group members urged to participate and share.

3.5.4 Organisational Strategies

As organisations have significant power to either mitigate or exacerbate trauma responses, employers need to be aware of the potential impact of trauma on their staff. In fact, organisations have an ethical responsibility not only to educate staff about the effects of indirect trauma exposure but also to monitor these effects, ensuring that the necessary supports and systems are formalized to assist employees. Sansbury et al. (2015) suggest that workplace practices and procedures need to be tailored to promote healthy work practices for employees.

3.5.4.1 Procedures for the recruitment of appropriate professionals

Selection procedures should consider potential employees' training and prior experience in working with trauma as well as their willingness to comply with ongoing training and counselling when required. Not every mental health professional can work in the trauma field; employers should therefore endeavour to ensure that rigorous selection procedures are implemented so that the 'personality-job fit' is appropriate. Concomitantly, organisations should develop appropriate recruitment strategies in order to try and select social workers who are less likely to be vulnerable to secondary traumatic stress.

3.5.4.2 Education about the occupational hazards of trauma work

Social work students are often not taught about the phenomenon of secondary trauma during the course of their undergraduate degree. As Hesse (2002) explains, secondary trauma is a very serious and inevitable effect of working with trauma survivors for not only are many students often unaware of this phenomenon but also many practitioners in the field.

Authors such as Munroe (1999) believe that it is the organisation's responsibility to inform newly employed trauma therapists that secondary traumatic stress is an occupational hazard of the job, thus 'warning' the new employee of job risks. Moreover, Munroe believes that therapists should sign a contract indicating that they have been informed by the organisation possibility experiencing secondary trauma and they therefore undertake to implement self-care strategies in order to reduce these effects. Managers in particular have a vital role to fulfil in educating and alerting staff to their risk of developing secondary traumatic stress. Best professional practices should be encouraged in order to help counsellors navigate the process during and after interventions with traumatised clients and communities.

3.5.4.2 Debriefings, defusion and supportive strategies

Organisations employing trauma workers need to be particularly sensitive to their employees' own trauma histories. Rather than ignore the fact that therapists' own histories might make them more vulnerable to secondary trauma and vicarious trauma, employers need to acknowledge this factor and help put strategies in place to support therapists (Stevens & Higgins, 2002).

Best professional practices should be encouraged in order to help counsellors to navigate the process during and after interventions with traumatised clients and communities. Myers and Wee (in Figley, 2002b) believe that debriefings should be offered to mental health practitioners if this is appropriate. The most well-known debriefing model is the critical incident stress debriefing model (CISD) developed by Mitchell (1983). Additional models such as Mitchell and Everly's (1995) mass disaster/community response model; Dyregov's (1997) psychological debriefing (PD); and Armstrong, O'Callahan and Marmar's (1991) multiple stressors debriefing model, encourage participants to explore their experiences of a traumatic event and incorporate a discussion around coping. However, a critical incident stress debriefing is not recommended during a practitioner's assignment to a specific traumatic event as it may result in the practitioner exposing emotion, lowering defences and feeling quite vulnerable. It would not be ideal for the practitioner to continue assisting with the same traumatic event the following day. In recent years the controversy about the effectiveness and appropriateness of debriefings has become a predominant discourse within trauma literature (Campfield & Hills, 2001).

Taking into account the SAPS environment one could question whether debriefings would be effective for the mental health practitioners working within the system and who are exposed to trauma on an almost daily basis. Instead a 'defusion' approach might be deemed more appropriate. A *defusing* technique is a shortened version of CISD, designed for use when work trauma is a daily event and this procedure takes place for 20-40 minutes at the end of a shift or week (Mitchell, 1983). This type of technique promotes a culture of talking and collegiality which may counteract the macho culture evident in the police force.

When social workers are not coping it is important for the organization to show support and to refrain from condemnation or criticism. Within the corporate culture there needs to be an understanding that social workers may also experience excessive stress and trauma and not only their clients. This recognition would help to ensure that the stigma associated with these experiences is reduced.

3.5.4.3 Changing the variety and extent of work tasks

While some counsellors may not have the autonomy to structure their work allocations, where possible counsellors need to include a variety of tasks and professional involvements within their work spectrum. There are numerous strategies that can be used to reduce the extent of indirect trauma to which the social worker is exposed, including: varying one's case load, having clients with differing types of trauma as well as dealing with non-trauma cases; and balancing direct social work interventions such as counselling with indirect practice, which may include attending meetings, workshops, supervision or working on preventative programmes (Badger, Royse & Craig, 2008). Counsellors may need a break from emotionally demanding cases which can be emotionally enervating. At times, this break may mean that the individual needs a temporary reprieve from the work environment, either a vacation or a secondment, in order to avoid resignation, which represents a permanent reprieve (Ross, 2011; Thompson et al., 1994). Skovholt (2001) refers to the establishment of multiple roles for the practitioner as a protective strategy against stress and trauma.

3.5.4.4 Ensuring adequate leave policies

Due to the high case loads that social workers often have, there is seldom little time for social workers to process their own reactions and feelings towards traumatic material to which they are exposed from clients. Moreover, the fast pace of the job frequently does not allow the social worker to meet personal needs (Badger et al*.,* 2008). Practitioners need to have regular respite from the trauma world, in order to ensure that they remain objective and keep a healthy perspective on life. Pearlman and Mac Ian (1995) believe that organisations should encourage trauma therapists to actively create time on a daily basis for self-care, such as taking lunch breaks, going for walks or attending yoga or aerobics classes. Other strategies which organisations can employ to protect the therapist from the

effects of indirect trauma include encouraging therapists to take adequate vacations, to take time off when they are ill, and to continue with educational courses (Rosenbloom, Pratt & Pearlman, 1999).

3.5.4.5 Promoting a safe, healthy and resilient work environment and organisation

Just as the therapist is expected to provide a supportive environment for the client, so too does the therapist need to work in a safe environment. It is therefore imperative that organisations provide a supportive environment and implement specific strategies to reduce the effects of indirect trauma. Unsupportive work environments can exacerbate occupational and traumatic stress that employees may experience as a result of their work. Yassen (1995) suggests that prior to the implementation of any work interventions to reduce secondary traumatic stress an organisational audit should be conducted in order to assess the physical environment, the corporate culture, value systems and expectations. Both employers and employees have a responsibility to create a work environment where diversity, mutuality and professional development are respected.

Taking into the account the bureaucratic and political nature of the SAPS, desired structural changes to the workplace may not be easily implemented. Employees, however still have a responsibility to assume an active role in promoting teamwork and communication (Slattery & Goodman, 2009) and they can also assist with the development of workplace policies and best practices in order to ensure that clients, practitioners and the organisation have opportunities in which to flourish. In this regard, promoting a healthy work environment is a reciprocal responsibility. Maslach and Leiter (1997) maintain that often the cause of burnout can be attributed to the organisational factors such as work overload, employees' lack of control over their work, insufficient rewards, a breakdown of community in the work organisation, unfairness and value conflicts. Skovholt (2001, p. 110) suggests that in order to prevent burnout organisations should address these aforementioned factors and ensure that employees have: sustainable workloads, a sense of autonomy over their work, are recognised and rewarded for their work and that there is a sense of work community that emulates fairness and justice in order that employees can feel a sense of meaning and value inherent in their work.

Van Breda (2015) raises a concern as to why resilience research has not yet significantly expanded to explore resilience in organisations. He proposes four factors to increase workplace resilience, namely: ensuring supportive networks; enhancing problem solving capabilities; constant rigorous appraisal of stressors, challenges and successes, and promoting harmony. The responsibility of the workplace to become more resilient may in turn provide the platform for workers to achieve this and hopefully become more productive.

3.6 CONCLUSION

The synergy between trauma and coping is not a simplistic process that can be encapsulated in one model. Various theorists and traumatologists each emphasise different aspects requiring consideration. This theoretical chapter has attempted to convey some of the contentious understandings about these two constructs and how they interact with each other. Individual self-care strategies are essential but need to extend beyond the individual to incorporate professional strategies. Killian (2008) advocates a paradigm shift from predominantly promoting individualistic self-care strategies to a more systemic approach of promoting healthier work environments. Incorporating professional self-care strategies can positively impact not only on the counsellor's professional development but also on the work environment. It may be necessary for organisations to adopt a flexible approach when dealing with the effects of secondary trauma as opposed to having a rigid established plan (Munroe, 1999).

What is apparent is that strategies to ameliorate the effects of indirect trauma should be multi-levelled and should not only be left up to the individual. Organisations need to be proactive and recognise their responsibility to provide support and developmental opportunities for their employees who work with traumatised individuals. However, these strategies do not minimise the responsibility of practitioners to ensure that their own mental health and development are intact as they navigate the impact trauma has on them either directly or indirectly. It is possible that the function of coping strategies is not to reduce symptomology but rather to help the individual deal with the continued presence of trauma symptoms, the exposure to which is inevitable if you are a South African social worker.

CHAPTER FOUR

THE WORK MILIEU

"Love and work are the cornerstones to our humanness" Sigmund Freud.

4.1 INTRODUCTION

Since the beginning of time man has had to work in order to survive. Understandings as to what constitutes work and employment have changed and developed over time. The concept of work generally delineates the act of performing a task for financial gain. Although there are various definitions of the word 'work', the term usually implies that effort and action are exerted towards a particular goal. Grint's (2005) discourse about understanding work emphasises that one should consider the past and present definitions of work as symbols of cultures and power in society.

This study explores the experiences of social workers who are employed at the South African Police Service. Consequently, it is important to understand the role of work in an individual's life, occupational stress and how factors within an organisation have the potential to affect the employee. An overview is provided of some of the most well-known models of occupational stress as well as a review of various dimensions of the work environment which reduce or exacerbate employee stress and influence the effectiveness of an organisation. The last section of this chapter addresses the development of employee assistance and wellness programmes which have arisen to ameliorate this stress.

4.2 THE DEFINITION AND MEANING OF WORK

4.2.1 Defining Work

Cultural, spatial and societal understandings determine the meaning of work or leisure. Unemployment is a term recognised only in a specific time and space, and Grint (2005) explains that the term "unemployment" tells us more about the society in which we live than the stigmatisation of the unemployed. To be categorised as "employed" or "unemployed" signifies the formal division of labour between employment and work, which is a facet of Western life. Watson (2009, p. 869) continues on this trajectory and explains that work can be understood to be "tasks which enable people to make a living within a social and economic context in which they are located". Perhaps a suitable definition of work in Western life would be that of Webster, Buhlungu and Bezuidenhout (2003, p. 7) who define work as, "a social activity where an individual or group puts in effort during a specific time and space sometimes with the expectation of monetary - or other kinds of - rewards or with no expectation of reward but with a sense of obligation to others". Furthermore, they explain

work to involve "effort (manual, emotional or mental) that is exerted during a specific time in a particular space (office, factory) for a reward (salary or wage)". This understanding of work is far broader and perhaps more appropriate in today's times as it also includes the housewife who cooks, cleans and looks after the children whilst also involved in the activities of the executive who is employed by an international organisation.

4.2.2 The Meaning of Work

Freud maintained that in order to accomplish adult challenges one must address two aspects, namely love and work (Brown & Pedder, 1991). Work has a central role in people's lives touching upon the economic, social and psychological aspects of their lives. As Ardichvili and Kuchinke (2009a, p. 155) explain, "Work is central to human existence, it provides the necessities for life, sources of identity, opportunities for achievement and determines standing within the larger community". These authors maintain that from a constructivist frame of reference, the meanings and experiences attributed to work define one's choice of career, educational path, job satisfaction, work motivation and work performance. It is therefore important to briefly explore the significance and importance of work.

Karl Marx believed that work was a primary human activity that has the potential to either fulfill people's potential or to destroy and distort not only their nature but also their relationships with others. He believed that if people were unable to find satisfaction or fulfillment in their labour or the products of their labour, they would become alienated and become strangers to themselves. Work therefore provided an avenue for people not only to fulfill their basic needs but also to ensure their humanity (Haralambos & Heald, 1985).

One of the aspects of work that warranting a more thorough exploration is the sense of identity derived from work. Identity theorists explain how work affects all aspects of one's identity: (a) the perceived self - which describes an individual's perception of his/her traits, competencies, and values; (b) the ideal self - which refers to traits, competencies, and values; and (c) social identities - individuals belong to certain groups and categories due to the work in which they engage. Moreover, work is one of the most important means used in building one's self-concept and self-identity. The development of a person's concept of work and self-identity is influenced by a complex interplay of internal and external factors, which include local customs, cultural norms of an ethnic group, religious beliefs, and the culture of the organisation. These factors contribute to a positive or negative self-image and help shape what is considered acceptable work and what type of work should be avoided (Ardichvili & Kuchinke, 2009b).

The meaning of work should possibly not be considered as a fixed trait or as a feature of an individual's personality but rather as a socially constructed phenomenon that is subjected to

numerous influences. Influences are not only within the individual but also outside of the individual and include situational and historical influences. Moreover, the meaning of work can be subject to social influences within a particular reference group. It is also subject to differences in countries; for example, some professionals are given more credibility in some countries than in others. Time is another factor requiring consideration when understanding professional credibility as occupational tasks can change significantly over time (Kuchinke, 2009).

The next section provides a brief overview of the history of work, showing how the meaning of work and the nature of workers' stress have been affected by, and have changed along with advancements in the world of work.

4.3 AN OVERVIEW OF THE HISTORY OF WORK

4.3.1 Prehistoric and Medieval Societies

Work in ancient Greek and Roman times was looked down upon and understood to be an activity reserved only for non-citizens and slaves. Instead, Greeks spent their time philosophising about life and engaging in leisure activities. Farming was the only activity that was regarded as significant. In Roman times this negative perception about work prevailed and like the Greeks, farming was the one work activity that was viewed as credible. Merchant and craft guilds dominated from the twelfth to the fifteenth century. Craft guilds were established around specific skills and recognised further specialisation (Haworth & Veal, 2004).

4.3.2 Capitalism and the Industrial Revolution

As social relations between serf and master were replaced by economic relations, so began the dawn of market capitalism and the end of feudalism. From the sixteenth century, as goods and capital were traded in markets so capitalism started to develop incrementally in Europe. In the seventeenth century, the industrial revolution brought about significant changes in agricultural, mining, transportation and technology. As the focus shifted from agriculture to manufacturing and service industries, so labourers were no longer needed on the farms and moved to work in the urban industries. Capitalism exists when the production process is organised by a market system and commodities are bought and sold according to monetary exchange. De Giorgi (2010) equates the capitalist system of production with what Michael Foucault called the 'torturous spectacles of suffering' that occurred in the 18th century in the main squares of European cities. Instead of using the human body in symbolic rituals of corporal punishment, in a capitalist society the human body is exploited in the process of production. Max Weber (1930) referred to the 'spirit of capitalism' and analysed the manner in which the spirit in Western Europe was to be productive and to accumulate wealth. This ethos was in contrast to other societies where people were satisfied by ensuring that their needs were met and did not need to accumulate riches. While there are many critics of

capitalism, what is evident is that capitalism significantly changed the nature of work. Webster et al. (2003) identify four specific phases of the transformation of work from the nineteenth century onwards, namely: the rise of the factory, scientific management, Fordism and post-Fordism.

4.**3.3.1 The rise of the factory**

The creation of factories in the nineteenth century significantly increased the control that factory owners had over employees. Work was now conducted within a specific space and time and with the introduction of supervisors and clocking-in systems, workers were closely monitored. As the division of labour was increased so did the social control and exploitation of workers. Karl Marx's book Das Kapital was written almost 150 years ago, yet his theories and works are still debated today. Alienation, according to Marx, naturally occurred due to the capitalist mode of production where worker's autonomy was removed and where the means of production was owned by the bourgeoisie. The mechanisms of production and the specialisation of the division of labour were two important characteristics of society contributing to the alienation of workers (Finnemore, 1999; Webster et al., 2003).

4.3.2.2 Scientific Management

In the late 1800s Frederick Taylor, a mechanical engineer, analysed ways of improving the productivity of workers. He assessed every task and determined a standardised time for the accomplishment of each task. Taylor's approach became known as scientific management and was based upon three principles: to place all the decisions and knowledge in the hands of management; to record the tacit skills that workers possess and record them as a set of rules; and to control each step of the work process and production (Smit & Cronje, 2002; Webster, et al*.,* 1993). What is clearly apparent in this approach is the lack of human understanding, since workers were viewed as machines with no aspirations or motivations and management was structured around managing work and not people.

4.3.2.3 Fordism and Post-Fordism

In 1913 Henry Ford introduced the assembly line in factories in order to build the model T car. This resulted in increasing the pace of the production process. This process became known as Fordism and was seen as an extension of control over the worker formerly introduced by Taylorism. People were often fatigued, labour turnover increased and high levels of absenteeism were recorded (Webster et al., 2003). Post-Fordism developed in order to address the limitations of Fordism. The assembly line not only contributed to high absenteeism rates but also became an obstacle to further productivity. What developed was 'flexible specialisation' – work became decentralised, more flexible and specialised (Grint, 2005).

The development of information capitalism has meant that workers have been separated from the social relations of production as they are often located in small offices far away from others. With development in the information technology sector, creation of the internet and emails have reduced the need for social contact in the workplace. Furthermore, with the growth in call centers a new concept has emerged, namely that of 'emotional labour' and a shift in the form of control (Webster et al., 2003). Moreover, since the 1990s a radical shift is evident in work structures. The traditional concept of a work day being 8 hours, in an office or factory and involving long term employment has significantly changed. Today work is structured around far more fluid and complex arrangements which include: contract work, flexi-time agreements, part-time employment and working from home arrangements (Ardichvili & Kuchinke, 2009a).

A key aspect of work in the 21st Century is that information and communication technologies have developed at an exponential pace. Glover and Kirton (2006) postulate that this development in the world of work has brought with it blurred boundaries of work and non-work in both time and space. With technological advancements people can now also continue working at home in the evenings and on weekends. These authors advocate that organisations have become greedy as they demand longer hours, and a higher quality of work. With post-Fordism also came changes in identity, whereas previously under Fordism middle class identity was constructed through aspects such as professional achievement, long-term commitment and earning rewards, in post-Fordism the emphasis shifted to personal lifestyle choices and the pursuit of hedonism (Binkley, 2004). Critics of post-Fordism such as Kallinkos (2006) purport that one should not talk of the post-Fordism era but instead of 'Neo-Fordism'. He argues that work is still structured around Fordist and Taylorists' methods of work and that the assembly line has simply been replaced by cellular or team-based forms of production. This author specifically articulates that even social work, a profession previously regarded as fairly autonomous, caring and creative, has adopted aspects of Taylorism as social workers often tend to describe their work as if they were in a factory with clients moving along an assembly line (Kallinkos, 2006). Whilst the understanding in social work is that each client is unique, the limited labour time and need for increased production has influenced the manner in which even social work functions.

This section has portrayed the manner in which the nature of work has changed over time and how the demands upon the employee have also changed over time. The next section addresses work stress and reviews dimensions within the work environment which may exacerbate or ameliorate work stress.

4.4 WORK STRESS

4.4.1 Understandings of Work Stress

During the last 50 years work or occupational stress has attracted an enormous amount of research from disciplines such as psychology, management, sociology and occupational health fraternities (Knudsen, 2006). Occupational stress research has evolved to such an extent that it has become an emerging field in the organisational sciences (Meurs & Perrewe, 2010). As understandings in occupational or work stress have deepened over the decades, this understanding has also been matched by increases in worker compensation claims and more stringent employee health and safety policies. Many occupational stress models have been developed in the last few decades and have guided theoretical understandings of occupational stress. In this section elaboration is made upon only a few of the most well known models.

4.4.2 Models of Work Stress

The **Job Characteristics Model** developed by Hackman and Oldman in 1980, identified specific job characteristics such as skill variety, task identity, task significance, autonomy and feedback as contributions to critical psychological states of meaningfulness, responsibility and knowledge of outcomes. The model proposed that cognitive and behavioral outcomes (such as motivation and job satisfaction) are influenced by positive or negative work characteristics. Work stress can then be reduced by job-redesign, creating feedback methods or through job enrichment (Cartwright & Cooper, 1997).

The **Person-environment Fit model** focused on the match between persons and their work environment as the key determinant of health. Workers' needs, knowledge and skills should ideally be complemented by the work environment and job requirements. A mismatch between these factors and the workers' ability, knowledge and attitude are likely to result in strain, evident through health related issues, lower productivity and increased tension between colleagues. In order to reduce the misfit, employees may utilise defences such as denial, or reappraise their needs and coping strategies. Lazarus's understanding of the Person-Environment fit complimented this model but he emphasised the concept of fit not as a static one, but proposed it to be a process of action and interaction between persons and their environment (Mark & Smith, 2008). Closely related to the work of Lazarus is Cox's (1978) **Transactional model of work stress.** The stages and processes are similar but Cox's model places a greater emphasis on occupational health and individual differences, highlighting the subjective nature of the transactional model.

Karasek's (1979) **Job Demands-Control Model** and Karasek and Theorell's (1990) revised model, the **Job Demands-Control-Support Model** emphasise that employee strain can be predicted by two job characteristics, namely job demands and job control and the synergy between these two

characteristics. The extent to which employees have control over their jobs will determine both the personal and job-related outcomes (Meurs & Perrewe, 2010). Control is therefore perceived as a type of recourse which helps to mediate the effects of stress. In the later model the role of social support was acknowledged, as social support from supervisors or colleagues has been found to be important in determining an employee's job satisfaction (Brough & Williams, 2007).

Most workplace stress models tend to focus on the negative aspects of stress and fail to incorporate the positive aspects to stress. Meurs and Perrewe (2010) critique the conventional models of work stress, arguing that they do not indicate whether (and how) an individual will learn from stress experienced previously; the timing of the stress in an individual's life and how expected outcomes of a stressful situation influence the response to stressors. In order to address this discrepancy, models such as the **Cognitive Action Theory** have been developed as individuals' ability to self-regulate is acknowledged and minimise the discrepancies between their expectations and their current realities. This model postulates that stimulus expectancy is learned from previous stressful encounters and so defending against a stressor, results in one consciously altering one's stimulus expectancy. The role of psychological defence mechanisms is understood not be maladaptive and instead suggests how individuals subjectively adopt various defence strategies. This explanation partially accounts for the disparities between work stress and psychological strain. Meurs and Perrewe (2010) suggest that future studies on work stress should investigate how individual learning relates to the experiences of work stress, and that constructs such as resilience as well as the focus on positive emotions and learning experiences require significantly more investigation within the area of occupational stress.

4.5 DIMENSIONS OF THE WORK ENVIRONMENT THAT REDUCE OR EXACERBATE WORK STRESS

Moos (2008) identified ten characteristics that need to be considered as factors which contribute to the promotion of a healthy and productive work environment. In particular, he identified how these characteristics address three dimensions, namely: the relationship dimension, personal growth dimension and lastly, the system maintenance and change dimension of the work environment.

4.5.1 The Relationship Dimension

The relationship dimension includes employee involvement, co-worker cohesion and supervisor support.

4.5.1.1 Involvement

Employee involvement refers to employees' motivation and commitment to their job. Hertzberg's classic two factor motivational theory explores the relationship of employee motivation with job satisfaction and productivity. He identified sources of work satisfaction which he termed "motivator factors" which include factors such as achievement, recognition, fulfillment from the work itself;

responsibility and advancement. Factors which contributed to a lack of employee motivation include: the organisational policy, supervision, salary, working conditions and interpersonal relationships (Smit & Cronje, 2002). This understanding of employee motivation provides a useful framework for management to assess and enhance employee motivation.

The personal values of workers is another variable shown to be significant with respect to the levels of involvement of the worker. While traditionally financial reimbursement and promotional opportunities were the strongest influences on job choice decisions, other work values, such as achievement, concern for others and fairness, have been found to have greater influence (Cox, 2004). Employees' motivations may also be subject to change over time and so might the type of work that they consider to be meaningful.

4.5.1.2 Co-worker Cohesion

Colleague support is particularly important when helping an individual cope with trauma and is seen as a buffer against psychological stress. This type of support is understood to be a form of problem solving since, in the process of talking about an event information is gathered; as well as emotion-focused coping the employee has the opportunity to talk through stressful emotions. In a study with SAPS members, Gumani (2014) found that social support was not a linear process but a multifaceted one and that support from within the different rank structures within the SAPS context (managers and colleagues) was important for police officers.

The absence of reliable supportive relationships in the workplace can also be considered to be a significant source of stress for employees (Fisher, Katz, Miller & Thatcher, 2003). In essence conflict in the workplace is a common occurrence and can occur as a result of personality differences, value differences and competing goals (Hitt, Miller & Colella, 2006). Hence, employers need to have procedures and processes in place in order to appropriately deal with co-worker conflict.

4.5.1.3 Supervisor Support

The Path-Goal Model suggests that leadership effectiveness is determined by the factors that influence a situation. This model identifies four leadership styles that a leader needs to adopt in order for subordinates to feel supported and directed in their work. Characteristics of an effective leader usually incorporate the following leadership styles: instrumental/directive; supportive; participative; and achievement orientated. A supportive leadership style requires the leader to be approachable and to show concern for the well-being of employees (Bergh & Theron, 2009).

The supervisor also has an important role to play in communicating to the subordinate the organisation's vision, changes and procedures. The Superior-Subordinate Communication Model helps

to explain the nature of communication within an organisation. This model identifies supervisors (*the sources)* in communication with the sub-ordinates *(the receivers).* The message is then transmitted either orally or through a written medium *(the channel)* and the *decoding of the message* occurs by the receiver, which may or may not reveal a proper *understanding* of the message. If the communication from the manager is not properly interpreted or understood, the employee's behavior may become unpredictable or unacceptable (Gray & Starke, 1988). This model highlights how important it is that the supervisor and supervisee have open communication and that both parties are approachable and willing to converse effectively with one another.

4.5.2 The Personal Growth Dimension

The personal growth dimension incorporates autonomy, task orientation and work pressure.

4.5.2.1 Autonomy

Autonomy addresses employees' self-sufficiency and ability to make decisions in their work. Cartwright and Cooper (1997) acknowledge the importance of rules and regulations in the workplace in order to address health and safety laws and requirements, productivity and reward issues. However, they caution that too many workplace constraints are likely to inhibit an employee's control, creativity and autonomy. McClelland's achievement motivation theory identifies how an employee's motivation addresses three needs: the need for achievement, the need for affiliation and the need for power (Smit & Cronje, 2002). These needs differ in importance from one person to another. For some individuals the need for autonomy and achievement may not be as important as the need for affiliation. Mirowsky and Ross (2007) found that employees who have greater autonomy in their work enjoy better health. Their study highlights the importance of employee creativity in work activities as creativity provides the opportunity for innovation, expression and originality. The possibility of creative activity is increased when an employee has a degree of autonomy in their work.

4.5.2.2 Task Orientation

Task orientation refers to effective planning and efficiency in respect of completing a job. How tasks are combined and the specific responsibilities an employee is allocated refer to the design of a job. Job design incorporates aspects such as job specialisation (which refers to job simplification where tasks are narrowed down and clarified) and job expansion (involving job rotation, enrichment and enlargement). Job rotation creates the opportunities for the employee to be cross- trained, as the employee is placed in a similar job at the same level with similar skills and knowledge requirements. Job enrichment refers to the vertical expansion of jobs and increases employees' freedom, responsibility and independence which often create the opportunity for employees to start and finish a task. Job enlargement refers to the expansion of jobs horizontally, increasing the number and variety of tasks in jobs which create greater diversity (Robbins, Millet, Cacioppe & Walters-Marsh, 2001). The

benefits of job rotation, job enlargement and job enrichment include an increase in the employees' motivation and satisfaction which may, in turn, produce a positive overall effect on the work environment and productivity. However, the drawbacks of job design are that training costs can increase and be experienced as stressful or disruptive by employees.

4.5.2.3 Work Pressure

Work pressure can occur as a result of either quantitative work overload (too many tasks) or qualitative overload (where the tasks are too complex). Hitt et al. (2006) caution that depression, reduced enjoyment of work, and greater hostility result from qualitative work overload. Qualitative overload has been found to create far more stress than quantitative work overload.

Work pressure or strain can be understood through Lazarus's model of Person and Environment Fit. In his model, Lazarus identifies three types of cognitive appraisals: primary appraisal – individuals evaluate environmental demands in terms of the threat or benefit to their own well-being; secondary appraisal includes how individuals evaluate their own coping strategies and resources that can reduce the levels of stress; while, reappraisal is the individual's evaluation of how successful previous coping attempts have been (Lazarus & Folkman, 1984). Fischer et al. (2003) explain that the importance of this conceptual model when analysing work stress is threefold: as the model highlights the subjective nature of work stress; emphasises the active role that employees play as they attempt to control their situations; and indicates how individuals evaluate the outcomes and consequences of stress.

4.5.3 The System Maintenance and Change Dimension

The system maintenance and change dimension encompasses job clarity, managerial control, innovation and physical comfort.

4.5.3.1 Job Clarity

Employees need to have clarity in their job description or role ambiguity may arise. If employees do not have a clear picture of their work objectives, roles and responsibilities this lack of clarity can lead to conflict with colleagues, and/or superiors. A lack of clarity in work dimensions can result in an employee feeling tension and anxiety and can negatively impact on work performance. Hitt et al. (2006) maintain that role ambiguity is strongly related to employee tardiness, absenteeism and staff turnover. In a study with healthcare practitioners in the United Arab Emirates, Barhem, Younis and Younis (2010) found that job satisfaction levels were determined mostly by leadership style and job clarity. Furthermore, in a longitudinal study, Fried, Slowik, Shperling, Franz, Ben-David, Avital and Yeverechyahu (2003) found that when there were higher levels of role clarity, job performance increased whereas job performance decreased when job security was high and role clarification was high. As soon as employees understood the nature and extent of management expectations and felt

that their employment was secure, a decrease in performance could be seen. Apparently the reason for this was that there was no longer a need to prove their competence, as may have been the case previously, when job security was not assured.

4.5.3.2 Managerial Control

Management styles differ significantly according to the personality of the manager and the requirements of the job. The combination of certain employee personality types and particular managerial styles can result in employees experiencing adverse stress levels. In professional jobs, and for employees who prefer greater self-determination in their jobs, a less directive management style may be preferred (Hitt et al., 2006). Cartwright and Cooper (1997) identify different types of managers: *the autocrat* – who holds strong views on what should be done in an organisation; *the bureaucrat* – who is cautious in decision-making and generally abides by the rules and the rulebook; *the reluctant manager* – people who generally adopt a laissez faire approach to management and let people manage themselves; and the *open manager* – who has a participatory management style.

Varying management styles may be appropriate in different situations; however, constant changes in management are unsettling for employees and can negatively influence employee morale. The Vroom-Jago model proposes that leaders assume a leadership style that is suitable for a specific situation. Three critical aspects this model highlights include: *decision effectiveness* - here effectiveness is dependent upon the decision quality and subordinate's commitment; *decision styles* - here individual decision-making situations as opposed to group decision-making are considered; and *diagnostic variables* - leaders need to perform a situational diagnosis before deciding on the appropriate decision-making style (Bergh & Theron, 2009).

4.5.3.3 Innovation

Due to the constantly changing dynamics of work, many types of employment require employees to adjust to new changes and technological developments in the field. These changes can enhance the productivity of the individual as processes may become more streamlined. However, changes which are foreign may also make it difficult for the employees to adjust to the differing systems and processes consequent to these changes. Advances in technology have presented many challenges, particularly for the older generations, who never grew up with exposure to technology. Organisations have a responsibility to assist employees in keeping up-to-date with changes through training and development programmes. Robbins et al. (2001) identify innovative organisations as those emphasising innovation at structural, cultural and human resource levels. These organisations encourage experimentation, reward both successes and failures and successfully promote a corporate culture which supports employee development.

4.5.3.4 Physical Comfort

The physical environment within which individuals work can influence employees' attitudes to their jobs and their work productivity. Physical environment stressors have often been referred to as 'blue-collar' stressors as these stressors have traditionally been most problematic in blue-collar occupations (Ivancevich, Konopaske & Matteson, 2013). Lighting, temperature, noise levels, office space and arrangement are all aspects which need to be appropriately considered. Smit and Cronje (2002) maintain that the physical layout of the organisation can either facilitate or inhibit interactions within groups at the workplace. Employees are more likely to interact and establish informal groups when they are in close proximity to each other. Managers can strategically allocate offices and workspaces to individuals in order to encourage specific group interaction.

The Occupational Health and Safety Act no 63 of 1996 addresses health and safety procedures to which employers are obligated to adhere. This Act stipulates that employers have to ensure that the work environment is reasonably safe and without any health risks. The Act also emphasises the role employees have in ensuring their own health and safety, therefore placing joint responsibility on the employer and employees regarding workplace health and safety aspects (Nel, Swanepoel, Kirsten, Erasmus & Tsabadi, 2005). International and local employee assistance and wellness programmes have developed as one of the main responses of organisations to address occupational stress and in helping promote a healthy work environment. The development of these programmes is explained in the following section.

4.6 THE DEVELOPMENT OF EMPLOYEE ASSISTANCE AND EMPLOYEE WELLNESS PROGRAMMES TO DEAL WITH WORK STRESS

Worldwide the need to enhance and maximise employee productivity and effectiveness has become paramount in light of the global economy (Naicker & Fouche, 2003). Furthermore, the nature of work stress has been researched extensively and the need to assist employees to cope appropriately with work stress has become a predominant discourse. More stringent recruitment and selection procedures have evolved in order to ensure employment of appropriate personnel and maintain the correct person work fit of employees. In the last few decades it has become more apparent that the dichotomous understanding of the work/home divide was rather superficial and that employees need to be understood more holistically. Absenteeism, presenteeism (when a person is physically present but not functioning optimally in the work environment), poor employee work performance and increased colleague conflict can be indicative of an employee's underlying personal and/or health problems. This synergy between the work-home interface has received greater attention and employers have acknowledged the importance of implementing programmes to assist employees to deal with work stress. This awareness has lead to the development of employee assistance programmes and workplace health programmes, a trajectory which Van den Bergh (2000, p. 3) has

called "one of the most important workplace innovations of the 20th century". Today with more than 5000 members in more than 30 countries, the Employee Assistance Professionals Association (EAPA) explains (2011, p.1) what employee assistance programmes are:

> Employee Assistance Programs (EAPs) serve organisations and their employees in multiple ways, ranging from consultation at the strategic level about issues with organisation-wide implications to individual assistance to employees and family members experiencing personal difficulties. As workplace programs, the structure and operation of each EAP varies with the structure, functioning, and needs of the organisation(s) it serves.

Occupational Alcohol Programmes (OAPs) which were the precursors to employee assistance programmes, were established in the 1940s to address employees' alcohol problems in the workplace. In the 1970s and 1980s as these programmes grew in acceptance, they started to offer more comprehensive services, offering employees counselling that addressed a range of personal problems (Attridge, Herlihy & Maiden, 2005; Du Plessis, 2001). By the 1990s programmes had developed to offer management and employees, assistance with a range of issues affecting the workplace, including: work stress; mental health; the work/family interface; trauma; older persons as well as organisational downsizing and restructuring (Van den Bergh, 2000). For an effective EAP essential components of the programme would include: a clear written policy and outline of procedures of the programme; clear stipulations around confidentiality aspects; support from both management and unions; effective programme marketing through supervisor education and employee awareness campaigns; and evaluative processes (Naicker & Fouche, 2003).

Numerous factors can influence the success or failure of an employee assistance or wellness programme. Ivancevich et al. (2013) suggest seven aspects needing to be incorporated in these workplace programmes if they are to be successful. These include: evidence of top management support both philosophically and practically through providing adequate facilities and resources; union support and sanction of the workplace programme; the inclusion of both preventative and curative programmes; extensive employee involvement in the planning, maintenance and evaluation of the programme; clearly stipulated programme objectives that can be monitored and where possible measured; the principle of confidentiality must be adhered to and participation in the programme should not be mandatory for employees. In addition, Naicker and Fouche (2003) maintain that the programme should be marketed through supervisor education and employee awareness campaigns in order to be effective.

The potential benefits of these programmes far exceed assisting the employee, as they contribute to the organisations' education and empowerment of workers, social responsibility goals and help to

curtail health and medical costs (Department of Public Service Administration, 2008). However, as these programmes were still guided by the underlying philosophy of the "prevention, identification, and resolution of productivity issues" (Employee Assistance Professionals Association, 2011, p.1), their credibility and integrity have often been questioned. For example, Arthur (2000, p. 549) questioned whether these programmes were not "the emperor's new clothes of stress management" and whether they actually assist employees with work stress. Hansen (2004) suggests that EAPs are one of a family of particular post-industrial surveillance technologies. Traditionally it has been through this sceptical lens that South African workers have viewed most EAPs and not as programmes designed to truly assist employees with personal or work stress. In fact, during the years prior to democracy these programmes were often seen as management's way of pacifying the workers in order to maintain the existing status quo of the organisation.

The need to expand the EAP's philosophy and incorporate the concept of employee wellness, is a trend that originated overseas and has been adopted in South Africa. In 2008, the South African Department of Public Administration developed the Employee Health and Wellness Strategic Framework, to be implemented across all government departments. This Framework identifies four strategic objectives which include: HIV and AIDS management; health and productivity management; health, environment, risk and quality; and lastly, employee and organisational wellness management (Department of Public Service Administration, 2008).

Due to South Africa's discriminatory past, the majority of employees in South Africa, continue to experience multifaceted social and economic problems. Triegaardt (2009) identifies one of the main challenges for occupational social workers working within work wellness programmes, as being a process of learning to learn to navigate the nexus between the worker and the organisation. Furthermore, if occupational social workers in South Africa are to offer appropriate and effective workplace programmes they need to encompass the social development paradigm which incorporates a rights-based approach; an integration of economic and social development; promotion of democracy and citizen participation; a commitment to social development partnerships and welfare pluralism; and bridging the micro-macro divide (Patel, 2015; Triegaardt, 2009). The appropriate development and implementation of effective and relevant EHWPs is a significant imperative in the process of the transformation of South Africa. Such programmes are particularly relevant in highly stressful bureaucractic work environments such as the South African Police Service, which require community and police partnerships.

4.7 CONCLUSION

The importance of satisfied employees in the workplace is of paramount concern to organisations since satisfied employees who find meaning in their work are more likely to be committed to the

organisation and go the extra mile, whereas, dissatisfied employees tend to have higher absenteeism records, more stress-related medical problems (both physical and psychological) and greater turnover (Cox, 2004). This chapter has provided an overview of the dimensions in the work environment that can positively or negatively influence the employee's level of work satisfaction, organisational productivity and work stress. The following section, part three of this thesis, explores the context of this study.

PART THREE

THE CONTEXT OF THE STUDY

CHAPTER FIVE

THE SOCIAL CONTEXT OF WORK IN SOUTH AFRICA

"Blood, sex, music, disease, miracles, murder, poverty, race, profit, beauty. These are the narratives of post-apartheid South Africa..." (Kevin Bloom, 2009, p.193).

5.1 INTRODUCTION

The context for social work practice is determined by the political, social and economic domain of a country and concomitantly by the setting or employing organisation where social workers practise (Payne, 2005). Therefore, it is imperative to understand the South African context in order to understand the nature of occupational stress and trauma which South African social workers experience. South Africa is a land of contrasts and diversity, situated on the Southern tip of Africa and extending over 2,708km between the Indian and the Atlantic oceans. It is also the 25th largest country in the world (Meredith, 2005). Its diversity is not only evident in the terrain of the land, which ranges from arid deserts to mountainous forests and tropical coastlines, but in the multicultural nation that resides in this land. With a population estimated to be almost 55 million (Statistics South Africa, 2015), its pluralist nature is evident in the multi-ethnic nature of citizens, the variety of religions, cultures and eleven official languages.

The South African story has set an example to the world of the manner in which forgiveness and racial reconciliation averted a civil war. Nelson Mandela will forever be remembered for his role in bringing about transformation in a country that was deeply segregated, traumatised and polarised upon racial lines. Desmond Tutu, a Nobel Peace Prize laureate who is often described as the country's moral beacon, described his experience of casting his first vote in the 1994 elections as "a religious experience, a transfiguration experience, a mountaintop experience" (Myre, 2014). Since the abolition of apartheid, South Africa has made tremendous progress in becoming a democratic nation with a strong human rights culture. Many refer to South Africa as the most advanced country in Africa, its integration into the global economy and progressive constitution are hallmarks of this advancement (Meredith, 2005). Politically there is a level of stability as the country has held relatively peaceful elections since 1994 (Habib, 2013). Today many millions more Black families have access to basic facilities and to education. In just over twenty years, more than three million free houses have been built. Twelve million households have access to electricity, seven million more than in 1994 and 92% of South Africans have access to portable water, 60% more than in 1996 (Zuma, 2015). However, it is of concern that despite political emancipation, numerous socio-economic realities for many citizens have not changed in the last 21 years. Many critics argue that the country has diverted from the remarkable path that it navigated 21 years ago.

This chapter begins by exploring the South African context and the current realities and challenges confronting the country. One cannot understand this country's tumultuous history without exploring its traumatic past and how this factor manifests in current levels of violence and traumatic stress, resulting in South Africa being one of the most violent countries in the world (Bruce, 2007). As work also reproduces social relations of a particular time (Webster, Alfred, Bethlehem, Joffe & Selikow, 1994), it is important to understand the history of work in South Africa, particularly with reference to race and gender. The tumultuous journey of the struggle for workers' rights and the formation of the labour movements were a reflection of the political and economic uncertainty in South Africa. Whilst this journey is only briefly expanded upon in this chapter, it provides an initial understanding of how the manner in which work was structured in South Africa. Moreover, what is apparent is that the consequences of the apartheid policies and discriminatory practices are still prevalent in the current South African workforce today. Finally, the South African Police Services (as the employer of the research participants) is discussed, detailing the history of the South African police as well as current developments and challenges within this organisation.

5.2 THE SOUTH AFRICAN HISTORICAL CONTEXT

South Africa is a country that is steeped in a history of conflict, dominance and inequality. Southern Africa was initially inhabited by Khoisan, a term which referred to the 'San' who were often called bushmen and the 'Khoikhoi' a term which referred to the Hottentots. Anthropologists propose that African tribes, originally migrated from the great lake regions to Southern Africa. Different ethnic groups settled in various areas in Southern Africa. For example, within the Nguni group a specific settlement pattern formed: the Xhosa in the south, the Zulu towards the east and the Swazi in the north (The Early History of South Africa, n.d.).

During the last few centuries Dutch, Portuguese and British imperialism and the acquisition of colonialist territory saw the fight for land and domination and subjugation of the indigenous peoples. The Dutch were the first Europeans to inhabitant the Cape when Jan van Riebeeck from the Dutch East India Company arrived in April 1682 to establish a supply station. The population at the Cape grew as the Dutch East Indian company brought many slaves from parts of Africa, Madagascar and India. Many French refugees also began to settle in the Cape after Louis XIV had banned Calvinism in France (The Early History of South Africa, n.d.). After the French Revolution, the British occupied the Cape from 1795 – 1803, but returned the Cape to the Dutch in the Peace of Amiens (signed between England and France), which ended British Rule. However in January 1816 the second occupation of British rule occurred as the British tried to increase their trading opportunities and expand their markets. The Cape was to be governed as a British colony and in 1819 the British government sent British emigrants to the Cape. However, this increasing British occupation was met with resistance by the other White occupants who then decided to move north into the interior of the country in order to establish their

own homeland. In 1835 more than 10 000 White people left the Cape Colony in what became known as the Great Trek. Most of these voortrekkers (Dutch pioneers) were farmers and they started to develop their own identity calling themselves Afrikaners (Boers), and they developed their own language which stemmed from high Dutch but incorporated strong French, Malay, German and Black influences (Carver, 1999). As the Voortrekkers encroached on Natal they fought many battles with the Zulus for the ownership of the land. The British then tried to annex Natal and a war between the British and the Boers followed but the Boers were defeated and established Natal fell under British control. The British introduced a "scorched earth" policy under which they destroyed crops, homesteads and poisoned water supplies so that the Boers could not survive. They also established concentration camps where they kept Boers and African people as prisoners of war in local camps under inhumane living conditions (Pakenham, 1982). The Fawcett commission investigated the living conditions in these camps where more than 26 000 had died. While the living conditions were improved for the Boers these improved conditions were not evident for a significant time in the African camps. Although the British won when the Boers surrendered in 1902, the Treaty of Vereeniging was signed which ended the existence of the South African Republic and an independent Boer state, the Orange Free State, was established as a member of the British colony (Carver, 1999).

The Union of South Africa was established in 1910 as a member of the Commonwealth. The period from 1910 to 1948 in South Africa's history was one that was marked by segregation and building the legal framework for racial discrimination. The Native Labour Regulation Act No. 15 of 1911 made it a criminal offence for Africans not to uphold a labour contract. The Natives Land Act No. 27 of 1913 prohibited Black people from owning land in certain areas. The Asiatic Land Tenure and Indian Representation Act No. 28 of 1946 (known as the Ghetto Act), placed restriction on Indian property ownership; This Act made provision for Whites to own more than 92.5% of the land and restricted Blacks to owning 7.5% of the land. In opposition to the Native Land Act, the African National Congress was established which called for a constitution that promoted equal rights for all races (Meridith, 2005). Gandhi called on Indians to passively resist the Asiatic Registration Act of 1906 which required Indians to be registered and fingerprinted (Cachalia, 2013).

While colonialists purport that colonised countries benefited from these imperialistic endeavors, postcolonial theorists highlight the array of hegemonic discourses that colonialism imposed upon society. Anti-colonial theory can be summarized in the sentiments of Dei and Kempf (2006, p.5),

> The anti-colonial, challenges any form of economic, political and spiritual dominance. It is about identifying and countering all forms of colonial domination as manifested in everyday practice, Including individual and collective social practices, as well as global interactions.

The discriminatory foundations and ideologies of superiority that were laid down through colonialism became further entrenched through the implementation of racial segregatory policies and the apartheid system. The Afrikaans National Party formally implemented the system of apartheid in 1948, which ensured that the interest of the White majority was prioritised and the Black majority was governed by discriminatory laws and inhumane practices. A bedrock of discriminatory policies was introduced in the years that followed. These included: the Natives Urban Areas Act No 21 of 1923 which required African men to carry passes in order to limit their movement in White areas, as well as control urbanisation and promote the migrant labour system; the Group Areas Act No 41 of 1950 which controlled the acquisition of property and the occupation of land. This Act as well as state mechanisms of influx control were the governments deliberate attempt to create impermanence in the urbanisation process of black South Africans (Clark, Collinson, Kahn, Drullinger & Tollman, 2007); the Immorality Act No 5 of 1927 which prohibited Blacks and Whites from having sexual relations with one another; the Prohibition of Mixed Marriages Act **N**o 55 of 1949 that prohibited marriage between Whites and other races; the Bantu Education Act No 47 of 1953 which created separate educational departments and educational curricula for different race groups; and the Reservation of Separate Amenities Act No 49 of 1953, which created separate facilities and services for different racial groups (Nkosi, 2011).

After World War II, the international climate was very much against discriminatory policies. As a result of this trend, South Africa's racist and discriminatory policies were frequently placed on the agenda of the United Nations. Consequently, South Africa began to withdraw from international bodies but continued entrenching discriminatory practices and banning oppositional parties. In 1960 the Union of South Africa withdrew from the British Commonwealth and the Republic of South Africa was established. In 1966 the United Nations declared apartheid a crime against humanity and this declaration resulted in South Africa's isolation from the world and the global economy as many countries imposed sanctions in protest against apartheid (Meridith, 2005). With increased international pressure and the rise of resistance campaigns within South Africa, the tide of change was imminent. Desmond Tutu, the Anglican Archbishop and ANC stalwart explained how important international support was in helping to dismantle apartheid,

> In South Africa, we could not have achieved our freedom and just peace without the help of people around the world, who through the use of non-violent means, such as boycotts and divestment, encouraged their governments and other corporate actors to reverse decades-long support for the Apartheid regime (Gish, 2004, p.83).

Nelson Mandela's release from prison after 27 years of incarceration and the unbanning of the ANC and other political parties in 1990, provided the impetus for the abolition of apartheid and the advent

of democracy and marked a new chapter in South African history. On 20 December 1991 negotiations took place at the World Trade Centre in Kempton Park between the ANC, the government and other bodies. Eighteen delegations met together to discuss the future of South Africa, which became known as the Convention for a Democratic South Africa (CODESA). The path ahead was rather turbulent as various groupings wanted to derail the democratic process. The violence between Inkatha and ANC supporters escalated and in June 1992, some Inkatha members murdered 46 ANC supporters in Boipatong, a township in the Vaal area. Suspicions of a third force, the government, inciting the violence became stronger when the government did not appear to intervene to stop the violence or to hold the perpetrators accountable. The ANC resorted to mass action and when 29 ANC protestors were shot and killed in Ciskei, Mandela and De Klerk (the then president of South Africa) entered into a Record of Understanding. A Government of National Unity would be established to rule the country for five years, after which a single majority rule would replace the government of national unity. Furthermore, a new constitution based on human rights and democracy would be drafted (Mandela, 1994). On the 27 April 1994 South Africa held its first ever democratic elections, and millions of South Africans cast their votes for the first time. Nelson Mandela was sworn in as the first Black president of the country on 10 May 1994.

Habib (2014) believes that South Africa is a far better country to live in than it was in 1994. South Africa has made significant progress since 1994 to dismantle the discriminatory apartheid system and to live up to the ideals of the Freedom Charter declaring that the people shall govern the country. The Freedom Charter was promulgated by the Congress of the People in Kliptown on 26 and 27 June 1955 (Cachalia, 2013). This process has affected all levels of society. The economy developed from being a siege economy into an internationally competitive one allowing for economic growth. With a Constitution that promotes human rights and dignity, "an independent judiciary, an assertive press and vigorous civil society" (Meredith, 2005, p. 674), South Africa has made significant achievements as it has focused on the reconstruction and development of the country. South Africa's progress in the last twenty years is encapsulated in the following quotation by Jacob Zuma, the President of South Africa:

> Democracy has brought freedom of movement and of association, the right to own property, freedom of expression and freedom of the press, the equality of women, religious freedom, workplace freedom and the right to strike and protest, all in an attempt to restore the human dignity that was stripped away from us in our colonial and apartheid past (National Planning Commission, 2012, p.2).

Bundy (2014) maintains that with the democratisation of the political system and constitutional inclusion, members of the populous have experienced a sense of dignity, agency and a sense of power.

Tragically however, South Africa is still marked by the traumatic legacy of the apartheid system. Authors such as Du Plessis and Louw (2005, p. 425) purport that, "Few will dispute the claim that South Africa's transition to democracy has been a remarkable success" as they relate how the country moved from an autocratic and oppressive regime to a country with one of the most advanced human-rights-based constitutions in the world. While not many would dispute this statement and the transformational successes that South Africa has achieved, the imbalances of the past still remain a reality today. The gross inequalities based on race and human rights abuses are aspects that will haunt South Africa for decades to come.

5.3 THE SOCIO-ECONOMIC REALITIES OF SOUTH AFRICA

The socio-economic ramifications that emanate from apartheid are still highly prevalent 21 years into democracy and include social problems such as extreme poverty, high crime rates, unemployment, housing shortages, inadequate healthcare and a dysfunctional schooling system. The National Development Plan - Vision for 2030 estimated that 39% of the population was living in abject poverty (National Planning Commission, 2012). Unemployment rates for 2014 were recorded at 25.2%, however if discouraged workers who had given up looking for work were included in this statistic it would be closer to 35.5% (Statistics South Africa, 2014a). Of particular concern are the rates of youth unemployment, with more than 44% of youth aged between 18-35 years being neither employed, studying or in training (Moloi, 2014). In an attempt to address the unemployment situation government has initiated various projects including the Expanded Public Works Programme which has helped create employment opportunities for more than six million unemployed people (Zuma, 2015).

According to the Gini coefficient, which is a measure of inequality, South Africa is the country with the highest level of socio-economic inequality in the world. It is of concern that South Africa has held this position for many decades (Statistics South Africa, 2014b). The gross disparity between rich and poor has contributed to anger, frustration and increasingly violent crime as structural poverty does not appear to be dissipating but instead appears to be getting more entrenched within South African society. The government has implemented numerous policies and programmes to address the poverty of the country. More than seven million school children from poor households do not pay school fees and receive free meals at school (Zuma, 2015). In a further attempt to make tertiary education more accessible to all, more universities have been built so that every province now has a university. In an effort to reduce poverty, the increased availability of social grants has seen that more than 16 million people receive social grants. Grant recipients include people from the most vulnerable groupings in society, particularly older persons, vulnerable children and people with disabilities (National Planning Commission, 2012). Acknowledging the importance of social security in the prevention and reduction of poverty, Kaseke (2010) advocates that social assistance should be part of a broader programme that helps people to become self-reliant. What is apparent is that due to the gross inequalities of the

past the majority of South Africans need assistance in order to break the cycle of poverty that is so entrenched.

The HIV/AIDS pandemic has had a profound effect on South African society and in particular on families and children. The link between poverty and HIV/AIDS is well acknowledged (Tladi, 2006). In 2015, it was estimated that more than 5, 51 million people (10.2% of the population) were living with HIV in South Africa. About 16.8% of adults between the ages of 15-49 years were HIV positive (Statistics South Africa, 2015). According to USAID (2004), there were approximately 43 million orphans in Sub-Saharan Africa, mostly due to the AIDS pandemic. The South African Medical Research Council estimated that by 2015 the number of children in South Africa who will have lost one or both parents to AIDS would be close to six million (Holborn & Eddy, 2011; Maqoko & Dreyer, 2007). Child-headed households (households headed by persons who are younger than 18 years of age) is an increasing phenomenon and of great concern to the social and moral fabric of society. In 2011, approximately 96 000 children lived in child-headed households (Statistics South Africa, 2012). These children often have to leave school to care for younger siblings, are often malnourished, prone to illnesses and have limited access to healthcare. Many resort to prostitution and crime in order to survive. Child trafficking has also become a concern on the national agenda resulting in the promulgation of various bills to address this concern.

Authors such as Holborn and Eddy (2011) raise concerns regarding the circular nature of the familial breakdown, where children who grow up in dysfunctional families, are likely to perpetuate the cycle and have dysfunctional families themselves. As most South African children do not grow up with both of their biological parents and live in single parent families, these children are more likely to grow up in poverty than couple parent households. Of particular concern is the increasing number of 'absent fathers' who due to poverty, unemployment or the long-term effects of the migrant labour system are not significantly financially or emotionally involved in their children's life (Mavungu, Thomson-de Boor, & Mphaka, 2013). Almost one-third of South African teenage girls fall pregnant and at least a third then drop out of school. These figures can be attributed to many factors including lack of sex education, poverty, gender inequalities, gender expectations, and lack of access to contraceptives and condoms (Thobejane, 2015).

More than 69 000 cases of sexual assault were recorded for the year 2014/2015 (South African Police Service, 2015b). Meinck, Cluver, Boyes and Mhlongo (2015, p. 81) reviewed 23 quantitative studies exploring child abuse rates in Africa and a range of correlates of abuse which included community level factors (exposure to bullying, sexual violence and rural/urban location), household-level factors (poverty and household violence), care-giver level factors (caregiver illness, caregiver changes, family functioning, parenting, care-giver child relationship and substance abuse as well as child-level factors

(age, disability, physical health, behaviour and gender). While there are many national agendas to address the issue of child abuse and neglect, current interventions are not sufficiently ameliorating the problem. One of the government's recent intervention strategies has been to employ forensic social workers in the South African Police Service, who then investigate cases of child abuse and neglect (Stutterheim & Weyers, 2004).

Despite South Africa's population officially recorded at almost 55 million (Statistics South Africa, 2015), one can question the accuracy of this figure as it is estimated that there are millions of illegal and undocumented immigrants living in the country. After the 1994 elections an increasing number of people crossed the porous South African borders in search of economic prosperity or as refugees trying to escape human rights abuses in their countries of origin. It is estimated that there are at least five million illegal immigrants in South Africa. A large percentage of these immigrants are Zimbabwean and have come to South Africa due to the political and economic instability in their country. It is often difficult for these immigrants to find employment and they are not able to access the social security provisions of South Africa. Many of these immigrants are exploited in low paying jobs, live in horrendous conditions in derelict buildings or informal settlements and have very few rights or support systems to assist them. Recent xenophobic attacks in the country have created a climate of fear and mistrust, which has raised questions about whether the interventions from the South African government to address this growing social and political concern are sufficient (Bruce, 2010; Maistry, 2015).

What appears to be embedded within the fabric of South African society is intolerance for the 'other', which is again evident in homophobic hate crimes which are inflicted on people who deviate from a hetereonormative identity. Williams (2012) warns how homophobic hate crimes undermine the efforts of a society to promote respect for the dignity of all its citizens. Furthermore, she maintains that the psychological effects on victims of homophobic crimes are often far more severe and long-lasting than the psychological effects of other crimes. 'Corrective rape' is still a common practice, especially in townships, and is aimed at 'helping' lesbians realise their heterosexual tendencies. However, the Constitution advocates that all citizens have the right to freedom of sexual orientation, conscience and thought. All marriages, whether customonary, traditional or same sex marriages are now recognised, promoting more rights - particularly for women - compared to the apartheid era (National Planning Commission, 2012). Although South Africa has made tremendous progress in the transformation of the country, its democracy is still in the infancy stage and this infancy brings with it many challenges.

Social change can in itself be stressful as individuals' sense of security is threatened. A significant consequence of this stress is that people may resort to alcohol and drug abuse as a form of coping

with the constant fear in which they live. This response can become a cyclical situation where these abuses may in themselves lead to criminal activity (Bruce, 2006a). It is evident that South Africa is a country with numerous social problems and it is against this backdrop that social workers need to offer appropriate and relevant services. Considering the complexity of all these factors that influence social work practice in South Africa, it is not surprising that the occupational stressors in this profession are numerous.

5.4 CONTEXTUALISING TRAUMATIC STRESS IN SOUTH AFRICA

South Africa is often referred to as one of the most violent countries in the world as violence and traumatic stress are ubiquitous in South African society (Bruce, 2010). By its very nature the apartheid system was violent as the dignity and integrity of racial groups were violated. The apartheid system itself propagated violence through the forced removals of communities from urban to more rural areas. The continual police and military presence in the townships contributed to an atmosphere of tension and mistrust within communities (Hamber, 1997). In the 1990s the term 'culture of violence' became synonymous with South Africa – a society that endorsed violence as an acceptable means to resolve problems and achieve goals (Hamber, 1999; Simpson & Vogelman, 1992). Dixon (2015) drawing on Galtung's dichotomous understanding that violence is either structural or personal, explains how South African society is saturated with both types of violence. The effects of structural violence have been felt for centuries by millions of South Africans and emanated from colonial rule, apartheid and exploitative systems such as the migrant labour system, which was not only exploitative of workers but contributed significantly to the breakdown in African families as husbands and fathers no longer lived with their families (Nkosi, 2011). Structural violence is determined by differences in power and in the uneven distribution of resources, such as education, land, income and services. Personal violence is evident in the criminal activities inflicted by one human being on another as well as the police brutality experienced by thousands of people. In recent years the increased lethal force of the police has become a disturbing trend (Bruce, 2010).

Since the advent of democracy, the nature of violence has changed from vertical, state against citizen and citizen against state to horizontal involving citizen against citizen (Hamber, 1999). The South African Police Service Government Statistics show that murder has increased from 16 213 in 2013-14 to 17805 in 2014-15, which equates to almost 48 murders a day and there are an average of 118 recorded rapes per day (South African Police Service, 2015b). Murder rates are an important statistic to monitor as the number of murders recorded is likely to be close to the actual figure, unlike other statistics where crimes may not be reported such as rape or sexual assault. For example the Medical Research Council has estimated that only one in every nine rapes is reported to the police. Furthermore, the murder rate is regarded as an indicator of a country's stability as the higher the murder rate the less stable the country is perceived to be. South African murder rates are five times

higher than the global average of 6 murders per 100 000 (Watson, 2015b). For the first time since the advent of democracy the murder rates have increased for a second consecutive year (South African Police Service, 2015b). Bruce (2010) has argued that since 2004, SAPS has taken to under-recording crime as a distorted response to meeting their key performance indicator of a reduction in violent crime.

The South African government's failure to adequately acknowledge and prevent the levels of violence and trauma for citizens and communities alike is an ongoing discourse that is raised by certain sectors of civil society. The state's inadequate response to the issue has contributed to the normalisation of violence and crime as an accepted discourse of contemporary South Africa. The failure of the government to understand the complexities that underpin the violence and crime in society can be seen as they present policing as the primary response to crime without sufficiently acknowledging the complex matrix of social risk factors involved (Gould, Burger & Newham, 2012). Bruce (2007) argues that traumatic stress is a significant health problem in South Africa and that the epidemiological evidence shows that traumatising events associated with PTSD are a daily occurrence. He emphasises that the Ministry of Health has a profound responsibility to prevent and ameliorate the levels of traumatic stress in the country.

The inadequate state of the justice and correctional systems have also been considered as factors that contribute to the high levels of violent crime in South Africa. These systems face numerous challenges which include: insufficient prison facilities and resources; over-flowing prisons; court backlogs; corruption within the prisons and high rates of recidivism. The philosophy of restorative justice has been espoused by the state but appears to be more entrenched in the youth justice system than with adult offenders (Hargovan, 2012). Communities are often left frustrated with the state's justice system and frequently resort to mob justice and killing the alleged perpetrators (Bruce, 2010; Hosken, 2015b). A cycle of violence and trauma continues to destroy and fester as these community members are then charged with murder.

Kaminer and Eagle (2010) note that significant gaps exist in the knowledge base of traumatic stress in South Africa. They attribute the lack of research on traumatic stress to practitioners prioritising social activism above documenting and publishing in the area of traumatic stress. However, in the last two decades the interest in traumatic stress has grown considerably and this increase is evident in the burgeoning research and publications that have emanated. The events of the Truth and Reconciliation Commission (TRC), a restorative justice commission set up to deal with the atrocities of apartheid, placed traumatic stress on the map and pointed out to South Africans the need to deal with past and present trauma (Kaminer & Eagle, 2010). The ability to acknowledge the past in order to move forward was the premise on which the TRC was based. What the TRC revealed included violent actions

from both sides of the struggle that included: the establishment of death squads; the political detention, abduction, torture and murder of political activists; shootings; beatings; destruction of homes and property; necklacing[2] of suspected informants and many other human atrocities. More than 5 000 incidents of torture were recorded at the TRC, predominantly concerning Black males and almost 10 000 politically motivated killings were reported. Many critics have contended that the TRC did not provide the reconciliatory platform that was anticipated. What it did do was provide citizens with the opportunity to 'tell their story' where previously they could not and to help to give loved ones closure. The TRC not only highlighted the extent of the human rights violations but also provided a cathartic and empowering opportunity for victims. Moreover, it was indisputably apparent that individuals, families and communities have been collectively traumatised by the events of the past (Goldblatt & Meintjies, 1996; Hamber, 1999).

One cannot understand South Africa's traumatic past without understanding the concept of **transgenerational trauma,** and acknowledging how transgenerational trauma still affects most South African citizens today. Transgenerational trauma refers to trauma that is passed on from generation to generation, sometimes consciously but often unconsciously. Trauma can be transmitted consciously transgenerationally or it can be assimilated as it was never verbally spoken about but remains hidden among unspoken family secrets (Schutzenberger, 1998). This type of trauma is explained by Young (2007, pp. 342-345) in numerous ways: Firstly, *latency* – this theory postulates that individual and collective trauma are similar and that 'latency or belatedness' is an inevitable feature of individual trauma. As the trauma may be so incomprehensible, latency is inevitable and the trauma is only understood retrospectively, or as Freud termed it 'Nachtraglichkeit' (afterwards). A clear example of this phenomenon was the trauma of the Holocaust, which was only truly acknowledged almost two decades after it had occurred. Whilst knowledge of the death camps was circulated in 1942, commemorative activities were only conducted after 1960. Secondly, *lamarckian memory* – this theory refers to the transmission of collective knowledge through *genetic inheritance*. Unconscious trauma that is repressed in one generation becomes conscious trauma in the next generation. Again the full meaning of the trauma is only grasped retrospectively. Thirdly, *contagion* – traumatic memories are passed from one person to another in such a way that they are transmitted into the next generations' minds or consciousness. Contagion does not only have to occur from a generational perspective but can also refer to the manner in which therapists are traumatised vicariously. Bloom (1997) further explains that a traumatic emotion can be passed on to successive generations, which is unattached to a verbalized memory experience. The subsequent generation often then makes sense of the emotion and places it in its proper context. Often by the time the traumatic affect is passed on to the third or fourth generation, it is without any cognitive framework to help the children

[2] Necklacing is a method of murder where a tyre filled with petrol is placed around the victim's head and then set alight.

understand what they are feeling. Kira (2001) differentiates collective cross-generational trauma transmission into two kinds of collective trauma: historical trauma – which relates to a collective complex trauma inflicted on specific groups of people relating to their group identity or affiliation, and multigenerational transmission of structural violence which is created by the effects of social or structural violence through extreme social disparities.

Transgenerational trauma is particularly relevant to the South African context. The atrocities of apartheid and the trauma experienced by many South Africans have invariably passed on from one generation to the next generation. Currently, there is insufficient research in this area, and most transgenerational research has been conducted with victims of the Holocaust (Schutzenberger, 1998). In South Africa it is an area of trauma that urgently needs to be further explored, the paucity of which continues to contribute to the selective trauma discourse of South African society.

Given the historical background of South African society, it is inevitable that apartheid and its demise have taken a tremendous toll on the physical, mental and spiritual well-being of the majority of South Africans (Hamber, 1999). The National Crime Prevention Strategy identifies two predominant factors to which the roots of crime in South Africa can be attributed: those associated with the legacy of apartheid and those emanating from the transition to democracy. The residue from apartheid included social and economic aspects such as poverty, unemployment, deprivation and youth marginalization. In analysing the roots of crime occurring as a result of the transition to democracy Bruce (2006a) notes numerous factors. These included: the breakdown of social controls that were instituted by apartheid state institutions which contributed to an abyss of legitimate social authority; the culture of violence that transgressed from political to criminal violence; and a culture of entitlement and expectations that were fuelled by the belief that the new democracy would significantly change the standard of living of most South Africans.

However, the slow pace of transformation brought with it resentment and frustration which has increased the levels of criminal justice. In Franz Fanon's (1970) writings he cautioned that in post-colonial states, a new class of national elitists would emerge who would utilize the government's infrastructure for personal gain and to the detriment of the masses. On a daily basis the South African media report on new corruption and money laundering cases, many of which are related to fraudulent government tenders. It is reported that South Africa has in recent years lost more than R700 billion due to corruption. South African Public Protector Advocate Thuli Madonsela recently spoke about how administrative failure and corrupt decisions can undermine social justice and is a violation of people's human rights (Nkhwashu, 2015). Government corruption is particularly evident in the allocation of some government tenders as critics allege that only people with political connections appear to be awarded government contracts, and businessmen who are skilled at getting government contracts or

tenders are referred to as “tenderpreneurs" (Myre, 2014). Unfortunately the culture of corruption is apparent in most sectors of society, and is evident not only in government sectors but the private sector as well.

The presidency of Jacob Zuma has regrettably been one fraught with controversy and conflict. As the former deputy president, Zuma was removed from this position when his financial advisor was found guilty of fraud and corruption. Allegations of rape, fraud and corruption have haunted his presidency, but have not appeared to minimise his popularity with the majority of South Africans as he was re-elected for a second term as president by an overwhelming majority. In recent years there has been an escalation in the number of violent service delivery protests of communities against the lack of access to basic facilities such as water, housing and electricity and the rising cost of living. The increasingly violent nature of these community protests and strikes by workers for higher wages is evidence of the frustration of communities who are demanding a better standard of living. Langa and Kiguwa (2013) attribute the levels of violence demonstrated in these protests to a mechanism for working class men to express their sense of disempowerment and emasculation. In a study with male informants about their involvement in these violent protests, participants complained about men within the Black elite, men who are able to attract women with their expensive cars and other status symbols. Feeling disempowered due to their social and economic situations, these informants found that participating in violent strikes helped to enhance their masculinity. Within Black communities, the divides between rich and poor are also increasing. Sewpaul and Holscher (2004) believe that one’s own deprivation becomes more pronounced when members of one’s own reference group succeed and the sense of ‘other’ is no longer based upon race but is defined along social and economic lines.

In the 1980s a group of South African therapists coined the term **continuous traumatic stress (CTS) to** try to explain the psychological and cumulative effects of continuous trauma, as distinct from repeated abuse at the hands of someone known to the victim. ‘Continuous traumatic stress’ referred to stress that clients experienced whose danger was not over, but who faced ongoing risk of further traumatisation (Kaminer & Eagle, 2010). In contrast to **post**traumatic stress where the trauma occurred in the past, **continuous** traumatic stress tries to encapsulate traumatic stress and occurs when the stressor is still ongoing. (A criticism that can be leveled against this construct is that it should possibly have been referred to as continual traumatic stress as the word “continuous” implies that the trauma happens all the time without cessation). Due to the subjective nature of how risk is perceived, Eagle and Kaminer (2015) propose that CTS is defined in situations when it is normal to be concerned about one’s safety. A characteristic feature of CTS is the failure of civil society to maintain law and order. Straker (2013) argues that as the construct CTS was not developed in the Northern Hemisphere, traumatologists have not sufficiently explored or encompassed the concept of continuous traumatic stress. She compares CTS to that of Complex Posttraumatic Stress Disorder (CPTSD), which also

acknowledges the traumatisation of an individual due to multiple stressor events, and how CPTSD is far more accepted as a construct. In particular, the construct of CTS is particularly relevant for trauma experienced in war times and times of civil unrest. For a South African police officer who is confronted with traumatic situations on a daily basis, this term might be the most appropriate explanation for their traumatic experience.

Hamber and Lewis (1997) advocate the notion of multiple causal factors of violent crime in South Africa, which extends far beyond the notions of poverty and violence. In particular, violence against women that is engendered upon a patriarchal society, has resulted in women and children often being marginalised and vulnerable. In particular, South African Black women have experienced a double oppression based on their race and their gender. While there has been significant progress in the emancipation of Black women in South Africa, traditionally Black cultures are predominantly patriarchal and still advocate that a woman's role is subservient to that of a man (Nuttall & Van der Merwe, 2004).

Gender discrimination was apparent when women could not become members of the newly formed African National Congress in 1912. The role that women played in fighting against apartheid, raising consciousness and advancing the struggle for a democratic society, has never been disputed. Yet even within their own structures women had to fight for equality. Charlette Maxeke, one of the resistance stalwarts and one of South Africa's first Black social workers, resisted government attempts in 1913 to impose passes upon women and led protests against the pass laws in the Free State. The Bantu Women's league was formed in 1918 to address the oppression that affected them both as women and workers. Women played a significant role in the fight for liberation and participated in the Defiance Campaign (1952-1954), which was the first large-scale multi-racial political mobilisation against apartheid. Women were not only limited in their political participation, but would often be tortured and sexually assaulted when they were not in possession of their pass books or 'dompas' (government issued books carrying identifying information that African people were required to carry with them at all times or risk imprisonment) (Goldblatt & Meintjies, 1996).

In 1954 women from all racial groups joined together to form the Federation of South African Women and formulated a Women's Charter which pledged to bring discriminatory laws to an end. This development led to a watershed moment on 9 August 1956 when 20 000 women of all races united and marched to the union buildings, where they held a silent protest for 30 minutes, and delivered a petition with 100 000 signatures to the Prime Minister's office protesting at having to carry pass books (Goldblatt & Meintjies, 1996). This march was spear headed by Lilian Ngoyi, Rahima Moosa, Helen Joseph and Sophie Williams (Cachalia, 2013). Women also participated in all four of the pillars of the struggle, namely: mass mobilization, mass armed operations, underground organisation and

international solidarity. With the unbanning of political organisations in 1990, many women returned from exile and joined their families inside the country to help negotiate for a new South Africa. The Women's National Coalition formed in 1992 brought together women from different political, religious, social and cultural arenas to identify and explore the changes required for emancipation (Goldblatt & Meintjies, 1996; Meredith, 2005). Their research placed gender concerns on the national agenda which were then incorporated into the new Constitution and the South African Bill of Rights. Consequently, new laws have been introduced including those that address domestic violence, recognition of customary marriages and child maintenance (Finnemore, 1999).

The Promotion of Equality and Prevention of Unfair Discrimination Act of 2000 was also promulgated in order to promote equality and eliminate unfair discrimination and harassment. Discrimination on the grounds of race, gender orientation, sex, marital status, ethnic or social origin, sexual orientation, age, disability, religion, belief, culture, language and birth are explicitly prohibited (Promotion of Equality and Prevention of Unfair Discrimination Act, 2000). The ANC has taken significant steps to improve the representation of women in all spheres of life. In 2007 at the National Conference of the ANC in Polokwane, the 50/50 gender parity principle was adopted. What is apparent in the last two decades is the significant increase of women in the South African cabinet when one considers that prior to 1994 there was only one woman in cabinet (Zuma, 2011b). Gender equality has been promoted and in this regard South Africa has been placed in the top ten countries globally due to the high percentage of women parliamentarians in national parliament (National Planning Commission, 2012). Yet despite this success in government, the status and representation of women in the workplace still lags significantly behind men. The lack of women in top corporate positions can still be seen as problematic to the equitable advancement of South African society. A recent call from the ANC woman's league for a female president has been regarded as premature by some and a sentiment that is not upheld by various sectors of the South African society.

The foregoing discussion forms the backdrop to the discussion of work as the South African context has shaped the work environment of social workers and police personnel in this country. In order to understand the dynamics of the South African workforce, one needs to understand the history of work in South Africa that was shaped by racial and gender discriminatory policies.

5.5 THE HISTORY OF WORK IN SOUTH AFRICA

5.5.1 Industrialisation in South Africa

Work in South Africa has been based on specific characteristics, particularly racial despotism and coercion rather than consent. Industrialisation was shaped in particular ways due to the fact that the White minority had political power, unlike the Black majority. Capitalism, class and race have been

closely associated in South Africa and as Webster et al. (1994) point out, the policy of apartheid was particularly beneficial to the development of capitalism.

Up until the later part of the 1860s South Africa had not been significantly affected by industrialisation and urbanisation which were characteristic of Europe and other parts of the world at that time. Prior to this time the economy was still based on agrarian and pastoral systems. During this phase there was little economic growth which could be attributed to the lack of agricultural commodities (Feinstein, 2005). The discovery of diamonds at Kimberly in 1867 dramatically changed the economy of the country, bringing with it a significant movement of people from rural to urban communities. Fifteen years later, these changes were compounded by the discovery of gold on the Witwatersrand in 1885. However, the lack of available skilled and unskilled labour prohibited entrepreneurial growth. Consequently, employers recruited skilled labour from Europe and Australia. Many overseas immigrants who were hoping to make a fortune joined in the gold rush, which had significant effects for both Black and White South Africans. The White South Africans could not compete with the education and trade skills of the immigrants and were not willing to work as manual labourers. The consequences were extensive and resulted in a 'poor White problem' (McKendrick, 1987). These changes also had a significant impact on the Black African population as Africans were only allowed to work as manual labourers, which was lowly paid employment in a cash economy. Furthermore, the segregatory policies of the time prohibited Africans from residing permanently in towns and cities. Black people were classified into ethic groups according to the promotion of the Bantu Self-Government Act No 46 of 1959. Through the Bantu Homelands Citizenship Act, Black people could only live in White areas if they were granted special permission. However, in order to establish readily available workers, urban townships were developed. These townships had to be far enough from White residential areas, which resulted in poor people traveling long distances daily to and from work. The Group Areas Act prohibited certain racial groups from living in areas designated as 'White areas' (National Planning Commission, 2012). This system also contributed to a significant growth in the number of migrant labourers in South Africa (McKendrick, 1987; Zuma, 2011a).

The genesis of the migrant labour system was inextricably linked to the expansion of capitalism in South Africa. By 1890 the migrant labour system was fully entrenched within the mining sector in South Africa. Migrant labourers are relatively unskilled labourers and are considered as cheap labour. Standing (1982 cited in Golden, 1995) argues that the push–pull factors that result in migration occur as a result of the exigencies of capitalist development and the demand for labour. Rural poverty, population growth and the aspiration of being able to obtain money through wage labour in order to obtain agricultural equipment were some of the 'push-pull' factors. Not only were these labourers receiving a poor wage but their living conditions were often appalling. They lived in mass accommodation in single sex hostels at the mine or place of work and as their homes are often hundreds of kilometers away, they only visited their families periodically (Golden, 1995). Furthermore,

the reproduction of the migrant labour system was reinforced as the extended family lived in the rural areas, which would fulfill the social security functions necessary to sustain wives and children. An essential characteristic of the racialist capitalist system was that women were left in rural areas to bring up children while men worked on the gold or diamond mines in urban areas (Hunter, 2011). These social living conditions often led to extreme alcohol abuse as well as miners having extra-marital affairs as their wives and children were so far away. Miners would often have children with their girlfriends, which meant that these miners would have two families to support on a minimal wage. Furthermore, many children were growing up without their fathers (Holborn & Eddy, 2011).

In 1910 the Union of South Africa was established, which promoted White unity and excluded Black South Africans from parliament. This period ushered in alliances between White English capitalist mine owners and Afrikaans farmers. The economy was predominantly controlled by the English through the Chamber of Mines, an influence which is still very prevalent today (Webster et al*.,* 1994). One of the most contentious issues currently debated in the South African political and economic arena is the nationalisation of the mines. Political parties such as the Economic Freedom Fighters (EFF) advocate for the mines and banks to be nationalised in order for the wealth from South Africa's raw materials to be redistributed to the poor. Opposition parties such as the Democratic Alliance (DA) argue that nationalising the mines will not benefit the country and instead reduce foreign investment.

The statutory colour bar in the workplace was formalised through The Mines and Works Act of 1911. The 1913 Land Act also restricted the amount of land that Black South Africans could own. Only about 10 per cent of land was reserved for Black ownership. With the shortage of land and overcrowding, many Black people sought work in the mines and so the migrant labour system became entrenched. These acts contributed to the impoverishment of the Black nation. Furthermore, as Black mine workers' wages declined, poverty levels were exacerbated. In 1924, with the National Party's victory at the elections, the economic philosophy shifted from economic liberalism to economic nationalism as there was increased state control and protected external policies (Finnemore, 1999; Webster et al., 1994). Job reservation for Whites meant that the better paying jobs were kept for Whites and disadvantaged other racial groups. Moreover, the Minimum Wages Act No.27 of 1925 enabled the Minister of Labour to give preference to Whites when employing workers (Zuma, 2011a).

Conflict on the mines characterised the years from 1897 – 1922. Resistance was still delineated along racial lines. While the Chamber of Mines had recognised White worker unions, Black unions were not established on the mines. This lack of unionisation among Black workers could be attributed to numerous factors: the mining compounds were isolated from each other; Black workers received no support from White workers who had union experience and skills; and tribal allegiances were still very strong. However, outside of the mines, Black workers' interest in unionisation was growing and in

1919 the Industrial and Commercial Workers' Union (ICU) was established. Membership continued to grow as the ICU took numerous issues to court and advocated for Black workers' rights (Finnemore, 1999). As a result of the miners' strikes in the 1920s the government passed the Industrial Conciliation Act in 1924. While White trade unions were acknowledged, the power to strike was severely prohibited. Black workers were also excluded from the provisions of the Act. The result was the existence of a dual labour relations system in South Africa where White workers were increasingly protected by legislation and the capitalist system while Black workers had no political or economic power (Finnemore, 1999).

In 1924 the South African Trade Unions Congress was founded, which encouraged the development of industrial unionism. Many more unions were started as industrialisation developed and some of these unions were non-racial. Subsequently in 1930 the South African Trade and Labour Council (TLC) was established on non-racial grounds. While this council represented a move towards unification, most unions still remained divided on racial grounds. In 1941 the Council for Non-European Trade Unions was established by Black workers. In 1946, when the government crushed a strike by 75,000 migrant mine workers, this action resulted in many ideological and attitude shifts among the workers. Consequently, the TLC drew up a Workers' Charter and began to promote socialist ideologies. While the manufacturing sector developed rapidly, this sector's long term growth was constrained by an inability to compete in international markets (Feinstein, 2005).

5.5.2 Work in the Apartheid System

The apartheid system was another significant factor that shaped work in South Africa. In 1948 when the National Party came into power, the party entrenched apartheid policies. Labour Legislation followed the ideology of apartheid and created division in the non-racial unions. During the first three decades of apartheid the economy of the country improved (Feinstein, 2005). When in 1950 the Suppression of Communism Act was passed, many union leaders were arrested and unions banned. In protest, the Defiance campaign was organised by the ANC and other parties and was accompanied by strikes, boycotts and stayaways. Police activity and the level of unrest increased during the course of the campaign and the ANC developed and emerged as a mass movement. On 20 March 1960 the Sharpeville Massacre occurred in which, 59 people were killed by police while demonstrating against the pass laws at a police station. Due to banning orders that were issued on organisations such the African National Congress (ANC), South African Communist Party (SACP) and South African Congress of Trade Unions (SACTU), these organisations went into exile. Consequently, the 1960s were characterised by limited union activity and a period of relative calm and economic growth (Finnemore, 1999).

The Bantu Education System that was introduced by H F Verwoerd through the Bantu Education Act No. 47 of 1953 provided basic and minimal education for Africans, ensuring that Africans would only occupy menial employment positions and ensure White supremacy and domination. The Bantu education system was not only meant to promote an ethnic consciousness in students but also to teach African children to accept an inferior position in society. In 1963 and 1967 separate education departments were established for so called 'Coloured' and Indian people respectively. The Extension of University Education Act in 1959 had closed what were identified as White universities to Black students (Webster et al., 1994). The inferior quality of education that was available particularly to Black South Africans meant that many Black people remained uneducated and occupied the unskilled positions, and so the cycle of poverty continued.

The 1970s was a period marked by two watershed moments, the Durban strike in 1973 and Soweto uprising in June 1976, when township children objected to being taught in Afrikaans as a medium of instruction and the police opened fire killing children. The Durban strike in 1973 over wage increases had a significant effect on the workforce as the intensity of the strike inspired hope and confidence in the workers. Industry was nearly brought to a standstill and the real power of united Black workers was demonstrated. Furthermore, Marxist ideologies and a commitment to social justice and equality increased amongst the workers and union officials, which laid the foundations for mass mobilization and the emergence of militant and resilient union movements in the late 20th century. During this period the economy was faltering and contributed to the economic and political crisis of the country (Buhlungu, 2009; Feinstein, 2005).

During the 1980s and the early 1990s trade union movements in South Africa were militant and progressive with a dual agenda: to improve the wages and working conditions of their members as well as fight against the apartheid regime in order to bring about a democratic dispensation in South Africa. This process was labeled social movement unionism (Webster & Buhlungu, 2004). In 1979 the Federation of South Africa Trade Unions (FOSATU) was established and was based on the principles of non-racialism and industrial unionism. In 1981 the Labour Relations Act was amended and significant changes were introduced. Every worker in South Africa, irrespective of race, had the right to belong to a union; workers were given autonomy in respect to their union membership and all racial restrictions were removed (Finnemore, 1999). While these changes were progressive, they were still a far cry from a democratic South Africa.

When in 1984 the government created a tri-cameral parliament, which included Coloured and Indian people but still excluded Black people, FOSATU and the Council of Unions of South Africa (CUSA) campaigned against the elections. Political alliances between unions and political alliances such as the Azanian Peoples Organisation (AZAPO) and the United Democratic Front (UDF) were strengthened. As

many political organisations were banned and working underground the unions continued with the fight for liberation (Finnemore, 1999; Webster & Buhlungu, 2004). During the height of the unrest in 1985 the Congress of South African Trade Unions was formed. Thirty-three unions comprising FOSATU affiliates and independent unions amalgamated. Sociologists like Buhlungu (2009) believe that the formation of COSATU marked a significant era for work in South Africa, as the labour constituency had a medium through which to be heard. In 1988 when various amendments were made to the Labour Relations Act, COSATU was very active in the fight against these amendments. The years 1988 - 1990 were very active years for the unions, with more workdays being lost to strike action during this period than in the entire preceding 75 years (Finnemore, 1999).

Due to increasing international and internal pressure, in 1990 President FW De Klerk announced the unbanning of numerous political parties including the ANC and the SACP as well as the release of various political prisoners including Nelson Mandela. The transitional period from 1990 – 1995 was marked by significant violence and bloodshed due to feuding between rival political parties Inkatha and ANC. Evidence later emerged from the Goldstone Commission that a third force which emanated from the South African security forces was responsible for igniting violence between the two parties (Zulu, 1992). In the early 1990s unions objected to retrenchments and financial cutbacks that were occurring due to the decline in economic growth. This transitional period was further marked by many traumatic events including the Boipatong massacre where 46 people were killed by Inkatha Freedom Party (IFP) supporters; 29 people were shot by the police while marching in protest against the Ciskei government; and Chris Hani, the leader of the SACP, was assassinated by right wing supporters. Due to pressure exerted by COSATU and the ANC the Interim Constitution and Bill of Rights were established. This step led to the first democratic elections being held on the 27 April 1994, in which the ANC won the outright majority and which marked the dawning of the “New” South Africa (Finnemore, 1999). The role that COSATU played in the first 10 years of its existence was central to the transformation and democratisation of South Africa (Buhlungu, 2009).

5.5.3 Work Post 1994 in South Africa

With the new democratic government in power it was necessary to change the Labour Laws of South Africa. The newly appointed minister of labour initiated a five year plan to amend the labour laws, which led to the promulgation of the National Economic, Development and Labour Council Act of 1994. This Act provided for the establishment of the National Economic Development and Labour Council (NEDLAC), which aimed to promote and formulate policies on economic growth as well as promote participation in economic decision-making and social equity (Du Plessis & Fouche, 2006).

After the 1994 elections the government’s economic policy was based on the Reconstruction and Development Programme (RDP), a socio-economic policy that was built on the concepts of

reconstruction and development. The RDP advocated for a neo-Keynesian framework for job creation and co-determination within the industrial sector (Wood & Sella, 2010). However, the RDP was not as successful as initially anticipated. While there were significant developments in sectors such as housing and rural development, the anticipated growth of the economy did not occur. In addition, numerous other factors such as the effects of globalisation, the increasing crime rates and the devaluation of the rand resulted in the government reconsidering its economic policies. The ANC found itself in a dichotomous position as on the one hand the government tried to satisfy the International Monetary Fund (IMF) and the World Bank and show allegiance to the neo-liberal orthodoxy, yet on the other hand they needed to satisfy the demands of the majority of South Africans who were Black and poor. Whereas traditionally the ANC had adopted a leftist, basic needs stance as its economic framework, within two years they had switched to a more rightist approach, replacing the socialist economic policy with neoliberalism. In June 1996 the ANC established the Growth, Employment and Redistribution Policy (GEAR) which advocated for privatisation, deregulation and trade liberalisation. What was significant about this policy is that government initiated economic strategies without significant consultation with the labour movements (Finnemore, 1999; Wood & Sella, 2010). With the implementation of this macroeconomic policy government spending was reduced and basic services such as water and electricity were privatised. Consequently, this change resulted in many households being unable to pay for these services and also led to the sharp rise in the unemployment of the previously economically active population (Ferreira & Henk, 2008).

As Peet (2002, p. 55) explains, “economic discourses are symbolic formations arranged around persuasive political ideals”. This notion is further explained by Gramsci’s notion of hegemony, in which economic behaviour or rationality is constituted by convictions and beliefs which then culminate in collective consciousness. While the ANC had advocated for a more democratic, redistributive and even socialist society for many decades, they were now moving to more neoliberal policies. When the then Minister of Finance, Trevor Manuel, was asked to explain the adoption of GEAR, he answered that the collapse of the Soviet Union, had destroyed romantic illusions previously held by many leftists in the ANC. It is possible that this change in the economic policy had been brewing for some time within the ANC and was evident in the ANC’s stance on nationalisation in 1992 when Mandela publically rejected the notion (Peet, 2002).

During colonial and apartheid times the participation of Black South Africans in the economy was never designed to go beyond the provision of cheap labour. Zuma (2011a) asserts that political freedom must be accompanied by significant economic transformation and emancipation. The African National Congress (ANC) has developed strategies and introduced legislation to encourage various forms of collective ownership of the economy such as employee shareholding schemes, co-operatives and public ownership. Furthermore, the ANC claims that assistance to small and micro enterprises, in

both rural and urban areas has increased. While there has been significant progress in some aspects, many argue that this progress is not sufficient. An interesting saga that continues to dominate the media is the nature of the relationship between the ANC and COSATU. Traditionally, they stood as a unified entity in the fight for liberation. However, there have been significant clashes and struggles between the two. COSATU has made clear its agenda for a more redistributive approach and the need to move away from markets and competitiveness (Southall & Webster, in Beckman, Buhlungu & Sachikonye, 2010). While the ANC claims to support some of these aspects, their neoliberalist stance does not compliment that of the socialist agenda to which they initially subscribed. Hence the debates between labour and government inevitably continue and have culminated in dire consequences such as the Marikana massacre (De Rover, 2015).

The preceding section provided an explanation of work in the South African context as the background to this study. The multiplicity of stressors evident in the macro context should not be underestimated. In addition, it is important to explore the concept of occupational stress and the South African Police Service as the work context within which the participants of the study were employed.

5.6 THE WORK CONTEXT OF THE SOUTH AFRICAN POLICE SERVICE

5.6.1 Historical Overview of the South African Police Service

Prior to 1995, South Africa comprised the old South Africa as well as six self-governing territories (homelands) and four independent states. In 1994, these homelands were abolished and integrated into a united South Africa under the Interim Constitution. As a result there were 11 different policing agencies that were combined in 1995. Each policing agency had different uniforms and rank structures, and was developed and monitored under different legislative frameworks. When President Mandela appointed General George Fivaz, as the first National Police Commissioner, he had the enormous responsibility of transforming the South African Police into the South African Police Service (Bruce, 2006b).

Colonial and apartheid governments dictated the nature of militarised and discriminatory policing of the police force (Dixon, 2012). For Black communities to reframe the concept of the police force as a humanitarian extension of the government and not as a brutal coercive force will probably take decades. Steinberg, an eminent South African writer and academic, spent time working alongside the police in order to discover the 'unwritten rules of policing' in the New South Africa. He encapsulates the essence of the Black community's mistrust of the police as he explains,

> When the police's new bosses came to power in 1994, they gave themselves the tasks of stabilising the organisation, knitting its allegiances to the new democratic order, and winning legitimacy for it in Black communities….it understood the violence that had wounded

> township life in the dying years of apartheid to be circumstantial and thus superficial…yet the violence was neither circumstantial nor superficial. It was an inflammation of the very tissue of urban South African life…To get South Africa to give its consent to being policed would require breaking down generations-old architecture of security and protection (Steinberg, 2008, pp. 97-98).

During apartheid the police represented a government that was regarded as lacking legitimacy in the eyes of the populace. The police were used by the state as the apparatus to enforce racially discriminatory laws and legislation. The events of June 16th 1976 will never be forgotten as police shot and killed students in Soweto who were protesting at having to be taught in Afrikaans as a medium of instruction in their school. On that historic day Hector Pieterson was the first young scholar falling victim to police brutality. South African society has never forgiven the police for these killings and for their role in apartheid. As Steinberg (2008, p.22) explains,

> In the wake of the 1976, the police were forced out of some of the urban townships. They were evicted from most of the rest a little less than a decade later during the insurrectionary period of the mid-1980s. Even before they were thrown out, the policing they provided was grossly inadequate: they did little to provide township residents with a bare modicum of personal security, and were in fact often among the various agents that periodically violated it.

According to Altbeker (2010, p. 77) "the history of police abuses of power in South Africa is deep and rich". The Independent Police Investigative Directorate (IPID) revealed that incidents of police brutality have increased in the past few years and that more people have died in police custody during 2014/2015 than in previous years. During this period police incurred civil claim liabilities exceeding R9,5 billion due to police misconduct (Merten, 2015a). For police officers who serve the community, knowing whether to use force or not in a situation and the subsequent consequence of that decision, makes police work in South Africa complex and stressful, particularly when the police receive so little public support. It is not surprising that the police force in Gauteng alone is losing 130 officers a month to either resignation or dismissal (Dlamini, 2015). While the police are called in to intervene in individuals' personal problems e.g. domestic violence, housebreaking and theft etc., it is extremely difficult for them to implement police community protests where they are vastly outnumbered and often the target of people's aggression.

Despite the fact that since 1994 SAPS has represented a legitimate government, the legacy of mistrust still prevails and as Steinberg (2008. p.68) states, "South Africa has still to give its consent to being policed". "Of the 2322 protests recorded between Jan 2013 and December 2014, 11% were against

crime or bad policing. Vigilantism constituted 161(7%) of all these protests" (Masombuka, 2016, p.2). Notwithstanding attempts to re-engineer SAPS and to develop trusting relationships between communities and the police services, SAPS appears to be continually clouded with corruption scandals, lack of appropriate political leadership and mismanagement problems (Mthethwa, 2015). While there are many hard-working, courageous and dedicated police officers, corrupt police officers do little to promote the image of the SAPS. Moreover, despite the National Police Commissioner, Riah Phiyega's warning that "Police officials who bring shame to the badge by getting involved in crime and human rights abuses have no place in our organisation", this type of statement does not appear to deter deviant police officers. Cases such as that of a Johannesburg police officer who was arrested for allegedly detaining a woman for fraud and then raping her in the police cells, continue to make media headlines (Watson, 2015a). In the first six months of 2015, 381 police officers were fired, while 504 were dismissed the previous year. Furthermore, during a three month period in 2015, 90 'tsotsi'[3] police officers in Gauteng alone had been charged for either 'internal corruption, soliciting or accepting bribes or aiding and abetting criminals' (Germaner, 2015, p. 1). A recent SAPS audit has revealed that police officers often inaccurately record illegal drugs and alcohol that they confiscate and that these illegal substances then disappear from police evidence rooms (Sidimba, 2015).

Ironically, this corruption is not only evident amongst the lower ranking police officers but has permeated even the highest office within SAPS. Jackie Selebi, a former national police commissioner and former President of Interpol, was convicted of fraud, corruption and racketeering in 2012 and sentenced to 15 years imprisonment. In 2008, Susan Shabangu, South Africa's Deputy Minister of Policing, addressed a public meeting about how the state could improve public safety. This account is captured by Altbeker (2010, pp. 77-78),

> Shabangu said she wanted to assure police officers 'that they have permission to kill these criminals. I won't tolerate any pathetic excuses for you not being able to deal with crime. You have been given guns, now use them'. Warming to her theme, she said that the police should 'shoot the bastards' and went on to offer the wisdom in the battlefield: 'I want no warning shots. You have one shot and it must be a kill shot. If you miss, the criminals will go in for the kill. They don't miss. We can't take this chance. Criminals are hell-bent on undermining the law and they must now be dealt with. If criminals dare to threaten the police or the livelihood or lives of innocent men, women and children, they must be killed. End of story. There are to be no negotiations with criminals'...Shabangu received a standing ovation.

Selebi's successor, Bheki Cele, was fired a few years after his appointment due to suspected allegations of corruption. Cele's adoption of the mantra 'police must shoot to kill' did not enhance the

[3] Zulu word meaning thief or thug

image of the SAPS or promote the 'service' emphasis that the police force was trying to develop. Seedat (2015, p.23) points out that "the emotional and social disconnections that characterise South Africa are evident in the lethal police responses to poor and marginalised people's acts of insurgent citizenship".

One of the suggested outcomes of the Farlam Commission, the government's official investigation into the Marikana massacre, was that the current police national commissioner, Riah Phiyega's competence to hold office needed to be reviewed. In accordance with this recommendation, President Jacob Zuma, has requested that Phiyega respond to this recommendation and defend her competency to hold this office. The continued changes in leadership of SAPS have not only raised questions about the credibility of the organisation, but have also affected police morale within the organisation (Van Onselen, 2015). Phiyega, in her rebuttable defence, outlined her strategic vision and the developments within SAPS that she initiated during the last three years she had been the National Police Commissioner. Drawing upon the National Policing Policy that was adopted in 2011, SAPS reviewed the existing public order policing standards and the use of direct force and had implemented appropriate training. SAPS training modules have been reviewed and appropriately adjusted in order to embrace a community policing ethos that is founded on human rights. Training in public order policing has been incorporated as part of the entry-level qualification for police officers. Many of the officers already employed in the system have received first responders training in public order policing. In addition, specialist detectives will be expected to ensure the arrest and prosecution of public order offenders and platoon commanders will be equipped with additional skills to effectively manage volatile situations. Partnerships with research institutes such as the Council for Scientific and Industrial Research will explore opportunities to modernise policing equipment and systems (Phiyega, 2015).

Tait and Marks (2011) observed how despite public order policing undergoing significant changes after 1994, this progress appeared to have regressed during the 2000s as community protests became more violent. Judge Farlam in his report on Marikana concluded that the militarisation of the police is problematic as it promotes a dichotomous understanding of us and them – the enemy. Furthermore, Judge Farlam raised the concern of how South Africa has diverged from the mandate of a modern democracy in that police follow a paramilitary style; leaders in the police do not have the necessary qualifications or experience in policing and there is not an appropriate separation between political processes and senior appointments in the police (Van Onselen, 2015).

5.6.2 Occupational Stress of the Police

Globally the occupational stress of police officers is a well documented and researched area. Kop and Euwema (2001) delineate police stress in Holland into two categories: the nature of work and

organisational aspects of police work. The nature of police work includes exposure to danger, confronting the unknown, the use of physical force and shift work. The use of physical force might be required when dealing with aggressive citizens, but the use of force can also lead to citizens' complaints, escalated conflict and concomitantly increased risks for the police officer. Organisational aspects include the confidence levels in management, internal communication and procedures as well as continual organisational change. This delineation acknowledges global stressors of police work, but it fails to acknowledge how the context within which the police operate tends to shape the stressors of the job. The environment in which South African police officers are required to protect others, is in fact not safe for themselves (Gumani, 2014).

Furthermore, the Police and Prisons Civil Rights Union (Popcru) has argued that the bulletproof vests issued to officers are too heavy and are not designed for female officers. As a result many officers remove the shielding component making them lighter to wear (Malefane, 2015). Since 2010/2011 more than 421 police officers have been killed, which has raised concerns over the standard of police training. Newman, the Director of the Institute for Security Studies, attributes the inability of the police leaders to adequately deal with crime in the country to have given rise to a 'brazen breed' of criminals who are far more heavily armed than the police (Laganparsad, Jika & Skiti, 2015). This anomaly raises the question whether poor police management is the only factor to account for the current crime situation. For example, Carlan and Nored (2008) found that frustration with the judicial system and disappointment with public apathy have been correlated with high crime levels and police stress.

Confronting such harsh realities, and working in a job that is often low paying and not sufficiently appreciated by society takes its physical and psychological toll on police officers. According to the SAPS Annual report (2014/2015) during the period from March 2014 – February 2015, a total of: 3477 SAPS employees 1013 resigned from the police force; 125 were dismissed; 220 were discharged due to ill health and 565 died (South African Police Service, 2015a). Of particular concern was that psychiatric conditions were identified as the leading cause for long periods of temporary incapacity. Despite the existence of a well established Employee Wellness Programme within SAPS, psycho-social problems still appear to exert a detrimental effect on police officers.

Boshoff and Strydom (2015) reviewed the programmes that are offered to police officers by the Employee Health and Wellness (EHW) division and found that despite programmes aimed at helping officers to deal with trauma such as trauma debriefing and counselling, there was not an all inclusive trauma psycho-social well-being programme for police officers. Suicide rates within the SAPS are unusually high and are recorded as more than double that of the national number of suicides. This situation is of particular concern when according to the South African Federation of Mental Health,

South Africa ranks eighth internationally for its suicide rate (Green, 2015). Police family murders is another concerning phenomenon within SAPS. In a recent event, a police officer killed his girlfriend, her parents and a fellow officer at a police station when his girlfriend was laying a charge of domestic violence against him. The officer in question was then killed by his colleagues as he tried to flee the scene. Scenes such as these can be attributed to the high levels of stress experienced by police officers, the easy access to firearms and a distortion of life and death – all factors associated with the nature of police work.

Burke and Shakespeare-Finch (2011) suggest that police officers are unlikely to be as affected by highly challenging situations as civilians due to their training, socialisation into the police culture, and the expectations that they have of the police role. This explanation could account for the manner in which many officers cope, but as South African police statistics portray, this explanation is often not the reality on the ground. The adverse effects of the trauma and occupational stressors that they face have a profound effect on the women and men in blue who attempt to serve and protect the citizens of South Africa.

5.7 CONCLUSION

What is apparent is that South Africa faces many challenges in the economic and social reconstruction of the country. While political emancipation was achieved more than two decades ago, economic emancipation lags behind significantly. The traumatic history of South Africa is evident in the collective trauma of communities, in the transgenerational trauma likely to be passed down to future generations and through individual trauma experienced as a result of violent crime or through racial and gender inequalities. The history of work in South Africa is paralleled by the struggle for liberation of the country. Very few would dispute the fact that one of the most stressful professions is that of policing and that policing in South Africa in particular is fraught with many challenges. In a similar vein, the profession of social work, while rewarding in many respects, is also fraught with many occupational stresses and challenges, which are explored in the following chapter.

CHAPTER SIX

THE PROFESSION OF SOCIAL WORK

"Social work involves entering into the lives of people who are in distress, conflict or trouble. To do this requires not only technical competence but also qualities of integrity, genuineness and self-awareness" (Lishman, 2002, p. 95).

6.1 INTRODUCTION

As social work is a relatively young profession, it continues to evolve with the philosophical, ideological and political shifts of time in its endeavor to remain relevant and appropriate to society. Internationally there is variance in the way that the profession is understood and the scope of practice often differs significantly from one country to another. The debates about the focus on individual versus social change, tradition versus postmodern understandings, and the shifts from Western paradigms to more indigenous approaches has meant that social work is in a state of quandary as to how it is defined and practised (Staniforth, Fouche & O'Brien, 2011). In order to regulate and promote consistency within the social work profession internationally, various associations and federations have been formed. In July 2014 the International Federation of Social Workers (IFSW) approved the following definition of social work:

> Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing (International Federation of Social Workers, 2014).

As social work is reflective of social change the changing and adaptive nature of the profession is an expected outcome. This definition of social work highlights the promotion of social change and human justice and gives credence to indigenous knowledge. Accepting that social work is a socially constructed activity that is bound by time, context and culture (Payne, 2005), its scope and practice will vary from country to country. Some countries, such as China, do not advocate for the emphasis on social change (Harington & Beddoe, 2014). Yet despite these differences, there are many challenges and limitations that are inherent in the profession across different countries. This chapter provides an overview of the origins of the social work profession and the establishment and evolution of social work in South Africa. Contemporary challenges and debates which are universal to social work practice are explored, with a particular emphasis on those that are germane to the South African

context. Given that within SAPS both forensic and occupational social work are practised, on overview of these fields of social work is provided.

6.2 SOCIAL WORK AS A PROFESSION

6.2.1 The Origins of Social Work

All societies have had ways of assisting individuals and communities in need of help. There is evidence of this function in the way that philanthropy and charity were part of the Greek and Roman traditions. Religion often controlled states and had immense authority up until the 1700s when the European Renaissance occurred which encouraged scientific and cultural ideas. In East Asia social development was promoted through Buddhism. In the Middle East Judaism and Islam encouraged mutual social support, whilst African and Islamic civilizations acknowledged the importance of welfare provision (Day cited in Payne, 2005). What is evident is that society has always addressed the social needs of society; however the formal conceptualisation of a profession to undertake this role has only developed significantly in the last century.

While there were many forerunners to the development of social work, such as Thomas Chalmers, Jane Adams and Eileen Younghusband (Payne, 1996; Potgieter, 1998), an essential development in social work occurred in the Victorian era when the Charity Organisation Society was established in 1869 to address poverty in England. The founders of this society comprised mainly middle and upper class women who had the time and resources to devote to the cause. Prior to the formation of this society the British government fulfilled its role in addressing poverty and encouraged the church and voluntary initiatives to address this social aspect. The Charity Organisation Society attempted to move away from a philanthropic approach and to include more theoretically informed services which were predominantly case work services (Woodroofe, 1968).

As histories are narratives, Payne (2005, p.9) argues that it is problematic to have only one single historical narrative of an event. He criticizes the recorded history of social work as being, “celebratory; hind-sighted-biased; Eurocentric, ethnocentric and gender biased; neglectful of the peoples served as well as institutionally constrained” as it is dependent on records from particular institutions with particular ideologies. It is possible that the origins of social work are far more elaborative than initially conceptualised. Furthermore, Payne (2005) advocates that when analysing the history of social work from a Marxist perspective, one can only understand how social work developed within a country when one analyses the particular economic and political structures which existed at that particular time. Therefore each country has its own story and trajectory of social work. In the United States of America, social work emerged in the twentieth century in response to the social problems caused by industrialization and urbanization (Hokenstad, Khinduka & Midgley, 1992). In many countries social work was established after the social and economic devastation caused by World War II. One such

country was Japan where social work was developed as a response to the new constitution that was adopted and which emphasised human rights (Matsubara in Hokenstad et al., 1992). Evidently, social work has been recognised as a profession by different countries at different points in history.

One cannot dispute the fact that the European influence and conceptualisation of social work have been highly prevalent and influential in the international development of this profession. While social work may have started in numerous countries in order to address a variety of social problems, what is apparent is the manner in which the profession has developed from the narrow discharge of statutory functions and welfare handouts to a profession whose key tenets include empowerment and advocating for social justice.

While understandings of social work may differ significantly from country to country, there appears to be a common recognizable matrix in social work practice internationally. With increased global interdependence, the call for 'internationalization' of social work has increased. As borders are permeable and many social issues such as refugees, child trafficking, and natural disasters have become international concerns, so the call for a more consolidated international approach to social work has developed. Xu (2006) acknowledges that while it is more than 80 years since the concept of international social work was first developed, it is still struggling to become a well recognised and permanent field of social work. To apply one approach to social work would be socially incongruent as different countries have different social issues and different cultural value systems. Significantly, social workers apply different methods and approaches in different countries (Harington & Beddoe, 2014; Xu, 2006). However what does appear to be the most predominant understanding among social workers internationally is that social workers see themselves as change agents, who empower the vulnerable in society and are committed to the values of social justice and promoting human dignity (Fargion, 2008; Hokenstad et al*.,* 1992).

Social work can be a very rewarding and satisfying profession, yet it is inherently a demanding profession, often with limited acknowledgement and reward. One could almost say that stress and burnout appear to be ubiquitous to social work practice. Accordingly, as Davies (1998, p. 9) purports,

> Modern social work is in a state of crisis. It has always been a profession towards which society has displayed ambivalence and it is now grossly underfunded and understaffed. Tragedies and subsequent vilification of social workers and their managers are reported with increasing frequency. The profession attempts to function in an environment of obstructive administrative 'systems'….severe financial restrictions and conflicting demands.

While this statement was written almost twenty years ago and referred to conditions that social workers in the United Kingdom were facing at that time, it still depicts some of the challenges and stressors facing social work as a profession in other countries today. These include a lack of societal recognition for the profession; understaffing; a dearth of funds and resources; and a plethora of bureaucratic and administrative structures that need to be negotiated. One can clearly see that the occupational stressors associated with this profession are numerous and require further elaboration.

6.2.2 The Status of Social Work as a Profession

Many professions have had to reposition themselves in the last few decades due to changing policies of economic rationalism (Harington & Beddoe, 2014). Early understandings of what constitutes a profession were guided by trait theories. Each occupation would be compared to a list of traits - the degree to which an occupation matched these traits would determine the extent to which that occupation was professionalised. Social Work was perceived to have developed some of the attributes of a full profession but not all, and was therefore regarded as being 'semi-professional'. The specific trait deficits that were identified in social work included: the lack of a clearly demarcated scientific knowledge base: the notion that social work appeared to be based upon skills and not knowledge; and the fact that independent self-government of social workers had not been achieved (Hugman, 1991). While this approach to understanding professionalism has been criticised as being based upon the 'traditional occupations' such as medicine and law (Hugman, 1991), and while countries such as South Africa have achieved self-government of social workers through statutory councils, other criticisms of social work still stand today.

The concept of 'professionalism' can also be viewed from a structuralist approach which analyses how specific groups define professionalism, how professionals emphasise their distinctive knowledge as well as the responsibilities of their members (Deverell & Sharma in Malin, 2000). As social work has its origins in charity and church work and was initially dominated by volunteers, many understandings and perceptions of the profession still retain some of these paternalistic and philanthropic approaches. The term 'social worker' was often given to anyone seen to be assisting the poor of society. Payne (1995) reflects on his journey as a social worker in Britain and how in the 1960s even health visitors and prison governors were regarded as engaging in aspects of social work.

What is clear is that the professional identity of social work has always been a controversial issue. Even today in many circles it is still disputed whether social work is a true profession. It is possible that some of these criticisms are leveled at social work because the theoretical foundation of the profession draws upon other disciplines, namely psychology, sociology and anthropology. A recent example of questioning the academic nature of social work was when the University of the Witwatersrand, one of the two top internationally recognised universities in South Africa,

recommended closure of the Social Work Department in 2007 (Ross, 2010). One of the main arguments used to justify this action was the concern that the quality and content of the social work degree were not of an acceptable academic standard. Perceptions existed that such a qualification would be more suitably placed at a technikon, the reason being social work as a profession appeared to be more skills-based rather than theoretically founded. Fortunately, due to the tenacious defence of a few leading academics this decision was overturned and the department which was started in 1947 continues to exist today.

Time and time again the debate about the scientific status of social work arises. Some pursue the profession's quest for scientific status; others reject this understanding and contend that social work is directly applied scientific knowledge. Fargion (2008, p. 207) in exploring the concept of social work's professional identity, identified three aspects of social work's nomenclature that are debated internationally:

> ..the struggle to keep the balance between the individual and social aspects of social work; the tension between scientific and humanistic view of social work; and the contrast between views of the profession as the application of existing theories or as theory generating practice.

Perhaps one could add another contentious issue to this list, which is whether social work should be clinically orientated or be guided and based on the social developmental paradigm (Patel & Selipsky, 2010). While some academics argue that the two paradigms are complimentary and can co-exist - others feel that each paradigm espouses a doctrine that is fundamentally incompatible with the other. This discourse is not a new development of the profession. In the 1970s in the United States of America there was tension within the National Association of Social Workers. Some clinical social workers felt that their interests were not being adequately protected as the Association's priorities had turned to addressing poverty, civil rights and civil change and in response to these concerns those clinical social workers began to develop Societies for Clinical Social Work Practice (Hartman, 1994). A more recent discourse is to revitalize social work within a social justice paradigm, advocating for human rights, democracy and equality (Harington & Beddoe, 2014; Smith, 2013).

This lack of clarity about the professional status of social work has had significant repercussions in that social workers are not always regarded as true professionals. The low salaries and limited recognition from the broader society and from other professionals are all contributing factors to the occupational stress of social work.

6.2.3 Financial Cutbacks and Changes in the Nature of Professional Services

In the last few decades there have been numerous changes in the ways in which many organisations have offered social work services. Due to increasing costs, reduced funding and increasing needs, many organisations have changed their methods of practice which in turn have had a detrimental effect on the quality of services offered to clients. Acker and Lawrence (2009) explain that this state of affairs is often the situation in the United States of America, particularly with the services offered to people with mental illness. In recent years different treatment paradigms have been adopted - fundamentally to accommodate funding issues. These have included: a focus on short-term services; limited access to necessary but costly services; reducing in-patient length of stay resulting in larger outpatient caseloads; reduced resources and increased accountability. Furthermore, there is a constant need to empirically validate the services and treatment methods chosen. These changes have significantly influenced and challenged the roles and values of professionals who are working in the field of managed care, consequently resulting in feelings of stress and anxiety concerning their profession's ability to provide effective services in this area.

These cuts in welfare services appear to be happening on an international level; the consequence of which is that social workers often have to justify and validate their services on a continual basis. Furthermore, these cut-backs may also impact the quality of services that social workers offer to the most vulnerable in society (Lombard, 2011).

6.2.4 The Care/Control Debate

In his article 'Social worker or policeman? Stresses of the moral guardians', Woods (1998) highlights how the care/control debate has been a long standing issue of contention and how the consequences of this debate are that social workers are increasingly required to enforce control through concentration on statutory work, often to the detriment of the caring role. This requirement can often be contradictory, as social work has a dual responsibility to care for the vulnerable in society as well as to control and maintain a level of social order that is acceptable to society. The complexity and paradoxical nature of social work practice is reinforced by Payne (2005), who maintains that there are three predominant discourses in social work practice, namely: the reflexive-therapeutic view; the socialist-collectivist view and the individual-reformist view. Whilst these views of social work can be complementary, they can also be potentially conflictual. The reflexive-therapeutic and individualist-reformist approaches address individual or micro aspects, while working from a socialist-collective view requires one to examine society and to work from a critical and anti-oppressive perspective which may challenge the way society is constructed.

While many debate the subject of what constitutes social work practice, and some believe in only adopting one of the above three mentioned approaches to practice, Payne (2005) suggests that the

approach to social work practice varies according to time and need. Social work is understood to be a product of modernization and therefore changes over time. Furthermore, social workers need to be aware of how society, social conditions, cultures and agencies construct social work practice and then find their own particular balance. This approach in itself can be a source of contention as other social work colleagues and agencies may offer services from a very different orientation, operating from an incompatible value base to that of a particular social worker. Consequently, even within the social work profession the discrepancies and variations in terms of what constitutes the social work profession, sets the scene for confusion and highlights the lack of unity within the profession.

6.2.5 Teamwork

Not only can working alongside social work colleagues with different ideologies be stressful, but also working in a team with other professions can be challenging. While a multidisciplinary teamwork approach is often the best holistic approach to helping an individual and/or family, there can be numerous turf issues that arise. There are many settings where social workers will be required to work in multi-disciplinary teams, for example, psychiatric social work, medical social work or social work in the field of substance abuse. Payne (2000) believes that there are three paradoxes that confront a multidisciplinary team: Firstly, working in teams may result in the team becoming preoccupied with team dynamics and having too much of an inward focus instead of also building relationships with professions and agencies outside of the team. Secondly, he raises the issue of whether multidisciplinary teams are supportive or oppressive of personal and professional freedom. Thirdly, while the purpose of a team should be to provide effective services to clients, if members of a team are too focused on colleagues and team interactions, the needs and opinions of the service users might be excluded.

Manning in Davies (1998) argues that in the multi-disciplinary team it can often be difficult to determine which areas fall within the particular territory or skills repertoire of the various professions in a particular team. If there is not a collaborative team environment, boundary issues, allocation of resources and understanding of roles can become problematic, affecting the overall performance and quality of the team. Often social workers are not regarded as integral members of these team settings. The social work role tends to be undervalued and social workers' skills and training are seen as subordinate to other professions such as psychology and psychiatry. This perception was one of the main findings of Ntsoane's (2009) study that explored the challenges confronting South African social workers working in multidisciplinary teams in psychiatric hospitals. The social workers who were interviewed felt that other professionals in the multi-disciplinary team did not acknowledge the social worker's clinical and therapeutic ability. Instead they were expected only to engage in assisting with practical aspects of client's treatment such as placements and helping clients apply for grants.

Moreover, ethical challenges can arise when working alongside professionals with different codes of ethics to one's own, particularly around aspects such as confidentiality and self-determination.

6.2.6 Ethical Dilemmas

The essence of the social work profession is that it is based on a core set of values that centres on enhancing individual well-being in the social context. However, social work is located within the wider political and cultural society. Hugman (2005) contends that the focus of the profession represents the values of society. Nevertheless many argue that social work practice is still based predominantly on Western values and while 'ethnic-sensitive social work practice' is a much used term today – very little application of this principle is evident in practice. For instance, Holtzhausen (2010) questions why Western values and theories of social work are still used when teaching social work in the Muslim and Arab worlds. Middle Eastern societies are strongly influenced by the Qur'an, which is based on the teachings of the prophet Mohammed. The values, principles and perceptions of what is right and wrong in Islam are very different to Western ideologies and values.

Modern social work has emphasised values around human rights, emancipation, democracy and social justice as being central to the social work profession. Yet for the social worker another source of stress could be advocating values of the profession that differ from his/her personal belief systems. For example some social workers may not believe that divorce is an option for an abused woman and by encouraging the client to take this path may contradict the personal values of the social worker.

In a pluralistic society like South Africa, many ethical conflicts may arise as numerous cultures co-exist. Ross (2008) brings to the fore the debate about when social workers should respect the rights of different cultural groups to engage in practices that can be seen to contradict their own value systems and at what point they should take a stand. She discusses this ethical dilemma in relation to certain cultural practices such as the practice of virginity testing. The purpose of this age old cultural tradition is to keep girls 'pure' and limit sexual activity to marriage. However, as Ross (2008) points out the South African Human Rights Commission advocates that virginity testing may be harmful to the girls as it may cause emotional distress and be considered an invasion of bodily privacy. Likewise, the practice of polygamy can be seen as promoting patriarchy and male superiority and undermining women's role in society. So the question arises, what stance should social workers take? While they should respect cultural practices of communities, should they not also advocate for human rights?

6.2.7 Dealing with Vulnerable Clientele

Another important aspect to consider when trying to understand the occupational stress of social workers is the type of clientele with which social workers traditionally work. The population groups that social workers generally serve are often those with a history of traumatic events. The very

essence of the profession therefore requires addressing the needs of marginalised and vulnerable populations with limited resources. The typical areas in which social workers are employed, include services that involve counselling survivors of child abuse, violent crime, disasters, war, refugee migration and terrorism. Social workers are therefore exposed to high volumes of traumatising material. Bride (2007a) indicates that secondary traumatic stress has been acknowledged as an occupational hazard, particularly for social workers. Secondary traumatic stress in social work is elaborated in Chapter Two.

Not only can listening to traumatic material be stressful for the social worker but terminating the counselling relationship can also be difficult. While there is extensive literature written about clients' feelings around termination, not as much attention has been given to how termination affects the social worker. The termination phase of the helping relationship can be a reflective and evaluative time, with much positive reinforcement and a sense of accomplishment for the social worker. While there may be more positive than negative emotions for the social worker regarding terminating, one should not under-estimate how difficult this process can be for the social worker as well. Emotional responses can include: anger, sadness, loss, as well as anxiety about the client's ability to function without treatment. Fortune (1987) believes that termination can also threaten practitioners' self-esteem and confidence as well as raise questions about the effectiveness of the intervention. Practitioners may also not acknowledge the impact of termination. They may unconsciously deny their feelings and cope with the loss through professional distancing. Termination can also be stressful for social workers who have not resolved personal issues such as the need to be needed, and the need to be in control.

6.2.8 Threats to Personal Safety

There are a wide range of professionals who are particularly vulnerable to experiencing aggression and even violence from clients and communities whom they strive to serve. Social work can be considered one of these professions. Neither formal training nor organisational policies and procedures can really equip the social worker to deal with this issue should it arise (Davis, 2006). As social workers deal with many disturbed individuals and clients with major mental health issues, their personal safety can easily be jeopordised. Clients may not only develop delusional beliefs about their therapists but they may also resent the power and authority that a social worker may legally have over their lives. They may resent the negative outcomes of an assessment or the removal of a child or even be angry about the termination of therapy or services. According to Regehr and Glancy (2011), surveys show that about 16% of social workers in Canada have been stalked by clients, which has far-reaching professional and personal consequences for the practitioner. Furthermore, physical assaults on social workers are not such a rare occurrence and at times have resulted in death. The case of Jenny Morrison, a social worker in England, who was stabbed more than a hundred times by a client with a

mental health problem, is an example of this type of danger (British Broadcasting Corporation, 1999). A social worker therefore always needs to be vigilant about his/her personal and professional safety, as negligence in this area can be detrimental.

6.2.9 Work Satisfaction and Staff Turnover

High staff turnover is another variable that appears to be synonymous with organisations employing social workers. In Sweden a study was conducted in 2006 that specifically explored factors that were associated with the intention of social workers to leave their place of work. The results showed that 54% of social workers had been in their current workplace for two years or less and that 48% intended to leave their jobs. Contributing variables which respondents identified included role conflicts, control of decisions and exposure to threats and violence. The impact of work tasks was compounded by negative dimensions of leadership and organisational culture. A regression analysis showed that the lack of a human resources orientation within the organisation was the variable of greatest importance contributing to the intention to leave the workplace. This variable referred to the extent to which practitioners were rewarded for their work as well as the extent to which management was interested in their health and well-being. What this study clearly highlights is how the organisational culture can affect employees' job satisfaction levels. It is not only the nature of the work itself that can be stressful; the work environment has a significant influence on how employees perceive and manage their stress and can contribute to the stress levels of the social worker. This factor has a systemic effect in that employee job dissatisfaction may lead to high staff turnover which can potentially exert an obviously disruptive impact on the services offered to clients (Tham, 2007).

All of the aforementioned factors can negatively impact upon the work satisfaction of the social worker. In fact, a study conducted in 2003 with social workers in the United Kingdom found that of the 50 social workers who were interviewed, 70% reported that they were prescribed anti-depressants to help treat depression. In addition, 75% of the 70% reported experiencing physical illness concurrently with their depression. Most participants identified work as the main cause of their depression. Furthermore, participants identified: heavy workloads, lack of control or boundaries in the workplace, the nature of their work - particularly emotionally distressing work; constant changes in the work organisation, as well as the lack of supervision and managerial support as significant work stressors (Stanley, Manthorpe & White, 2007).

It is apparent that numerous variables contribute to the occupational stress of social workers, variables that are often not adequately considered or mitigated by employers of social workers. If the social work profession does not offer its members the support, policies and structures that practitioners need in order to manage the occupational stress and demands of the job, the result can be poor service delivery and isolation of communities they are expected to serve (Stanley et al., 2007).

Furthermore, the status and image of social work can be further adversely affected. It is therefore essential to comprehend the contextual demands and pressures impacting South African social workers and how these factors impinge on or enhance practice.

6.3 SOCIAL WORK IN SOUTH AFRICA

6.3.1 Social Welfare in South Africa Prior to 1994

South Africa was the first country in Africa to establish social work education during the 1920s and 1930s. In order to understand the current challenges that social work faces it is important to understand how social welfare has evolved in this country. Prior to 1994 social welfare in South Africa was based upon apartheid ideology and services were demarcated along racial lines. Both colonialism and apartheid shaped the manner in which social welfare was formulated in South Africa. The colonial rulers, the British and Dutch, advocated exclusive group consciousness which resulted in the philosophy of racial and social supremacy. The customs and traditions of indigenised African people were seen as inferior (Patel, 2015). Urbanisation, industrialisation and apartheid laws contributed to the disruption of cultural mutual support and family systems of the African people – as pass laws prohibited the free movement of Africans and many men left their families in the rural areas to find employment in the cities. One of the most significant studies to be conducted was that regarding social problems in South Africa by the Carnegie Commission in 1929. While this study was commissioned to explore the extent of the "Poor White" problem in South Africa, its findings were very significant for understanding poverty in the country. The Commission indicated that the main causes of poverty could be attributed to the changes in social and economic conditions in the country and not to personal inadequacies. Notably, two of the predominant recommendations to be implemented were the establishment of the Department of Social Welfare in 1937 and the development of professional Social Work training at universities (McKendrick, 1987).

Racial differentiation was the underlying principle influencing the structure of welfare services. The political and military objectives of the National party determined how social welfare needs were interpreted and addressed. Thus Black, Coloured and Indian persons received inferior welfare services in comparison to Whites. Western ideology shaped and influenced interpretation of welfare needs which were subsequently addressed. First world models of welfare were implemented which were curative, remedial and statutory. These services were designed for urban areas and were inappropriate for the economic and social context of a developing country like South Africa. Welfare services in South Africa did not address the majority of its citizens' needs and so alternative social development initiatives emerged in order to address this gap in services. Many community-based organisations and faith-based welfare organisations were founded. This development was a direct response to the government's principle of privatisation in social welfare, which basically relinquished most of the responsibility of welfare to the communities as government argued that it was not a

welfare state. Furthermore, there was limited consultation or engagement with communities; instead a top-down approach was adopted in respect to the formation and implementation of welfare policies (Noyoo, 2003; Patel, 2015).

After the 1976 protests, resistance efforts to the apartheid system were amplified. With the growth of the Black consciousness movement under the leadership of Steve Biko, many more community development programmes were initiated. The 80s was a decade dominated by political protests and anti-apartheid activities, inspired by principles of equality and anti-discriminatory reform. In 1983 the United Democratic Front (UDF) was established in response to the tri-cameral parliamentary system of the government which provided for Whites, Indians and Coloureds and excluded Black persons. The UDF was established throughout South Africa and incorporated more than 700 grassroots organisations. These organisations encouraged local structures and communities to be empowered. Many social problems, such as substance abuse, crime and social conflicts, were addressed through these informal welfare organisations. While the government tried to repress many of these organisations, the roots of social development in South Africa can be traced back to these political struggles and demands. When in 1990 the National Party unbanned political parties, this step signified the beginning of a new era in the history of South Africa (Patel, 2015).

6.3.2 Social Work in South Africa Post 1994

With the watershed elections that occurred in 1994, the first democratic government of South Africa was elected and Nelson Mandela became the first Black president of the country. The enormity of the task of dismantling apartheid was, and still is, extensive – inequality and poverty were two of the predominant challenges which needed to be addressed by the newly appointed African National Congress (ANC) Government. The ANC had adopted the Reconstruction and Development Programme (RDP) as its policy framework. The RDP advocated a pro-poor developmental approach to social welfare; it focused on basic needs, social welfare rights and promoted the creation of a single national social welfare department. The Department of Social Development (DSD) and nine provincial departments were thus established. The essence of the RDP's approach to welfare was to promote a democratic and just welfare system for all South Africans (Earle, 2008; Patel, 2015).

In 1997 the South African Government adopted the White Paper for Social Welfare. This paper was formulated against a backdrop influenced by numerous aspects: the Bill of Rights and the new democratic Constitution of South Africa formulated in 1996, which advocated for the rights of all South Africans; the Reconstruction and Development Programme – a national policy of the ANC which linked economic and social development and the vision of social development as the paradigm to shape social welfare (Patel, 2003). Three basic principles of the White Paper included: The government and the private welfare sector would together be responsible for welfare; the developmental social

welfare paradigm would be adopted; and social security would remain a central and integral part in the provision of welfare services (Orner, 2003).

However, there have been many challenges to the actual implementation of a social development approach. Numerous factors have influenced the implementation of this approach including: macro social, economic and political factors. The negative effects of globalisation as well as rising unemployment, increasing crime and violence as well as the HIV and AIDS pandemic are all considerable challenges that need to be addressed by the South African government. Earle (2008) argues that the changes to the welfare system have not had the desired positive effect on social work practice. Instead, the impact on the social work profession has been predominantly negative. The lack of adequate leadership in driving this change process as well as the lack of understanding of the consequences of these changes have led to the fundamental nature of social work in South Africa being questioned. Moreover, the disjuncture between social and economic policies of the country has resulted in funding being reduced to the welfare sector, which has further impacted the nature and quality of services which social workers can offer.

6.4 OCCUPATIONAL STRESS OF SOCIAL WORKERS IN SOUTH AFRICA

6.4.1 Professional Status and Professional Identity

In a country like South Africa, where social problems are ubiquitous and pervade every facet of South African society, social work has a unique and essential contribution to make. Yet this potential contribution is not always acknowledged. As Sithole (2010, p. 8) explains, “social work occupies such a peripheral position in our society”. He attributes this position to the gendered nature of the profession, which is then reflected in social workers’ low salaries and poor working conditions.

In her study on the ecology of stress and burnout amongst social workers in South Africa which Ross (1997) conducted during the transition from Apartheid to a democratic dispensation, only 6% of respondents indicated that socio-economic and politico-cultural aspects affected their experiences of occupational stress. This finding was most surprising as social work is a profession that is rooted in the social and political context (Payne, 2005). However, the stressors that these social workers identified in Ross’s (1997) study do not appear to have changed in more than a decade. These included: the poor status of social work; fear regarding the future of South Africa and the future of social welfare; low remuneration; unsatisfactory working conditions; anxieties regarding safety at work; lack of resources and facilities; rapid social and political change which resulted in an unstable political climate; cross cultural tensions and differences; high workloads; macro factors such as poverty and unemployment over which one has limited control as well as the nature of clientele and the communities which social workers serve.

Earle (2008) conducted a national study on the status of the social work profession and found that in the previous decade the image of social work as a profession had declined considerably and as a result many social workers had experienced a professional identity crisis. This finding echoes that of an earlier study by Mkhwanazi and Triegaardt (2003) who explored South African social workers' perceptions of their profession. A significant finding was that there was no uniformity in the application of social work practice. What emerged was that there were different understandings of where the profession was at and practitioners used different intervention methods. This lack of uniformity could also be a significant contributing factor to the professional identity crisis: even amongst social workers there is such a variation not only in terms of understandings and paradigms of the social work role but also in relation to the nature of services offered.

Unfortunately, this poor perception of social work is evident even with students who are studying social work. In a study carried out with final year social work students in 2007 Chokwe found that the majority (58%) of participants felt that social work had a poor professional status. A further disquieting finding was that 30.7% of these students believed that other people viewed social workers as persons with limited intellectual capacity (Chokwe, 2007). The concern is that if newly graduating professionals have so little faith in the profession, can one expect society to have a different image of social work?

6.4.2 The Socio-Economic Realities of Social Work Students

Another aspect which needs to be considered when assessing the situation of the social work profession in South Africa is the socio-economic circumstances of South African social work students. While there have been numerous progressive changes in educational policies and an increase in the number of registrations of students from disadvantaged backgrounds, the throughput rates at universities has not progressed in a complimentary fashion (Collins, 2015). This phenomenon is known as the 'revolving door sydrome' as many students from disadvantaged backgrounds are admitted to university but fail to complete their studies due to exclusion on the grounds of poor academic performance (Ross, 2010). This syndrome can be attributed to poorly resourced and equipped schools, lack of preparation for university and difficulties with the transition from school to university. Moreover, experiences of institutional racism can hinder a student's ability to thrive and connect with others (Bozalek, 2010). Ross (2010) explored the biographical situations of applicants seeking admission to Social Work at a South African university. She found that difficulties with school experiences were exacerbated by poverty, illness and death of a parent, language difficulties and the trauma of rape. However, paradoxically many of the applicants explained that these experiences which they had endured were what motivated them to study social work.

What is apparent is that social work students are confronted by the same socio-economic challenges as that of the clients and communities with which they must work (Van Breda, 2013). Some students

have their own histories of unresolved trauma and yet they need to assist others to overcome challenges with which they have not yet learned how to deal. In a country that has been steeped in oppression and disempowerment of individuals, many students need assistance to empower themselves to overcome structural oppression. Through their social work training, students therefore need to be enabled to develop critical consciousness firstly about their own oppression in order to adequately address social change in society (Smith, 2013).

Social work educators have raised concerns about the character of some of the students. These concerns include: lack of respect for clients, inappropriate dressing, contempt for authority and poor work quality (Earle, 2008). The Department of Social Development offered full bursaries to students who wanted to study social work as part of a recruitment strategy to increase the number of social workers in the country. Concomitantly, these scholarships often attract students who want to obtain a tertiary qualification and are not necessarily committed to the profession. Schenck (2009) reviewed research on the socio-economic circumstances of social work students at a distance-learning university. Studies showed that 43% of students reported that they had experienced extreme poverty; 88% had experienced domestic abuse and 21% had been sexually abused. Schenck questions whether these experiences contributed towards a poverty of identity, as students may have struggled with the formation of self. Furthermore she argues that the socio-economic poverties may inhibit students' growth and development not only as people but also as students and ultimately as professionals.

6.4.3 The Appropriateness of South African Social Work Undergraduate Training

From 2007 all South African universities were required to align their social work undergraduate degree to the Bachelor of Social Work (BSW) requirements. All curricula had to be aligned to 27 specific exit-level outcomes of the BSW, in compliance with South African Quality Assurance's (SAQA) requirements for outcome based education (Collins, 2015; Earle, 2008). Social work students are required to complete theory and field practice components that are aligned with the 27 exit level outcomes (Ross, 2012). Prior to 2007 there were significant variances as to the manner in which the social work undergraduate degree was offered at universities in South Africa. This revision of the social work curriculum provided an opportunity for universities to assess their training and incorporate more aspects which address the needs of South Africa, thereby addressing the disconnect between needs and training. The question whether the curriculum is adequately incorporating culturally appropriate and diverse social work approaches has yet to be appropriately answered. In order to make a significant contribution to the healing of the South African nation and the alleviation of some of the traumatic effects of apartheid, social workers need to be trained to provide appropriate multicultural services (Smith, 2013).

Moreover, a report compiled by US AID (2009) on the social work workforce in Africa, revealed that social work education in Africa still appears to be based primarily on western-based ideology and curricula, which do not reflect indigenous knowledge systems or adequately address Africa's social needs. Furthermore, this report discusses a study that was conducted with social work students at two universities in the Eastern Cape. While students agreed that community work and group work were the most suitable methods of social work practice to address South Africa's social problems, they still preferred casework. One could question whether this preference was due to more emphasis being placed on training in casework at universities and so that students may not have had sufficient training and confidence in practising other methods of social work (Davis, 2009).

6.4.4 Working with Other Social Service Professions

In 1998 the Social Work Act (110 of 1978) was amended to become the Social Service Professions Act (110 of 1978). With this amendment other social service occupations such as probation workers, child and youth care workers and community workers were recognised as new 'professions' under this Act (Earle, 2008). Furthermore, the training and formalisation of social auxiliary workers gained impetus after the then Social Development minister, Zola Skweyiya signed an agreement with the Cuban government in 2007. The Cuban government agreed to help South Africa train social auxiliary workers to help alleviate the shortage of social work skills. However, this strategy has been met with extensive criticism from many different stakeholders. For example, Thabede (2005), a leading South African academic, argued that the introduction of numerous social service professions with limited training has an adverse effect on the social work profession and actually contributes to the de-professionalising of the social work profession.

This argument is reinforced by the unclear boundaries and lack of demarcation between social work and social auxiliary work. In a recent study conducted at the South African Department of Social Development, Mabasa (2010) interviewed social workers and social auxiliary workers to ascertain whether their working relationships were collaborative or divisive. The majority of social workers whom she interviewed appeared to have had negative experiences in working with social auxiliary workers. These social workers attributed limited training, as well as the lack of professional skills and clear boundaries as problematic when working with social auxiliary workers. Some of the social workers felt that the government had not clearly researched and planned for adequate implementation of social auxiliary work in South Africa, and instead of offering supportive services to the social workers, the existence of social auxiliary workers was another stressor they encountered at the workplace. However, a critique that can be leveled against this study is that it was based on a small convenience sample of social workers and social auxiliary workers.

6.4.5 Lack of Career Development and Opportunities

Social work is not a financially lucrative profession as most employers do not offer social workers significant benefits. The fact that social work is a profession which has traditionally been and is still currently dominated by women may be a significant factor in the low salaries that social workers generally receive. The issue of gender and low paying professions is a well documented one (Earle, 2008; Sithole, 2010). As men have traditionally been the bread winners in their families, the low pay and poor professional standing of the profession often deters men from studying social work which is perceived as not sufficiently masculine (Khunou, Pillay & Nethononda, 2012). Furthermore, social workers are also not rewarded according to experience, with starting social workers often earning the same salary as experienced social workers – which is not the incentive that experienced social workers may need to continue in the profession (Ross, 1997). Moreover, high turnover rates of social workers can be partly attributed to the movement of social work staff from NGOs, to government and the corporate sector, where the salaries tend to be higher. In addition, due to the multi skilled training of social workers, many move into other related fields such as human resources, policy analysis and management positions (Ross, 1997). Earle (2008) notes that these opportunities are particularly available to Black social workers, which can be attributed to the affirmative action policy of the country designed to redress past inequalities.

6.4.6 Excessive Caseloads

With the increase of HIV and AIDS and high unemployment rates, the number of citizens applying for grants has increased significantly. One of the objectives of the social development approach is an increase in social security and improved access to grants for recipients. Social workers at the Department of Social Development have experienced increasing case loads as more people apply for grants. This increased workload places significant pressure on social workers who need to ensure that court reports are submitted within the regulated timeframes. Furthermore, Soji and Pretorius (2008) found that social workers working for the South African Department of Social Development felt that the repetitive nature of the work required in statutory social work was tedious and uninspiring and the social workers wanted work that was not routine and repetitive. Moreover, Maphanga (2007) found that social workers working at the South African Department of Social Development felt they were unable to apply the knowledge and skills learnt at university in undergraduate social work training. Instead these social workers felt that they had been reduced to functioning as administrative clerks. This finding raises questions regarding the social work curriculum that is taught at South African universities and whether this curriculum is suitable for producing social workers who will adequately address the needs of the country.

6.4.7 Inadequate Supervision

Supervision is an integral part of the social work profession. The overall purpose of the supervisory process is to ensure that social workers are able to effectively deliver services to clients. The three primary responsibilities of a supervisor are to provide administrative guidance, education and support to the supervisee (Kadushin & Harkness, 2014). A lack of structured supervision and poor quality of supervision often lead to decreased productivity and less than optimal quality of services offered by social workers. While this phenomenon is not unique to South Africa, the quality of supervision often does appear to be problematic in this country. Numerous studies have been conducted internationally and locally highlighting the complexities of the supervisory relationship (Engelbrecht, 2006; Noble & Irwin, 2009). Although the supervisory process can be very effective, there can also be numerous difficulties which can be encountered due to aspects such as power relations, inexperienced supervisors as well as culture and gender differences. Unless roles and expectations are clearly defined, these factors can result in frustration and resentment in the supervisory relationship. Mavimbela (2009) interviewed both supervisees and supervisors in the South African Department of Social Development and found that supervisors and supervisees differed in their understandings of the supervisory process. Supervisors indicated that the administrative function was the most important whereas the supervisees expected more in terms of the educative and supportive functions. Expectations were significantly different and consequently, most supervisees did not feel satisfied with the level of supervision that they received. Furthermore, supervision procedures did not appear to be formalized but occurred on an ad hoc basis with lack of time attributed as the main reason for this situation by the supervisors.

Other difficulties in the supervisory relationship that this particular study highlighted included personality clashes, excessive workloads, as well as a lack of professional boundaries in the supervisory relationship. Engelbrecht (2006) acknowledges the diverse backgrounds from which supervisors and supervisees in South Africa may be drawn. He advocates that in order to ensure an effective supervisory relationship, supervisors should model what he terms ‘cultural friendliness’, behaviour which is sensitive to cultural differences and models the values and principles of social work to the supervisees.

6.4.8 Lack of Personal Safety

The absence of occupational safety standards within the workplace is another source of stress. In particular, this factor relates to limited measures in place to reduce the risk exposure to opportunistic infections such as Tuberculosis. Futhermore, the personal safety of social workers cannot be guaranteed. This factor is of particular concern during home visits which often involve travelling on deserted, poorly maintained roads and having to deal with aggressive clients (Ross, 1997). In South Africa, in recent years the xenophobic attacks have negatively impacted on many non-South African

social workers who are working in the country, as they are often afraid to go into communities for fear of being attacked. Many social workers working in South Africa are Zimbabwean and work in South Africa due to the economic and politically unstable nature of their own country.

6.4.9 The Working Environment

A social worker's job satisfaction is not only linked to personal or social factors but is also influenced by organisational factors. Malherbe and Hendriks (2004, p.29) state that "a social worker's measure of job satisfaction is particularly determined by organisational factors". In 2001, Matlhabe conducted a study in Johannesburg regarding social workers' experiences in their first year of practice. The majority i.e. 60% indicated that participants had negative experiences with the bureaucratic structures within their work organisations. Furthermore, the results indicated that many were even considering leaving their jobs and the profession (Matlhabe, 2001). This finding of dissatisfaction with social work as a profession was consistent with O'Brien's findings from an earlier study in 1990 that the mean time of a South African social worker's career was three years (O'Brien, 1990). Earle's (2008) findings suggest that after five years social workers often branch out from social work into other employment opportunities. These findings are quite disheartening when one considers that young, enthusiastic social work graduates apparently become disillusioned with the profession within a few years of actual practice.

Social workers at the South African Department of Social Development identified a lack of support systems within the organisation as another factor that contributed to organisational stress. Specifically they identified inadequate supervisory support, the inaccessibility of the Employee Assistance Programme (EAP) and insufficient peer support. In addition the lack of guidance and support from managers, the lack of communication in the department and the lack of planning all contributed to the organisational stressors that employees experienced (Soji & Pretorius, 2008).

6.4.10 Rural Conditions

South Africa comprises many urban cities and vast rural areas that are often under-developed with limited infrastructure. In a study exploring the challenges confronting social workers practising in rural areas of South Africa, Schenck (2004, pp. 165–169) identified the following particular stressors:

> the problems in rural areas (HIV and AIDS, poverty, unemployment and marital problems); the long distances social workers have to navigate are not only time consuming but are unsafe to travel alone; lack of confidentiality (i.e. no private office space in which to counsel clients); inclement weather conditions; the lack of private and public transport; the lack of support from the organisation; cultural issues (cultural practices often require that people first consult the elders in their family or the chief about a problem and not the social worker, as well as

working with clients from a cultural grouping different to the social workers); and the lack of childcare and other facilities and infrastructure.

The South African government has prioritised the development of rural areas in the National Development Plan 2030. In order to address the cycle of poverty in rural areas, access to basic social and infrastructural services is an essential requirement. For this reason, land reform and job creation strategies in rural areas are being introduced to begin to alleviate poverty (National Planning Commission, 2012, p. 217). Although most of these challenges can also apply to urban social workers, the isolation of rural social work and the limited support and infrastructure can exacerbate stressors that are inherent in the profession.

6.4.11 Language Barriers

South Africa is a nation of great cultural diversity. The fact that there are eleven official languages gives an indication of how diverse a country it really is. The term 'rainbow nation' that is now synonymous with South Africa, refers to the racial diversity of South Africans. There are also numerous ethnic, religious and cultural differences that a South African social worker needs to consider when interacting with clients and communities. Many clients who seek the services of a social worker may feel more comfortable speaking in their home language and would therefore prefer to speak to a social worker who understands their language.

Social workers also need to be culturally sensitive and try to accommodate their clients in order to ensure that clients receive the most appropriate assistance. However, due to our historical legacy of discrimination, most White, Indian and Coloured social workers are unable to speak an African language as they were never taught an African language at school. Many agencies often advertise a social work position, with the ability to speak an African language being a requirement for the job. The implication is that there are limited opportunities for White social workers to effectively help the majority of the population. More often than not the social worker will speak a different home language to that of her/his client. This language barrier could restrict the effectiveness of the social work intervention as it is possible that either the client or the social worker may not be able to adequately express feelings or opinions in a language other than their home language. For this reason, Qobo (2008) explored final year social work students' perceptions of language barriers when interacting with clients. Most students who could not speak the same language as their clients experienced difficulty understanding their clients. In particular, these students felt that the language barrier prevented them from successfully communicating with their clients and being able to use advanced counselling skills. While some students used interpreters to help them communicate with their clients, most indicated that the use of this medium raised concerns about confidentiality.

Although this study utilised a small sample from only one South African university, anecdotal evidence suggests that the issue of language barriers could be widespread.

6.4.12 Professional Exodus

A key aspect of globalization is the movement of professions often from developing countries to developed countries. The situation of social workers in South Africa has become of increasing concern. Many leave the profession in search of greener pastures or leave to practise in other countries. The effects of globalization has meant that many highly skilled social workers have left the country for more lucrative employment and better living conditions in other countries (Ross, 1997). This exodus has created a vacuum as many experienced and highly qualified social workers have left the profession. Consequently, those social workers who were left behind have had to increase their workloads as employers struggled to find social workers to fill those vacant posts. This attrition of social workers has reached alarming proportions, so that in 2003 politicians started calling for social work to be recognised as a scarce skill by the National Minister for Public Service and Administration.

There are numerous push and pull factors that contribute to the exodus of social workers from South Africa. Most of the push factors have been discussed in the previous paragraphs and include: poor working conditions, the poor status of social workers in South Africa, low salaries, limited career opportunities and specialisation, declining professional standards, high caseloads, limited resources and the socio-economic situation in South Africa, including extreme poverty, unemployment, high crime and HIV and AIDS rates. Pull factors include higher pay, greater career prospects, personal safety, as well as better educational opportunities for children (Earle, 2008). The South African government has tried to limit the exodus of professionals, particularly those professions in medicine and health care by enforcing a compulsory year of community service practice that is required before students can graduate. For example doctors have to complete a year of community service before they are allowed to graduate as medical practitioners. There has been talk that this concept should extend to professions such as social work – however this strategy has not yet been implemented. Nevertheless, a national strategy has been developed by the government to address the recruitment and retention of social workers (Department of Social Development, 2006). One of the factors that could contribute to the retention of social workers is the acknowledgement of specialist areas within the profession, which is discussed in the next section.

6.5 SPECIALISIED AREAS OF SOCIAL WORK

In recent years one of the developments in the social work profession has been the recognition of specialised areas of social work. Traditionally the South African Council for Social Service Professions (SACSSP) only recognised adoption work as an area of specialty. Occupational social workers then spearheaded the specialisation agenda in South Africa. As a result regulations for specialisation in

various fields of social work are currently being finalised by the SACSSP. Social work services in SAPS are made up of two of these specialised social work fields namely, forensic and occupational social work. The next section explores the nature and development of these two areas of social work in South Africa and in SAPS.

6.5.1 Forensic Social Work (FSW)

The roots of forensic social work are intrinsically linked to the origins of the profession itself. Only in the 1980s was forensic social work conceptualised as a specialist field of social work in the United States of America. In South Africa the criteria for specialisation in forensic social work are currently being finalised. The SACSSP acknowledges Barker and Branson's definition of forensic social work (2000, p.8):

> Forensic social work is a professional speciality that focuses on the interface between society's legal and human systems. It includes such activities as providing expert testimonies in courts of law, investigating cases of possible criminal conduct and assisting the legal system in such issues as child custody disputes, divorce, non support, delinquency, spouse or child abuse, mental hospital commitment and relatives' responsibility.

In a country like SA, where crime and domestic violence rates have reached epidemic proportions, the police, courts and justice departments battle to address the ever increasing number of cases. In particular, considering the high poverty and AIDS rates, children are the most vulnerable. The South African Police statistics for reported crimes against children in 2012-2013 were almost 500 000 with an average of three children murdered a day, suggesting evidence of the dire need to ensure that professional intervention is provided (Mathews & Benvenuti, 2014). Forensic social work entails work with children and families involved in abuse, neglect, divorce, custody and parental rights cases. Stutterheim and Weyers (1999, p.13) identified four dominant functions of the forensic social worker in South Africa.

> The forensic social worker's role in the pre-conviction or pre-findings phase entails the first three functions while the fourth function is relevant in the pre-sentencing or pre-court order phase.

- Function one: Conducting an assessment of an individual(s) who is involved and to present such assessment to a court or legal authority;
- Function two: To provide expert testimony in a court of law that is not based on an investigation of the case in question;
- Function three: To investigate civil cases and administrative enquiries and present findings to courts of law; and

- Function four: To make recommendations to courts of law regarding appropriate sentences and to make recommendations to courts of law regarding appropriate court orders.

Forensic social workers need to have a thorough knowledge of court processes and procedures as well as relevant legislation. Knowledge of the following acts is essential: Children's Act 38 of 2005 (as amended in 2007); Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2002; Child Justice Act 75 of 2008; Criminal Procedure Act 51 of 1977; and Prevention and Treatment of Substance Abuse Act 70 of 2008. Additional and specialised training on legal aspects; forensic assessments; report writing and providing expert testimony in court is therefore required by forensic social workers (Joubert & Van Wyk, 2014; Stutterheim & Weyers, 1999).

Forensic social workers work alongside many other professionals and departments such as juvenile courts, probation departments, child welfare organisations, correctional services, domestic violence and victim assistance programmes (Phiyega, 2014). Cussons and Strydom (2013) recommend that a multi-professional team should be established when investigating child abuse, which should be comprised of a forensic social worker, play therapist, doctor, the child protection unit, clinical psychologist, legal representative and a social worker. However, these authors found that most social workers who were investigating child abuse had negative experiences in working with other professionals and often felt threatened by them. This situation can result in turf battles and the avoidance of involving other professionals which ultimately compromises the quality of services offered to the client.

Forensic report writing is an essential contribution of the forensic social workers to social justice. Joubert and Van Wyk (2014) raise the concern that while the courts are increasingly acknowledging the importance of these forensic reports, the poor writing style, lack of structure and professional motivation in many of these reports make them unfit for use in court. In order to improve the professional and scientific quality of forensic reports, social workers should be competent in clinical and ecometric assessments, and have training in critical thinking and report writing skills (Joubert & Van Wyk, 2014). Kaliski (2006) found that most social workers in SA who conduct assessments on sexually abused children and submit these reports to court, do not have any specialised training. However, this situation is changing as forensic social work becomes more established and formalised through specialisation requirements.

6.5.2 Occupational Social Work (OSW)

Social work services in the South African workplace can be traced back to the railways in 1935 when social workers were employed to provide services to employees. In the 1980s, mines and trade unions employed social workers to assist employees. As the 1990s and 2000s saw the development of human

resources departments in organisations, the employment of social workers in this sector increased. Du Plessis (1994) explored the evolvement of occupational social work in South Africa, and discovered that the development of occupational social work was reflective on the state's welfare system and philosophy. Welfare services reflecting the discriminatory racial ideology of the government were initially focused on assisting the poor Whites. Reflecting this racist ideology, White social workers were employed in the workforce to offer services of a predominantly material nature to assist the disadvantaged White employees. Only in the late 1960s were Black social workers employed in organisations to assist Black employees (Du Plessis, 2001; Van Breda, 2009).

Like most fields of social work, in order to remain relevant OSW work has evolved over time to keep abreast with the developments in the profession and also to address the changing needs of the work environment. Initially social work in the workplace was called 'industrial social work' but this name was later changed to 'occupational social work' in order to encompass the diversity of work settings and not to be limited to industrial settings. As the definition of OSW has also evolved over time, possibly the most widely accepted is that of Straussner (1990, p.2) who explains that "occupational social work is a specialised field of social work practice which addresses the human and social needs of the work community through a variety of interventions which aim to foster optimal adaptation between individuals and their environments". In keeping with the systems understanding of social work, this definition acknowledges the needs of the employee, work community and the community at large. Furthermore, it promotes the understanding of the *'employee as person'* who may experience personal stressors, such as marital, health or alcohol problems as well the '*person as employee',* who may experience stress associated with the nature of the work or the work environment (Du Plessis, 2001; Van Breda, 2009). The evolving models of occupational social work (Googins & Godfrey, 1987; Ozawa, 1980) advocate the need for occupational social workers to acknowledge the *'organisation as a client'*, and address aspects of justice, equity and human dignity. Lastly, the importance of facilitating the well-being of communities, has gained credence in the last decade and the focus of *'employee as a citizen'* has become central (Van Breda, 2009). As corporate organisations have shifted from an understanding of employees as human resources to being human capital, so the focus on external stakeholders and community development has become paramount (Sarkar, 2008). The complex interplay of all of these client systems needs to be addressed in order for OSWs to deliver comprehensive services and strategically position themselves as an integral part of the organisation.

European models of employee assistance programmes, which were curative and clinical in nature, were adopted by occupational social workers. Considering the issues of inequality and extreme poverty that most employees faced, a casework approach was likely to be of limited benefit (Du Plessis, 2001; Smith, 2013). Similarly Rankin (1992), in his PhD study, which explored industrial social work practice in SA, found that most (90.6%) occupational social workers were predominantly

engaged in offering casework services in order to address personal problems of employees. His study also highlighted two other concerns about occupational social work practice: firstly, the majority of OSWs were practising without specialised knowledge, education or supervision; and secondly, there was a lack of referrals from trade unions to the occupational social work services. In South Africa trade unions have played a significant role in advocating political and economic equality. This role has been evident in the strong alliance that the Congress of South African Trade Unions (COSATU) has traditionally had with the ANC. However, 21 years after the advent of democracy, this relationship is fraught with tensions and ideological differences. The limited union involvement in promoting and accessing EAP worksite programmes, could be attributed to the lack of management consultation in the establishment of these programmes (Terblanche, 2009). Traditionally, management and labour's relationship has been one that is entrenched in suspicion and mistrust. EAPs have been seen to be management's way of maintaining the 'status quo' of the organisation and a tool to pacify workers. The inability of OSWs to adequately address the workforce's concerns, has contributed to their lack of professional recognition in the workplace, and possibly raised more questions about the suitability of employing social workers in organisations than promoting occupational social work.

In order to assist occupational social workers to gain more credibility in the workplace, Du Plessis (1994) developed a framework for OSW practice which comprised 12 principles. These principles guide and assist the occupational social worker in the evolution of practice from micro to macro interventions. These principles included: the promotion of social work as a profession; ensuring employee accessibility to social work services; maintaining professional curiosity, growth and support; dual accountability to management and employees; keeping an organisational wide vision; ensuring professional accountability to both management and unions; offering ecologically based service efforts; and the continual evaluation of practice.

Realizing the need for an indigenous model of occupational social work practice, Kruger and Van Breda (2001), both occupational social workers employed in the South African Defence Force, developed the Occupational Social Work Practice Model (OSWPM). This model postulates four positions of practice; the first two positions incorporate interventions focused on '*employee as a person'* while the last two positions focus on addressing the '*person as employee'*. Van Breda (2009) explains these four positions as: firstly, *restorative interventions* which aim to assist the employee with personal problems; secondly, *promotive interventions* which include promotive, educational and developmental programmes; thirdly, *work-person interventions* where employees and their families are assisted to adjust to or meet the needs of the workplace and fourthly, *workplace interventions* which aim to guide and help the organisation to address the needs of the workforce. Van Breda and Du Plessis (2009) critiqued the OSWPM and assessed its alignment to South Africa's developmental welfare approach. They suggested a series of adjustments in order to improve the alignment, which included: improving

the contextual relevance of OSW by advocating for rights, equity and promoting anti-discriminatory workplaces; placing a greater emphasis on addressing issues of power through promoting employee participation and democracy; having a more proactive involvement with corporate social investment; and through providing evidence of how OSW practice contributes to economic and social development. As mentioned earlier in this chapter, the shift of social work from maintaining the status quo to promoting social justice is an issue on the international agenda (Staniforth et al*.,* 2011).

6.6 SOCIAL WORK IN THE SOUTH AFRICAN POLICE SERVICE (SAPS)

6.6.1 Forensic Social Work in the SAPS

In 1997 forensic social work services were established in SAPS to focus on crimes against children. It was anticipated that these services would only be investigative in nature and would not include therapeutic services to the children. Forensic social workers would at the request of the investigating officer assist the Child Protection Units in SAPS and conduct forensic assessments with children who had allegedly experienced abuse. Forensic social workers might be required to appear as expert witnesses in court (Stutterheim & Weyers, 1999).

The need for the establishment of the FSW section was initially determined from a research study undertaken by social work students from the University of Potchefstroom. Furthermore, this study identified the need for social workers to receive specialised training in forensic social work in order to provide expert services in child abuse cases. In line with the policies which were established in SAPS to govern forensic social work, social workers were not allowed to be appointed as forensic social workers in SAPS without specialised training. FSWs already in SAPS attended the necessary training courses to enhance their assessment skills and learn about court procedures and requirements (Stutterheim & Weyers, 1999). Offering these services has provided children with the opportunity to talk about their traumatic experiences in a non-threatening environment.

In 2012, Forensic Social Work was migrated to the Detective Services in SAPS and the number of employed FSWs rose from 54 to 75 as a result of the increase in referrals directly from the courts. Subsequent to FSWs joining the Detective Services; 1 964 children were assessed; 5 892 assessments were conducted; 1 112 expert court reports were submitted to courts; which culminated in 110 convictions (Phiyega, 2014). Addressing the high levels of crime against women and children is a problem that has been placed on the political agenda of the country. In an address to parliament in 2013, Mr Nathi Mthethwa, the then Minister of Police announced that the members of SAPS would intensify their efforts in pursuit of public safety and that in particular crimes against women and children and the elderly remained a challenge and a priority for SAPS. This undertaking is in keeping with the SA government's National Development Plan 2030 to build safer communities. According to the Plan, the need to provide protection for all vulnerable groups, particularly women and children,

has been prioritised and will be addressed through the "effective and co-ordinated response of the police, business, community and civil society" (National Planning Commission, 2012, p. 386).

The importance of forensic social workers meeting the specific and changing needs of society was reflected in the address of the Police Commissioner, Riah Phiyega in 2014 at the SAPS first Forensic Social Work Conference in Pretoria:

> Numerous disciplines and professions are changing and responding to new developments, challenges and opportunities. Forensic social work cannot be immune to these changes. Today, its role in policing cannot be overstated. Owing to some of the brutal and barbaric acts of crime against the vulnerable in this country, social work attempts to deal with the social problems of humankind and, in the struggle, we find competing responsibilities that all demand our attention (Phiyega, 2014).

Considering the levels of violent crimes perpetrated against children in SA (Meinck, Cluver, Boyes & Mhlongo, 2015), FSW in SAPS has focused on addressing child matters in investigative assessments, writing court reports and providing expert witness in court. The proper establishment of the relevant structures in SAPS is imperative in the process of eradicating crimes against women and children. The increasing number of FSWs employed in SAPS over the last decade is not only essential considering the dire need for these services but it is also evidence of SAPS's commitment to assisting women and children to meet their needs through increasing the successful prosecution of perpetrators in courts.

6.6.2 Occupational Social Work in SAPS

Due to the stressful nature of police work in South Africa, there is a well developed EAP which employs occupational social workers to assist in the development and promotion of psychosocial services to police officers. Stutterheim and Weyers (2004) who traced the development of social work services in SAPS, maintain that the establishment of social work as an autonomous service in SAPS was a process that was fraught with discrepancies and the need for recognition of professional turf. They record that the origins of these services began in 1952 when a chaplain was recruited on a seasonal basis in order to assist police personnel with spiritual and social needs. The first fulltime chaplain was recruited in 1960 but despite the increasing number of chaplains being employed, it was evident that the services of welfare officials were also required. It was felt that these officials should be recruited from within SAP so that these officers would be familiar with the organisation, culture and stressors of the police. In 1971, after undergoing a selection process and three months training on welfare-related matters, welfare officers joined the chaplain service. Qualified social workers were then recruited in order to provide a more professional service (Stutterheim & Weyers, 2004).

In 1979 the social work division in SAP was established but these services were viewed as an extension of the chaplain services and not recognised for their own integrity. However, in 1991 an autonomous social work section was established with the Human Resources Management, after an inquiry into the need to separate the social work and chaplain services. The professionalism of social work was further acknowledged when in 1992 social workers were no longer required to perform police activities. As a result new social workers were employed under the Police Services Act and not the Police Act as they had been previously. This discrepancy was addressed in 1996 when all social workers were employed under the South African Police Services Act no 68 of 1995 (Stutterheim & Weyers, 2004). SAPS adopted an internal EAP model as opposed to an external EAP in order to offer a more appropriate and tailor made service to police offers. The goals of the EAP in SAPS as delineated by the National Instruction (3/2003:2) included the following:

> To assist an employee by promptly identifying and finding solutions to problems that may influence the employee's performance at work; and, To assist the employee in preventing a further decline in work performance and to instate the employee to acceptable levels of work performance (De Winnaar & Taute, 2008).

The transformation of South Africa to a democratic society in the 1990s required an overhaul of the SAP and an examination of all existing services and programmes within the SAP (Weyers, Huisamen, Kleingeld & Williams, 2006). In order to address concerns of the programme's cost effectiveness and the threat of being outsourced, the Police Social Work Services (PSWS) continually assessed and adjusted the nature of its services. This process was particularly evident after 1999 when pro-active strategies that included the development of personnel capacity building programmes (PCBPs) were implemented. The programmes addressed stress management, substance dependence, life skills, colleague sensitivity, financial education and HIV/AIDS prevention and awareness. Furthermore, a philosophical shift to the strengths-based approach, ensured that holistic services were offered and not only reactive clinical work (Stutterheim & Weyers, 1999). These five programmes were developed and their effectiveness evaluated. Weyers et al. (2006) studied the effectiveness of the programmes and found that they had a positive impact on the private and professional lives of police personnel. Management was so impressed with the success of the programmes that 2023 additional posts for occupational social workers were created. Based on the success of these programmes, these authors advocated that additional specialised training was not required and that generic social work training was sufficient. However, these authors admit that the training programmes and presentation guidelines need to be fully developed for SAPS social workers. One could argue that occupational social workers should be able to work independently and be proactive in assessing and addressing the needs of the workforce and that specialised training would help to equip social workers to fulfil this role.

The most recent study on occupational social work by Van Breda (2009), which included SAPS social workers, showed that contemporary occupational social work practice in South Africa has not evolved significantly. Using the OSWPM as a framework for assessment, Van Breda (2009) distributed a questionnaire to occupational social workers who were members of the South African Occupational Social Workers' Association in Gauteng. Of the 44 respondents, 23 were employed in SAPS as occupational social workers. Findings indicated that respondents allocated their work time as follows: 36.7% on restorative interventions; 29.4% on promotive interventions; 18.8% on work-person interventions and only 15.2% on workplace interventions (Van Breda, 2009). These findings indicated that occupational social workers were not engaging with their full scope of practice and that their repertoire of practice was more reflective of generic social work than occupational social work.

6.7 CONCLUSION

In a world where poverty, inequality and social problems are ubiquitous, the social work profession has a fundamental role to play. While the social challenges differ from country to country, ensuring that social workers are adequately trained to address these unique needs is the responsibility of every country. South African social work practice has required dramatic ideological and theoretical shifts in the last few decades in order to address the poverty, discrimination, and inequality that emanated from the apartheid era. Despite the occupational challenges and lack of professional recognition, social workers still strive to make a contribution to the improvement and development of society. The impact of exposure to such high levels of deprivation and trauma on social workers cannot be ignored and must not only be acknowledged but needs to be addressed through proactive strategies.

PART FOUR

THE EMPIRICAL STUDY

CHAPTER SEVEN

RESEARCH DESIGN AND METHODOLOGY

"If one knew what the answers were, it wouldn't be called research" **(Albert Einstein).**

7.1 INTRODUCTION

Researchers are influenced in terms of what they research and how they design their inquiry by their ontological and epistemological position, the way they perceive the world and their existing knowledge. Thus the researcher's knowledge and ideology determine what research methods and genre are selected for a study. Henning, Van Rensburg and Smit (2004, p. 36) maintain that the chosen philosophy and methods impact upon the design and execution of the study, and therefore researchers should argue their 'methodological reasoning'. Hence it is important in any study to have a detailed explanation of the suitability and utility of the researcher's choice of methods, which is what this chapter endeavors to achieve.

Moreover, Durrheim (2006) explains that the research design must be chosen considering the following four aspects: the purpose of the research; the theoretical paradigm informing the research; the context in which the research is carried out; as well as the research techniques. The current research comprised elements of both basic and applied research as it endeavored to contribute to knowledge and theory of secondary trauma as well as to illuminate a societal concern (Patton, 2002). Consequently, this chapter devotes considerable attention to clarifying the purpose of the research: the aims, objectives, hypotheses and research questions. Explanations of the research design and paradigms are provided and the research methodology is elaborated upon. The units of investigation, sampling methods, research procedures and data analyses are explicated while the strengths and limitations of these aspects are also discussed. Finally, the ethical considerations which underpinned this research are highlighted.

7.2 RESEARCH QUESTIONS

1. What is the nature and extent of secondary traumatic stress, vicarious traumatisation, compassion satisfaction, burnout, coping and resilience in social workers employed by the South African Police Service, as measured by standardised scales?
2. Do marital status, work experience and type of work (occupational or forensic social work) affect the manner in which social workers experience and cope with secondary trauma?
3. What are participants' perceptions of the work environment as measured by Moos's (2008) Work Environment Scale?
4. Is there a relationship between secondary traumatic stress, vicarious traumatisation,

compassion satisfaction, burnout, coping resources, resilience and the work environment as measured by standardised scales? If so, what is the nature of this relationship?

5. In what ways, if any, do social workers think they have changed, or their relationships with clients have changed as a result of the constant exposure to traumatic material?
6. How do the participants understand the transference and counter-transference reactions in the counselling relationship?
7. What coping mechanisms do social workers identify within themselves and their environment that help them cope with the continual exposure to traumatic material?
8. What factors do social workers identify that contribute to resilience?
9. How does the work environment influence the manner in which social workers cope with secondary trauma?
10. What recommendations would these social workers make (a) to SAPS to improve the work environment; and (b) to social workers to limit or curtail the effects of secondary trauma?

7.3 RESEARCH AIMS AND OBJECTIVES

7.3.1 Primary Aim

To explore the nature and extent of secondary traumatic stress and coping experienced by social workers employed at the South African Police Service.

7.3.2 Secondary Objectives

7.3.2.1 Secondary Objectives for the Quantitative Data Collection Phase

1. To determine the extent of secondary trauma exposure experienced by the social workers employed in the SAPS as measured by Norris's (1990) Traumatic Stress Schedule.
2. To measure the prevalence of secondary traumatic stress according to Bride, Robinson, Yegidis and Figley's (2004) Secondary Traumatic Stress Scale.
3. To ascertain levels of vicarious trauma experienced by practitioners, as determined by Pearlman's (2003) Traumatic Attachment and Belief Scale.
4. To measure levels of compassion satisfaction experienced by practitioners, as determined by Hudnall Stamm's (2010) Professional Quality of Life Scale (ProQOL).
5. To determine the levels of burnout as measured by Hudnall Stamm's (2010) Professional Quality of Life Scale (ProQOL).
6. To measure the ten work dimensions identified in Moos's (2008) Work Environment Scale.
7. To identify the levels of coping resources that practitioners utilise as assessed by Hammer and Marting's (2004) Coping Resources Inventory;
8. To ascertain levels of resilience as measured by Wagnild's (2009) Resilience Scale.
9. To determine the nature and extent (if any) of the relationships between secondary trauma exposure, secondary traumatic stress, vicarious traumatisation, compassion satisfaction,

burnout, the work environment, coping resources and resilience as experienced by the social workers working for the South African Police Service.

7.3.2.2 Secondary Objectives for the Qualitative Data Collection Phase

1. To understand the nature of secondary trauma exposure experienced by social workers employed at SAPS.
2. To explore the phenomenon of secondary traumatic stress among SAPS social workers.
3. To ascertain whether participants' worldviews have changed as a result of the secondary trauma exposure and to explore the phenomenon of vicarious trauma in the qualitative interviews.
4. To determine whether participants experience compassion satisfaction in their work.
5. To understand participants' experiences of burnout.
6. To explore participants' experiences of the SAPS work environment.
7. To identify practitioners' trauma coping mechanisms (formal and informal).
8. To explore the phenomenon of resilience with the interview participants.
9. To elicit information on practitioners' awareness of counter-transference and whether they recognise the impact of these factors on the therapeutic relationship; and
10. To obtain recommendations from participants (a) in order to improve the work environment and (b) to reduce the negative effects of the traumatic material encountered in their work.

7.4 HYPOTHESES OF THE STUDY

The following hypotheses were tested in the study:

H_1 Secondary traumatic stress levels in SAPs social workers are higher in social workers who are exposed to a greater range of traumatic cases that those exposed to fewer traumatic cases.

H_2 Vicarious traumatisation is positively and significantly correlated with secondary traumatic stress.

H_3 There is a significant difference in average vicarious traumatisation scores experienced by Forensic and occupational social work.

H_4 There is a negative and significant correlation between vicarious trauma and compassion satisfaction.

H_5 There is a significant and negative correlation between burnout and secondary traumatic stress.

H_6 A negative relationship exists between the work environment and burnout scores.

H_7 Significant differences exist between the levels of coping resources of male and female social workers.

H_8 A significant relationship exists between vicarious trauma and resilience.

H_9 There is a significant relationship between resilience and compassion satisfaction.

7.5 RESEARCH DESIGN

7.5.1 Description of the Research Design

The research design is a strategic plan or framework selected by the researcher in order to ensure that the research questions are answered and sound conclusions can be reached. As Durrheim (2006) explains, the research design acts as the bridge between the research question and the execution of the research. Important aspects that need to be considered in the selection of the research design include design validity and design coherence. These factors ensure that the design will yield valid and believable conclusions and that the influence of other factors has been taken into account. Accordingly, the research took the form of a case study that had an exploratory, descriptive and correlational design with both qualitative and quantitative elements. Design coherence is achieved if the researcher logically arranges the research purposes and techniques within the research framework (Durrheim, 2006). The design coherence and validity are further explained in the following sections.

The research was **exploratory** in that it aimed to establish new insights into particular phenomena, namely secondary traumatic stress, vicarious trauma, and coping strategies employed by practitioners at the SAPS. The purpose of exploratory designs is to uncover generalizations and develop hypotheses which can be investigated and tested with more complex techniques (Grinnell & Unrau, 2011). In addition, the study was also **descriptive** as it aimed to describe and examine phenomena as well as their deeper meanings (Terre Blanche, Durrheim & Painter, 2006). The purpose was to explain and illustrate how practitioners experience vicarious trauma as well as to understand how they cope and attribute meaning to their lives. Rubin and Babbie (2013, p. 125) explain that qualitative, descriptive studies, "are concerned with conveying a sense of what it is like to walk in the shoes of the people being described…providing rich details about their environments, interactions, meanings and everyday lives". The study was also **correlational** as it sought to explore the nature of the relationships between different variables, including secondary trauma, vicarious trauma, burnout, coping resources, compassion fatigue and compassion satisfaction, as well as how these variables are influenced by age, ethnic group, work experience and marital status.

The research took the form of a **cross sectional study** in that a sample of respondents was obtained and interviews and questionnaires were used to gather data at one point in time rather than over a longer period. According to Babbie (2013), many descriptive studies are cross-sectional as they research a phenomenon through taking a cross section of it at one time and then carefully analysing that cross-section. An inherent limitation with cross sectional designs is that whilst they try to understand causal processes over time, their conclusions are reached by the data that are only collected at one specific time. Babbie (2013) explains that in order to address this limitation, the researcher needs to be aware of both the implicit and explicit assumptions about time. Therefore,

researchers need to ensure that if they are unable to make observations at different points in the process and have to approximate such observations, they then draw logical inferences.

7.5.2 The Mixed Methods Approach

The research methodology employed was a hybrid of both quantitative and qualitative paradigms. In the past twenty years qualitative research in the social sciences has grown significantly (Macbeth, 2001; Shek, Hua Lee & Yan Tam, 2007). However, in recent years there has been an increasing demand and need for researchers in the social sciences to integrate both quantitative and qualitative designs (McCambridge, Waissbein, Forrestor & Strang, 2007).

This type of triangulation of qualitative and quantitative paradigms is termed by Creswell (2009) as "a two phase model combination". With this approach the two paradigms are distinctly separate and the advantage of this approach is that the researcher is able to thoroughly present the paradigm orientation at each phase. Creswell (2009) refers to this particular two phase combination as sequential mixed methods, where the researcher uses the findings of the second method to elaborate and expand upon the findings of the first method. Although there were a few qualitative questions in the first quantitative phase, the main focus of phase one was quantitative; and while there were a few quantitative questions in the second phase the focus was predominantly qualitative. The research design is summarised and illustrated in Table 7.1.

Table 7.1: Stages of the Research Process

Research Process	Paradigm	**Ontology**	**Epistemology**	**Methodology**
Phase One	Positivist	Empirical/Scientific understanding of reality	Objective and Detached	Quantitative: Standardised (Seven tools)
Phase Two	Interpretive	Subjective experience of reality	Empathetic	Qualitative: (Structured interview schedule)

(Adapted from Terre Blanche & Durrheim, 1999, p.6)

Tashakkori and Teddlie (2003) identify distinctive properties of both qualitative and quantitative approaches in each component of the research design. These properties are reflected in Table 7.2. The properties that are relevant to this research have been highlighted in blue. While this table provides a summary of the properties of this research, the characteristics of the research are further elaborated upon in this chapter.

The researcher selected a mixed methods design to use in this research study as there are numerous advantages to such an approach. The predominant strength of a mixed methods design is that it allows for research to develop as comprehensively and completely as possible. Furthermore, the domain of an inquiry is less likely to be inhibited by the method itself when compared with the single method study (Morrow, 2005). Moreover, through combining approaches the researcher aimed to enhance the validity of findings as the one method could be checked against the findings derived from the other type (Creswell, 2009).

Table 7.2: Quantitative and Qualitative Elements of the Design Components

	Quantitative	Qualitative
Purposes	Precise measurement and comparison of variables Establishing relationships between variables Inference from sample to population	Meaning Context Process Discovering unanticipated events, Influences, and conditions Inductive development of theory
Conceptual framework	Variance Theories	Process Theories
Research Questions	Variance questions Truth of proposition Presence or absence Degree or amount Correlation Hypothesis testing Causality (factual)	Process questions How and why Meaning Context (holistic) Hypothesis as part of conceptual framework Causality (physical)
Research Methods		
Relationships	Objectivity/reduction of influence (researcher as extraneous variable)	Use of influence as tool for Understanding (researcher as part of process)
Sampling	Probability sampling Establishing valid comparisons	Purposeful sampling
Data Collection	Prior development of instruments Standardisation Measurement/testing – Quantitative categorical	Inductive development of Strategies
Data Analysis	Numerical descriptive analysis (statistics, correlation) Estimation of population variables Statistical hypothesis testing Conversion of textual data into numbers or categories	Textual analysis (memos, coding) Grounded theory Narrative approaches
Validity		
Internal validity	Statistical conclusion validity	Descriptive validity Interpretive validity Construct validity Causal validity (identification and assessment of alternative explanations)
Generalizability	External validity (comparability)	Transferability Generalizing to theory

(Tashakkori & Teddlie, 2003, p. 252)

Qualitative data can 'put flesh on bones' (Patton, 2002, p. 193), as qualitative approaches may facilitate the interpretation of relationships between the variables and bring the results to life through in-depth case elucidation. For example the quantitative analysis of the variable 'vicarious trauma' was expanded upon by the social workers' experiences of vicarious trauma. Conversely, the incorporation of quantitative data helped to mitigate the fact that it is often difficult to generalize with qualitative data. When trying to understand phenomena, combining both methods not only helps to bridge the micro-macro divide but also helps to enhance understanding of the general picture (Punch, 2014).

However, purists would argue that one should not combine qualitative and quantitative paradigms in a research study, as the epistemological difference is too great. Mixed method designs may be considered less rigorous, as the supplemental data may be regarded as thin. In order to circumvent this critique, the researcher provided a detailed account of both methods and the manner in which the complementary data sets were verified (Tashakkori & Teddlie, 2003). While Table 7.2 provides a comprehensive overview of both qualitative and quantitative paradigms, aspects that are not incorporated in this table include: reliability/dependability; internal validity/credibility; and objectivity/confirmability. Accordingly, these aspects are incorporated later in this chapter.

7.5.3 The Quantitative Paradigm

Quantitative studies generally incorporate specific variables, random sampling and statistical analyses which attempt to verify hypotheses through deductive logic. Data are coded into numerical forms, so that statistical analysis can be conducted to determine the significance of findings (Shek, Hua Lee & Yan Tam, 2007; Terre Blanche et al., 2006). The first stage of the research was quantitative as it used descriptive statistics to measure the specific constructs such as: secondary trauma; vicarious trauma; compassion fatigue, compassion satisfaction, burnout and resilience through the use of standardised measurement scales. Furthermore, the study explored the nature of the relationship between these variables using inferential statistics.

Quantitative research is based on realism, the premise being that there is a unitary real world. Individuals are part of this real world and processes such as memory, emotion and thought are events with enduring characteristics. Through quantitative research these psychological characteristics can reveal themselves, and therefore the processes can be modeled. The world can therefore be described in terms of measurable variables (Smith, 2006). These variables interact with each other in determinate ways. Hence variables such as secondary trauma, vicarious trauma, compassion fatigue, compassion satisfaction and burnout can be measured. Furthermore, quantitative research can show how these aforementioned variables interrelate, which was one of the aims of this study. In addition, quantitative techniques allow for the testing of various hypotheses regarding relationships between variables; thereafter, theories can begin to be regarded as having the status of scientific law (Terre Blanche et al., 2006).

Limitations of the quantitative design included:

- The notion of realism can be questioned; the idea of an unequivocal real world gives credence to the understanding that people formulate their own reality (Smith, 2006).
- Due to the very structured nature of the questions in quantitative tests, participants' responses are limited (Franklin, 2008). Hence the researcher endeavoured to overcome this limitation by incorporating open-ended questions in the questionnaire booklet set out in Appendix A.
- Quantitative research can be viewed as superficial and only presenting a 'thin description' of phenomena (Henning et al*.,* 2004).
- In the quantitative research component, limitations included the reductionism in the operationalisation of variables which may have distorted or oversimplified phenomena. Whilst reductionism cannot be avoided, problems associated with it can be reduced if the researcher is aware of the possibility that reductionism can create distortions in the phenomena under study (Grinnell & Unrau, 2011).
- Quantitative data cannot adequately record emotions, feelings or experiences (Franklin, 2008). Therefore, in order to allow for expression, the researcher included a qualitative component.

7.5.4 The Qualitative Paradigm

The qualitative ontology in the second phase incorporated a subjective nature of reality. The nature of truth was socially constructed, interprevist and reflected the internal and external experiences of SAPS social workers and the meaning that these social workers attributed to their work. The nature of knowledge is interpretive as it analyses the lived experiences of these social workers. The role of the researcher in this second phase was emic and immersed, as the researcher's assumptions, reflections and role were considered in the collection and analysis of the data (Pascal, Johnson, Dore & Trainor, 2010).

While the qualitative strategy further explored the findings obtained from the quantitative data, the interpretative or naturalistic paradigm that was adopted during the second phase allowed for greater understanding of meanings and explanations of the phenomena under investigation. Grinnell and Unrau (2011) highlight the fact that a naturalistic research paradigm is a process of discovery, and focuses on adaptation and function through the emphasis on quality descriptions. This study employed a naturalistic approach as it aimed to understand the world of professional counsellors, and how they adapt and cope when dealing with trauma in the naturalistic setting of SAPS. Moreover, in qualitative research, it is the depth of the phenomena (in this case secondary and vicarious trauma) that is of interest, and not the description of the phenomena (Askeland & Bradley, 2007). Creswell (2009) maintains that qualitative research has become an accepted legitimate method of inquiry and there is significant value in obtaining detailed contextualized information. However, as researcher bias and data validity are always concerns when conducting qualitative research, the researcher paid

particular attention to trustworthiness and rigour when conducting the interviews and analysing the data.

Furthermore, the qualitative research strategy that was employed incorporated a phenomenological perspective. The German philosopher, Edmund Husserl (1859 – 1938) was the first person to use phenomenology as a philosophical tradition, while Alfred Shultz (1899 – 1959) played a fundamental role in applying and establishing phenomenology in the social sciences. Husserl's most basic philosophical assumption was that people can only know what they experience, if they attend to the perceptions and meanings that awaken their conscious awareness. Paramount to interpreting an experience is the understanding of the experience. Therefore, a phenomenological study focuses on how one interprets a phenomenon and how one then makes sense of the world (Patton, 2002). Creswell (2009, p. 13) describes a phenomenological study as "a study that describes the meaning that experiences of a phenomenon, topic or concept has for various individuals". In phenomenology the essential aspect when exploring the experiences of participants is to understand the meaning that participants ascribe to their experiences. In this way, researchers may then develop understanding of the perceptions and experiences of participants' worlds (Pascal et al., 2010). In essence, this study sought to understand how SAPS social workers were able to understand their world and the meaning that participants attributed to the secondary trauma to which they were exposed. However, one cannot state categorically that this study was strictly a phenomenological study; instead it might be more appropriate to argue that the research adopted a **phenomenological perspective**. As Patton (2002) explains, a phenomenological perspective aims to elucidate and capture participants' experiences whereas a phenomenological study focuses on the essence of shared experiences.

7.5.5 Case Study

This research could be considered a case study as it involved an in-depth analysis of a bounded system comprising social workers employed at SAPS. As Rossman and Rallis (2003, p. 114) explain, "case studies are in-depth and detailed explorations of single examples (an event, process, organisation, group or individual)". Despite the fact that case studies are generally associated with qualitative studies, a case study is not a separate research method technique and can be conducted as a qualitative or quantitative study (Payne & Payne, 2004). A mixed method approach, using both quantitative and qualitative data, can still be classified as a case study when it covers a bounded system. Henning et al. (2004, p.42) advocate this mixed approach when they explain, "case studies require multiple approaches in order to truly capture the case in some depth". The case study however can have different research genres; therefore this study could be considered a case study of social workers employed at SAPS, with a phenomenological component.

A case study was selected because they are generally not costly (Dumont & Sumbulu, 2010) and they are particularly useful for their rich descriptions, their detail, their complexity and the use of multiple sources to obtain multiple perspectives (Rossman & Rallis, 2003). In addition, case studies are often of significant benefit to research participants (whether individual, organisation or community) as this type of research can inform participants (in this case SAPS) about progress or weaknesses that emanate from research findings (Dumont & Sumbulu, 2010).

However, it is acknowledged that the limitations of selecting a case study were that such studies are often context dependent, and cannot be generalized as no two cases are identical (Durrheim, 2006a; Punch, 2014). Moreover, the principles of reliability and validity are often not fulfilled as it is difficult to replicate the same results with different participants (Dumont & Sumbulu, 2010). Conversely, Rossman and Rallis (2003, p.115) use the phrase 'reasoning by analogy', and maintain that despite a case study's lack of generalisability, lessons learnt from one case study can be applied to another population or set of circumstances, so that generalization would be appropriate if conditions in the new circumstances are significantly similar. This discourse is elaborated further by Ruddin (2006) in his article titled "You can generalize stupid! Social Scientists, Bent Flyvbjerg, and Case Study Methodology". He explains that if one tries to generalize using case studies one is confusing case inference with statistical inference.

7.5.6 Reflexivity

In the past twenty years incorporating reflexivity within the qualitative research process has become a contemporary norm. The reflexive stance postulates that the researcher is as much a part of the research process as the participants. The etymological roots of reflexivity are in self reflection and this process draws on critical theory, textual deconstruction, sociology and anthropologies of knowledge, power and agency. Reflexivity requires that researchers are aware or 'reflexive' of the multiple influences that they may have on the research processes which comprise aspects such as participants and researchers' experiences of research processes, the relationships between participants and researchers as well as changes that participants and researchers undergo through the research process (Gilgun, 2008; Macbeth, 2001). Furthermore, reflexivity involves including aspects of reflection such as the researcher's values, morals, and judgments on both individual and societal levels. Researchers also need to reflect on their 'situatedness' in society, their history, culture, race and gender (Phelan, 2011). Macbeth (2001) terms this type of reflexivity 'positional reflexivity' where the researcher analyses place, biography, self and other in order to understand how they shape the analytical exercise, while 'textual reflexivity' requires the researcher to analyse the textual representation of language used. This process involves the analysing and deconstruction of language and words.

For this study the researcher incorporated positional reflexivity, being very aware of being a White, heterosexual female, as well as middle aged, English speaking middle class social worker of British decent and employed as an academic at a prestigious South African university. Considering the atrocities of apartheid and the racial discrimination that apartheid enforced, it is not surprising that race is still a highly significant factor in South African society even though apartheid laws were abolished more than twenty years earlier. Therefore it was felt that the researcher's race and personal characteristics would be likely to have exerted a significant impact on the research process. The sample was predominantly comprised of Black African or White Afrikaans social workers, and thus one cannot ignore the apartheid past or the antagonistic history between the Afrikaners and the British. This history required the researcher to be aware of various dominant power relationships that may have impinged upon data collection, especially during the second stage of data collection. The fact that the researcher was employed by a highly influential organisation, known for its quality of research might have influenced participants to respond authentically and seriously. Mouton and Marais (1993) believe that this response is particularly common when the researcher works for a university or a research organisation.

Reflexivity is also intertwined with ethical and methodological aspects of the research. While researchers have a significant role to play in constructing the knowledge acquired in the study and in the analysis of data, this process does not entitle researchers to adopt a superior stance in any way or have the right to form a judgmental analysis. Only through nonjudgmental analysis and writing can the primary ethical obligation of safe-guarding the welfare of participants be achieved. Moreover, the use of reflexivity therefore requires the researcher to be transparent and accountable for the methodologies used as well as their limitations. Reflexivity is diagrammatically displayed in Figure 7.1 which indicates the numerous influences that the researcher must be aware of, such as: those studied; those receiving the study; as well as the researcher's own personal characteristics. These aspects should all be viewed through a critically reflexive screen which incorporates the culture, age, gender, class, status, educational standing, language and values of all those involved in the research process.

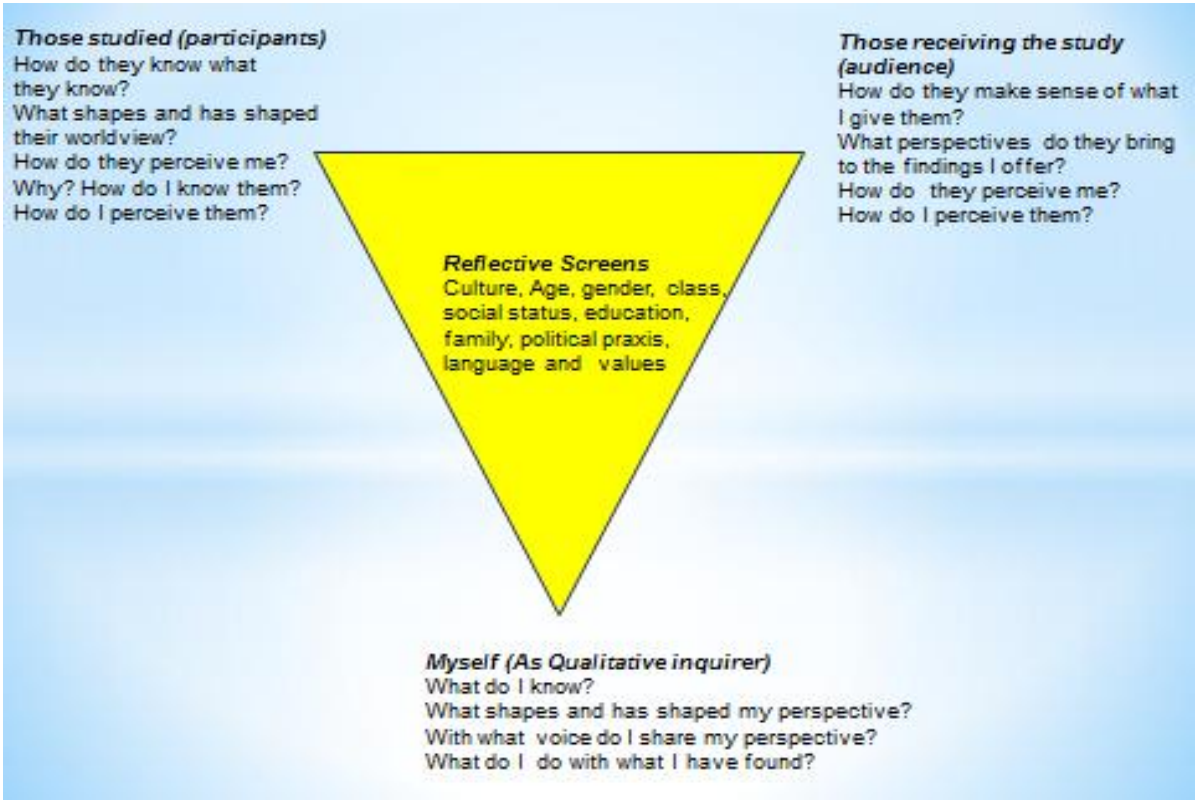


Figure 7.1: Reflexive Questions: Triangulated Inquiry (Patton, 2002, p. 66)

The predominant criticism levelled at a reflexive approach is the very subjective nature of reflexivity, which brings into question the scientific validity of this approach. However, incorporating reflexivity into the research design had numerous advantages. It encouraged the researcher to be mindful of research processes, the participants, as well as how they might impact upon the process. Moreover, it added authenticity to the research process as the researcher added her own experiences, personal awareness and insights to the process. It was hoped that through the appropriate application of research methods by the researcher, sound research would be achieved which would in turn have helped to promote a high level of professionalism (Payne & Payne, 2004).

7.6 RESEARCH METHODOLOGY

7.6.1 Unit of Analysis

The unit of analysis, which specifies who or what the researcher wants to understand, comprised social workers employed by the South African Police Service (Babbie, 2013). Participants were occupational and forensic social workers working for SAPS who were tasked with counselling police officials after experiencing traumatic events or assessing children in child abuse cases, respectively. Consequently, these social workers are exposed to a great deal of traumatic material in their counselling sessions with police personnel and children and it was anticipated that they might experience secondary trauma and vicarious trauma.

7.6.2 Sampling Procedures

7.6.2.1 Sampling procedure during the first phase

Questionnaires were distributed to the entire population of approximately 200 social workers who worked for SAPS at the time of the study; therefore sampling was not used in this first phase as every member of the population was invited to participate. At the time the study was conducted SAPS was unable to provide the researcher with the exact number of social workers in their employment. Hence, all social workers working for SAPS throughout South Africa, both occupational and forensic social workers, were invited to participate. The researcher attended numerous meetings that were held by different social work sections at SAPS. At these meetings the researcher explained the nature of her research, and invited members to participate.

Inclusion criteria for potential participants in the first stage of the research were:

- All social workers needed to be employed by SAPS and working as social workers (i.e. they could not be seconded to another position);
- The study population needed to include both forensic and occupational social workers;
- All ranks of social workers needed to be included namely: Lieutenant Colonels; Captains and Warrant officers; and
- Social workers needed to be recruited from SAPS branches in all provinces within South Africa including both rural and urban areas.

7.6.2.2 Sampling procedure during the second phase

Participants in the first phase of the study were requested to indicate their willingness and availability to participate in the second phase of the study. Sixty eight participants indicated their willingness to participate. However, only 42 gave permission for the interview to be recorded. The researcher then utilised non-probability purposive sampling and selected 30 social workers from those who had consented to tape recording of the interviews. This aspect was considered important as the researcher needed the tape recordings of the interviews in order to adequately analyse the qualitative data. When the researcher selected participants, she based this decision on ensuring adequate representation of the following aspects: the type of social work (occupational or forensic); the geographical location of employment; the ethnic group and gender of the participant and the rank of the social worker (Lieutenant Colonel, Captain or Warrant Officer).

The inclusion criteria for participants in this phase were:

- Social workers needed to have participated in phase one of the research;
- Participants needed to be working as social workers for the SAPS i.e. they could not have been seconded to another position;
- Social workers needed to have indicated their willingness to participate in the second phase; and

- Social Workers needed to have indicated that they would allow the researcher to tape record the interview for analytical purposes.

The exclusion criteria for participants in this phase were:

- Social workers who did not agree to participate in the second phase of the research; and
- Social workers who agreed to participate in the second phase but would not agree to the interview being tape recorded.

One of the strengths of this research is that the entire population of social workers employed at SAPS was invited to participate in this research. The researcher went to great lengths to ensure that every one was invited and even left questionnaires for social workers who were unable to attend the scheduled meetings. The aim was to ensure that there was no bias in sample selection and that results of the first phase could be generalised with regard to the entire population of social workers employed at SAPS.

However, limitations of the sampling procedures included the fact that generally when people are made aware of a concept they are more willing to assist in research about the concept than those who are not aware. Consequently, it is possible that social workers who were aware of the effects of secondary trauma may have indicated willingness to participate. This self-selection of volunteer participants may have altered the findings as social workers who were not experiencing secondary traumatic stress may have refrained from participating. As Strydom and Delport (2011) mention, this factor may introduce research bias. In order to circumvent this weakness the researcher personally administered questionnaires and explained to potential participants the importance of having as many people as possible and with different experiences participate in the study. A further limitation was the exclusion of participants who indicated that they would not like to be tape-recorded as they may have held different views from those who consented to the recordings.

7.6.3 Methods of Data Collection

Data were collected though different methods, namely survey questionnaires and interviews. This triangulation of data methods was adopted to enhance the validity of the research. Denzin (1970, cited by Durrheim, 1999) notes that there are numerous kinds of triangulation, including data; investigator; theory and methodological triangulation. In this research methodological triangulation was employed as evident in the different methods of data collection (questionnaires and interviews) utilised.

Data were collected in phase one of the research through group administered questionnaires and mailed questionnaires. Data were collected in phase two of the research through face-to-face interviews, telephonic interviews and Skype interviews. These three methods of data collection were

adopted in Phase Two due to the logistical and resource constraints as the costs involved in travelling to the different South African provinces were prohibitive. However, it is acknowledged that the use of these different methods constituted a limitation of the study.

7.6.3.1 Methods of data collection in phase one

In total 200 questionnaires were distributed and 132 were returned, constituting a 66% response rate, which according to Babbie (2013) is a good response rate. An example of the questionnaire is displayed in Appendix A. The questionnaires were distributed in the following ways: group administered questionnaires and posted questionnaires which were then self-administered. However, unavoidably the researcher also had to make use of postal questionnaires, as not every SAPS section could accommodate her visits. In order to enhance a positive response and the return of a completed questionnaire the researcher ensured that the questionnaires had pre-paid self-addressed envelopes (Delport, 2011).

(i) Group and self-administered questionnaires

The first method of data collection included group administered survey questionnaires, where the researcher handed questionnaires to participants and the latter completed the questionnaires while the researcher waited. In total the researcher attended 16 group meetings and a total of 84 questionnaires were completed during these meetings. Participants who were not present at the meetings received a questionnaire booklet, which they self-administered and posted to the researcher. If social workers were not able to attend the meeting or were absent from work on the day of the meeting the researcher left a prepaid self-addressed envelope with a questionnaire booklet for them and invited them to participate in the study. In this way the researcher attempted to include all social workers employed by the SAPS.

Survey methods are useful when describing the population characteristics of a large population, Furthermore they are a relatively cheap way of obtaining large sets of data and many questions can be incorporated in the survey which allows for flexibility when analysing the data (Dumont & Sumbulu, 2010).

However, limitations of group administered questionnaires included: firstly, participants may have felt pressurized to participate in the research due to group pressure but may not have actually wanted to participate. This phenomenon may account for the small number of spoiled questionnaires returned to the researcher. Secondly, there is usually a limited response with surveys which could adversely affect the validity of the study if insufficient questionnaires were returned. In order to encourage participation the researcher personally explained the nature of the research to participants at sectional meetings that they attended. Group administration of questionnaires was selected as this method of data collection is known to have a higher success rate than postal questionnaires.

(ii) Mailed questionnaires

The researcher couriered questionnaires to five different SAPS sections that had difficulty accommodating her. The researcher established how many social workers were employed in each section and sent through sufficient questionnaire booklets with pre-paid self-addressed envelopes so that participants could respond directly to her. Out of the 82 questionnaires that were couriered, 38 were returned, representing a 46.34% return rate. This response rate was not ideal as Delport (2011) considers a 50% response rate with mailed questionnaires to be adequate. However, considering that the researcher collected 90 usable questionnaires the overall response rate was 64%.

There were numerous limitations encountered through collecting data via the mailed questionnaires. For example, there was no control over the questionnaires that were posted and the researcher could not be sure that the intended participant completed the questionnaires or answered all of the questions. If the head of a section was not motivated to hand the questionnaire booklet to his/her staff then those social workers might not have had the opportunity to participate in the study. There is also the possibility that some of the mailed questionnaires may have been lost in the post as the South African postal service is not always reliable – particularly during postal strikes.

7.6.3.2 Methods of data collection in phase two

The second method of collecting data was through qualitative interviews that were conducted either face-to-face, telephonically or through Skype. Seidman (2006) believes that at the heart of the interview is an interest in other individuals' stories as they are considered to be of worth.

While conducting interviews it was imperative that the researcher was flexible and sensitive to the specific dynamics of each interview taking into account the particular dynamics of the various data collection methods. Irrespective of the method of data collection (face-to-face or telephonic), the researcher tried to create a warm, accepting and non-threatening environment so that the interviewees felt comfortable enough to share their experiences.

(i) Face-to-face interviews

The researcher initially tried to interview most participants who lived in Gauteng Province in person, as she resided in Gauteng and could easily travel to an appointment destination. However, she was only able to conduct four interviews face-to face as most participants in Gauteng preferred to participate in telephonic interviews. (Most indicated that this preference was for practical reasons as they anticipated having to cancel appointments at the last minute due to the unpredictable nature of their work. It was easier to cancel a telephonic interview at the last minute than an interview that was arranged in person. This type of cancellation in fact happened on numerous occasions and is indicative of the work environment of SAPS). The average time per interview was 60 minutes. At the end of each

interview the researcher asked if she could contact the participants if she required further clarification on matters arising from the interview. An advantage of conducting the interviews in person was that the researcher could observe body language and facial expression of the participants. Observation of these aspects helped guide the researcher in how to proceed with each interview.

(ii) Telephonic and Skype Interviews

It was too costly and time consuming for the researcher to travel all over South Africa a second time in order to interview the participants, so the researcher resorted to telephonic and Skype interviews to obtain the data for the second phase. An advantage of the telephonic and Skype interviews was that the researcher could interview participants from all over South Africa and not just Gauteng, where the researcher lived, thus limiting selection bias. The majority of the interviews (25) were conducted telephonically. One participant requested that the interview be conducted via Skype, as she had access to this facility. Conducting the interview over Skype helped the researcher to be aware of aspects such as body language and facial expressions.

While telephonic interviews remove the aspect of a personal interaction from the interview, the researcher was aware of this limitation and paid particular attention to the tone of participants' voices, words chosen and silences. An advantage of the telephonic interview was that talking on the phone is a medium with which people in today's world are all familiar as all participants had cellular telephones. Moreover, the telephonic interviews may have provided a level of anonymity, as the researcher did not know what participants looked like and consequently some individuals may have felt less inhibited to share their stories than if the researcher had been present sitting in front of them.

Interviews allow the researcher an opportunity to gain an in-depth understanding of the participant's world that cannot be gained through other methods of data collection. Furthermore, in-depth interviews are a vital way of discovering the subjective meanings and interpretations that people attach and attribute to their experiences. Interviews are also compatible with an inductive theoretical approach as new understandings and theories can be developed during the research process (Liamputtong & Ezzy, 2005; Smith, 2006). An advantage of the interview was that the researcher had the chance to answer any questions the participant wanted to raise and the interviewer could probe for greater clarity (Ross, 2010). Participants are also less influenced by peer pressure during one-on-one interviews than they may be in a group setting. Moreover, participants are more likely to share and discuss sensitive matters if they are on their own, which may not happen if participants are in a focused group setting (Liamputtong & Ezzy, 2005). Due to the sensitive nature of some of the research questions, the researcher realised that it would be far more appropriate to have individual interviews, where participants would feel more comfortable to tell their stories. Liamputtong and Ezzy (2005) believe that participants generally find the interview experience rewarding as they are given the

chance to tell their story. The researcher felt that this understanding was very real for some participants who were interviewed.

The researcher had to be consciously aware of not turning the research interview into a therapeutic one, particularly since she was exploring sensitive issues with participants. At times when participants appeared very emotional about matters discussed in the interview, the researcher offered to organise counselling for these participants – however, most of these participants were already attending therapy and so declined the offer.

7.6.4. Research Instrumentation

7.6.4.1 First phase of the data collection:

During the **first phase of the study** the following questionnaires were administered, (see Appendix A).

(i) Biographical Questionnaire

A biographical questionnaire was constructed in order to obtain information concerning age, gender, race, and marital status. Questions about work experience, the field of social work where they were employed and the participants' rank within SAPS were also included.

(ii) Traumatic Stress Schedule

Norris (1990) constructed the Traumatic Stress Schedule (TSS) which is a short questionnaire that assesses the occurrence of traumatic events in an individual's life. The schedule was developed from the DSM-III-R conceptualisation of 'traumata'. The schedule assesses how many times participants have experienced various traumatic events, including: loss of a loved one, motor vehicle accidents, robbery, rape, and personal injury as a result of natural disasters. The researcher adjusted the wording of this scale to make it more appropriate for assessing secondary trauma exposure as opposed to primary trauma exposure. The researcher acknowledges that this adaptation may have impacted upon the validity and reliability of the scale. Unfortunately, Norris (1990) does not provide any details of the psychometric properties of the schedule.

(iii) Secondary Traumatic Stress Scale

The Secondary Traumatic Stress scale (STSS) is a 17-item instrument designed to measure intrusion, avoidance, and arousal symptoms associated with indirect exposure to traumatic events through counselling traumatised clients. The Secondary Traumatic Stress Scale fills a need for reliable and valid instruments specifically designed to measure the negative effects of secondary traumatic stress in social workers. Initially the STSS was a 65 item scale; however, through refinement this scale has become a 17 item instrument with each item representing the 17 individual PTSD DSM-IV TR symptoms. Using a Likert scale, with ratings ranging from 1 (*never*) to 5 (*very often*), respondents are

asked to indicate how frequently in the past seven days they experienced the items. The STSS comprises three sub-scales: Intrusion (items 2, 3, 6, 10, 13), Avoidance (items 1, 5, 7, 9, 12, 14, 17), and Arousal (items 4, 8, 11, 15, 16). The full STSS (all items) and scores for each sub-scale are obtained by summing the items assigned to each sub-scale. Means (M), standard deviations (SD) and alpha levels (α) for the STSS and its sub-scales are as follows:

Full STS (M = 2.49, SD = 11.76 α = 0.93);

Intrusion (M=8.11. SD = 3.03, α = 0.80);

Avoidance (M = 12.49, SD = 5.00, α = 0.87); and

Arousal (M = 8.89, SD = 3.57, α = 0.83).

These alpha levels are above 0.8 and are sufficient as the correlations allow for little measurement error at that level. In a study of 287 licensed social workers evidence was found for reliability, convergent and discriminant validity as well as factoral validity in the STSS (Bride, Robinson, Yegidis & Figley, 2004, p. 29).

(iv) The Trauma and Attachment Belief Scale

The Trauma and Attachment Belief Scale (TABS) is based upon Constructivist Self-Development Theory and is intended to measure vicarious trauma, the disruptions in beliefs about self and others that arise from psychological trauma or the vicarious exposure to trauma material through psychotherapy. The scale has ten sub-scales; five need/schema areas are assessed in relation to self and other and are intended to diagnose the existence of vicarious trauma in helpers. The scale consists of 84 items. The respondent uses a six point Likert scale to indicate the extent to which s/he agrees with each statement. The scale options range from 1 to 6: with 1 (disagree strongly) to 6 (agree strongly). Once a total score is obtained, the standard score is calculated through using a scoring grid that is provided when one purchases the research tool. The lowest score indicates the least disruption or negativity in cognitive schema.

For the TABS total score an internal consistency estimate of 0.96 was obtained and test-retest correlation of 0.75, indicating high reliability. The median internal consistency that was obtained for the sub-scales was 0.79, with values ranging from 0.67 for the self-intimacy sub-scale to 0.87 for the other-intimacy sub-scale. The median test-retest value for sub-scales was 0.72. The estimates for test-retest of the sub-scales ranged from 0.60 for other-intimacy to 0.79 for other-trust, while the slightly low internal consistency estimate for the self-intimacy sub-scale is offset by good test-retest reliability along with factor-analytic evidence that supports retaining it as a single, separate sub-scale (Pearlman, 2003).

The TABS scale has face validity as it appears to measure what it purports to measure and asks participants about their beliefs around safety, trust, esteem, intimacy and control. Test results

indicated that the TABS is a reliable and valid tool for use in measuring disruptions in beliefs about personal and interpersonal safety, trust, esteem, intimacy and control (Pearlman, 2003). Many researchers have used the TABS scale to measure indirect trauma. Schauben and Frazier (1995 cited in Pearlman, 2003) assessed the effects of vicarious trauma on counsellors specializing in female sexual violence. They found that counsellors who dealt with more trauma survivors had more disrupted beliefs, had higher scores on the TABS scales and therefore more vicarious trauma than those with lower caseloads.

(v) The Professional Quality of Life Scale (ProQOL)

The burnout and compassion satisfaction scales were derived from Hudnall Stamm's (2010) Professional Quality of Life scale (ProQOL). These terms are defined as follows:

Compassion Satisfaction – This concept refers to the pleasure that may derive from being able to work well and make a positive contribution to the work setting and/or society in general.

Burnout – This phenomenon has a gradual onset and is associated with feelings of hopelessness and difficulty in doing one's job effectively. Burnout is often associated with high workloads or a non-supportive work environment.

Although this scale also measures secondary traumatic stress, Bride, Robinson, Yegidis and Figley's (2004) secondary trauma scale was used to measure secondary traumatisation as the sub-scales: intrusion, avoidance and arousal could then be explored. The ProQOL tool was initially called the Compassion Fatigue Self-Test and was developed by Figley in the 1980s but then modified and further developed by Hudnall Stamm. The scale has 30 items that need to be answered. Participants are asked to rate each statement according to a 6 point Likert type rating scale provided (0 = never and 5 = very often). The Cronbach Alphas for the scales are as follows: compassion satisfaction = 0.87; burnout = 0.72; and compassion fatigue = 0.80. Early returns on the test-retest suggest good reliability across time with a small standard error of the estimate. The construct validity for the scale has also been well established, with more than 200 peer reviewed articles. The scales on the ProQOL measure different constructs. The two scales, compassion fatigue and burnout are clearly different, while the 2% shared variance of the two scales reflect the distress that is common to both conditions. Discriminant and convergent validity still need to be established (Hudnall Stamm, 2010).

(vi) The Coping Resources Inventory (CRI)

The coping resource inventory (CRI) is a 60 item instrument that measures resources in five areas; namely, cognitive, social, emotional, spiritual/philosophical and physical. Each of these concepts is defined as follows:

Cognitive (COG) –"The extent to which individuals maintain a positive sense of self-worth, a positive outlook to others, and optimism about life in general" (Hammer & Marting, 2004, p.3);

Social (SOC) – "The degree to which individuals are embedded in social networks that are able to provide support in times of stress" (Hammer & Marting, 2004, p.3);

Emotional (EMO) – "The degree to which individuals are able to accept and express a range of affect, based on the premise that a range of emotional responses aids in ameliorating long-term negative consequences of stress" (Hammer & Marting, 2004, p.3);

Spiritual/ Philosophical (S/P) –"The degree to which actions of individuals are guided by stable and consistent values derived from religious, familial, or cultural tradition or from personal philosophy. Such values might serve to define the meaning of potentially stressful events and to prescribe strategies for responding effectively. The content domain is broader than traditional western religious definitions of spirituality" (Hammer & Marting, 2004, p.4);

Physical (PHY) – "The degree to which individuals enact health-promoting behaviours believed to contribute to increased physical wellbeing. Physical wellbeing is thought to decrease the level of negative response to stress and to enable faster recovery. It may also help to attenuate a potentially chronic stress-illness cycle resulting from negative physical responses to stressors that themselves become major stressors" (Hammer & Marting, 2004, p.4).

Respondents use a four point Likert type scale to indicate how often they have engaged in the behaviour described in the previous six months. Six items are negatively worded and the points must be reversed scored (Items 5, 36, 49 and 51, 58, 59). The result for each of the five individual scales is determined by adding all the item responses for each scale. A total resource score is obtained by adding the five individual scores obtained. Professionals suggest that the higher the score for resources that are identified, the greater the likelihood that negative psychological stressors may be reduced. An individual's high and low resources are identified (Hammer & Marting, 2004).

The reliability for item to scale median correlations ranges from 0.39 - 0.46. However, there is also a high internal consistency reliability for the Total Resource Score (Range: 0.71 – 0.91). When assessing the validity, the inter-correlations of the CRI scale reveal some overlap among resource constructs for the Cognitive, Social and Emotional Scales. In terms of predictive validity, the CRI Total Resource Score was found to be a significant incremental predictor of stress symptoms in children as measured by the Personal Stress Symptom Assessment (R change = 0.15, $p < 0.001$) (Hammer & Marting, 2004).

(vii) Resilience Scale (RS)

The Resilience Scale was first developed in 1993 to measure resilience. The developers, using grounded theory research, identified five characteristics of resilience. Wagnild (2009, p. 17) identifies and defines these characteristics as follows:

"**Self-reliance** - is a belief in oneself and knowing and relying on personal strengths, all the while being aware of limitations, but not being stopped by them. Self-reliant persons are often described as survivors;

Meaning - is the realization that life has a purpose and recognition that there is something for which to live. People with purposeful lives will say that others value their contributions and that they have a reason to get up in the morning;

Equanimity - is a balanced perspective of life and experiences and might be thought of as 'sitting loose in the saddle' and accepting what comes along, thus moderating the extreme responses to adversity. It is the ability to keep going despite setbacks;

Perseverance - is the act of persistence despite adversity or discouragement, connoting a willingness to continue the struggle to reconstruct one's life and remain involved in the midst of adversity. It is the ability to keep going despite setbacks;

Existential aloneness - is the realization that each person is unique and that while some experiences can be shared, others must be faced alone. With existential aloneness comes a uniqueness and perhaps freedom".

The scale has 25 items and comprises five sub-scales reflecting the five characteristics identified above. The total resilience score is obtained by adding the scores from the five sub-scales. Scores greater than 145 indicate moderately-high to high-resilience; scores from 126 to 145 indicate moderately low to moderate levels of resilience and scores of 124 and below indicate low resilience.

The Cronbach Alpha coefficients range from 0.84 to 0.94. Internal consistency reliability was strong (r = 0.91) and concurrent reliability also had good results. An exploratory principle components factor analysis suggested a two factor solution. Factor one, Personal Competence, included 17 items, such as self-reliance, independence, determination, invincibility, mastery, resourcefulness and perseverance. Factor two, Acceptance of Self and Life, incorporated eight items, which included adaptability, balance, flexibility, and a balanced perspective of life. The validity of this scale has been supported in many published studies and demonstrates excellent validity (Wagnild, 2009).

(viii) The Work Environment Scale (WES)

The Work Environment scale comprises 90 items. The scale assesses three main areas of the work environment, namely: the relationship dimension; personal growth dimension; and system maintenance and change dimension. The sub-scales that comprise each of the aspects and a description of these variables as stipulated by Moos (2008, p.9) are provided in Table 7.3.

To determine a person's raw score for each sub-scale, one needs to count the number of responses in the keyed direction and enter the total score at the bottom of the box. In order to convert the raw score to the standard score, tables were provided in the manual.

Table 7.3: Work Environment Sub-Scales and Descriptions

	Sub-scale	Explanation
	Relationship Dimension	
1	Relationship Dimension	The extent to which employees are concerned about and committed to their jobs
2	Coworker Cohesion	How much employees are friendly towards and supportive of each other
3	Supervisor Support	The extent to which management is supportive of the employees and encourages employees to be supportive of one another
	Personal Growth Dimension	
4	Autonomy	How much employees are encouraged to be self-sufficient and to make their own decisions
5	Task Orientation	The emphasis on good planning, efficiency, and getting the job done
6	Work Pressure	The degree to which high work demands and time pressure dominate the job milieu
	System Maintenance and Change Dimension	
7	Clarity	Whether employees know what to expect in their daily routine and how explicitly rules and policies are communicated
8	Managerial Control	How much management uses rules and procedures to keep employees under control
9	Innovation	The emphasis placed on variety, change and new approaches
10	Physical Comfort	The extent to which the physical surroundings contribute to a pleasant work environment

(Moos, 2008, p. 9)

Limitations of the research tools included the following:

- The research tools were standardised on American populations and it was anticipated that they might not be applicable to South African social workers. For this reason, the researcher pre-tested the questionnaires in order to change jargon and language and make the tools more applicable to the South African context - although it is acknowledged that these amendments could have affected the validity of the scales;
- Standardised questionnaires are often limited to the understandings of the developer and so may only gather limited information around a variable or issue, which can make the research less flexible (Dumont & Sumbulu, 2010).

Table 7.4 shows that the Cronbach Alphas, for each of the sub-scales in the WES are all in an acceptable range.

Table 7.4: Internal Consistencies, Corrected Average Item-Sub-Scale Correlations, and One-Month Test-Retest Reliability of the Work Environment Scale

		Internal Consistency			
	Sub-scale	Initial Sample (N=1,045)	Subsequent Sample (N=742)	Corrected Average Item- Sub-scale Correlations (N= 1,045)	One-month Test-Retest Reliability (N=75)
	Relationship Dimension				
1	Relationship Dimension	.84	.80	.52	.83
2	Coworker Cohesion	.69	.68	.36	.71
3	Supervisor Support	.77	.77	.44	.82
	Personal Growth Dimension				
4	Autonomy	.73	.72	.39	.77
5	Task Orientation	.76	.76	.42	.73
6	Work Pressure	.80	.78	.47	.76
	System Maintenance and Change Dimension				
7	Clarity	.79	.74	.45	.69
8	Managerial Control	.76	.75	.41	.79
9	Innovation	.86	.82	.53	.75
10	Physical Comfort	.81	.76	.49	.78

(Moos, 2008, p. 10)

7.6.4.2 Second phase of the data collection

During the second phase of the data collection, qualitative interviews were conducted using a qualitative **interview schedule** comprising 20 questions. The themes that were explored in the interviews included the social workers' perceptions of their experiences of secondary and vicarious trauma; their perceptions of how they might have changed as a result of their exposure to trauma; their understanding of how they cope or have adjusted to accommodate these changes; their understanding of how secondary traumatic stress and/or vicarious trauma had impacted their therapeutic relationships with clients; as well as recommendations they would make to reduce the effects of secondary and vicarious trauma. Table 7.5 shows the rationale for including the various items in the interview schedule. In order to enhance the comprehensiveness of the data, using a schedule outline ensures that data collection is systematic for each respondent.

The researcher was guided by the schedule rather than dictated by it. This approach allowed the researcher to attempt to establish rapport with the respondents. The order in which the questions were asked was flexible and so could be rearranged according to each interview. The researcher was then able to probe interesting areas that arose and could address any of the respondent's concerns or questions (Smith, 2006). The schedule also provided the opportunity to show that logical gaps in the data could be identified and addressed. However, inadvertently, the use of an interview guide may have resulted in important and salient topics being omitted. As the interviewer was fairly flexible in adhering to the sequencing and exact wording of questions this approach could have resulted in participants giving substantially different responses from different perspectives, which might have

reduced the comparability of responses (Patton, 2002). The average duration of each interview was about 60 minutes.

Table 7.5: Rationale for Inclusion of Items in the Interview Schedule

No	Question	Rationale for inclusion
1	Tell me about the extent of trauma counselling you have offered police officers (or children who have been abused).	The extent of trauma counselling therapists have conducted is likely to influence how they experience secondary trauma. Crestmann (1999) indicates that increased professional experience is inversely associated with experiencing symptoms of secondary traumatic stress. Hence this question sought to establish social workers' experience in trauma counselling.
2	Before you joined SAPS did you counsel trauma victims? If yes, please elaborate.	This question was asked to obtain a holistic understanding of the extent of trauma counselling experience the social worker had acquired. Consequently, previous experience before joining SAPS was considered significant, as they might have been exposed to trauma previously which would influence how they experienced secondary trauma (see theory under item 1).
3	In what way, if any, do you think counselling police officers or abused children may have affected you?	This question endeavoured to establish the social workers' own awareness of their experiences of secondary trauma as therapists have been found to be vulnerable to secondary trauma as a result of their counselling of trauma victims (Bride, 2007a).
4a b	Do you think you have changed due to the continual exposure to traumatic material? If so, in what ways? How do you think you have adjusted to these changes?	This question sought to understand how social workers may be negatively affected. Working with clients who have been traumatised can have inevitable, long lasting and often detrimental effects (Herman, 1997).
5	Did you experience any physical symptoms as a result of listening to police officers or children tell you about the about trauma they had experienced? Please elaborate.	Counsellors can experience symptoms after hearing about traumatic events as Pearlman and Saakvitne (1995a) believe that hearing about multiple trauma cases can cause the same symptoms as posttraumatic stress disorder.
6	How do you think, the way that you understand the world may have changed due to hearing about traumatic material during counselling?	It is important to unpack and understand changes trauma counsellors may experience as trauma counsellors can experience a change in their interaction with their world, their families and friends (Pearlman & Saakvitne, 1995a).
7	Do you think these experiences have affected you negatively? If so, in what way?	This question sought to understand how social workers may be negatively affected. Working with clients who have been traumatised can have inevitable, long lasting and often detrimental effects (Herman, 1997).
8	What supports can you identify that may have helped you deal with these changes?	Dutton and Rubenstein (1995) explain that a variety of factors such as personality and social support, influences how an individual responds to trauma, therefore it was necessary to ascertain what supports were available to assist the social worker.
9a b	Have these experiences affected you positively? If so, how? How would you build on these experiences?	Every experience has the potential to be growth producing, often referred to as posttraumatic growth (Tosone, Bauwers & Glassman, 2014); so hence this question sought to establish whether social workers could identify positive aspects.
10	Do you think that constant exposure to traumatic material has impacted upon your therapeutic relationships? If so, please explain.	This topic was considered an important area to explore as Matsakis (1994) believes that trauma therapists must either bear the anxiety of knowing that they may be the next victim or they can build defences against the clients and what they represent.
11	Have you found that over time you are less able to empathise with your clients? Please explain your answer.	Empathy is considered a key factor in the induction of trauma from primary to secondary victim as empathy helps one to understand another person's experience.

12	What do you understand by the term 'transference' and 'counter-transference? Do you think these concepts are applicable to your work with clients?	It was considered important to explore how aware social workers were of the concepts of transference and counter-transference. Wilson and Lindy (1994) propose that the primary cause of treatment failure with PTSD is counter transference reactions. They identify two types of counter-transference. Type one is characterised by avoidance, distancing, denial and detachment responses. Type Two is characterised by overidentification, overrealisation and enmeshment.
13	What factors can you identify within yourself, your work environment, your social environment, and your community that may have helped you become more resilient in your responses to trauma?	It is important to explore aspects when trying to understand resilience. Harvey (2007) identifies demographic factors (age, race, class, gender); neurobiological mediators of hardiness and vulnerability; social, cultural and political contexts as well as access to supports and professional assistance as factors that contribute to resilience.
14	Do you attend supervision sessions? If so, have you found these sessions beneficial in helping you deal with the constant exposure to trauma?	This question explored whether social workers had access to adequate supervision. Kadushin and Harkness (2014) emphasised how important supervision is for insight development and learning.
15	Have you attended your own therapy in order to deal with the constant exposure to traumatic material?	The rationale for inclusion of this question was that it helped the researcher understand if social workers utilised therapy as a coping strategy. Obtaining professional help is regarded as a healthy coping strategy (Killian, 2008).
16	Would you attend counselling if SAPS provided the opportunity? If yes, how would you like these services to be structured?	This question aimed to explore participants' levels of motivation to attend counselling if these services were made available to them by the organisation.
17	Do you think that your work environment (structure, culture organisation, leadership) has influenced the way that you have experienced constant exposure to trauma?	It was deemed necessary to explore how the work environment impacts upon individuals. Pearlman and Saakvitne (1995) explain that individual and environmental factors influence how an individual may experience secondary trauma.
18	How satisfied/dissatisfied are you with your job? Please elaborate.	It was felt that understanding how satisfied or dissatisfied individual were with their jobs, would provide insights into how they experienced the work environment.
19	What recommendations would you suggest to SAPS in order to improve the work environment and help social workers to cope with the secondary trauma?	The organisation can implement various support systems in order to help social workers cope with the trauma (Yassen, 1995). This question hoped to establish what supports had been implemented by SAPS to assist the social workers.
20	What strategies can you suggest that a social worker should employ in order to cope with secondary trauma?	Obtaining recommendations from participants about how to reduce secondary trauma was one of the aims of the study and it was anticipated that this item would provide insight into participants' understandings of preventing secondary traumatic stress.

7.7 THE PILOT STUDY

7.7.1 Piloting the Research Tools in Phase One

The quantitative tools were piloted in order to determine if participants understood the questions and whether the way the questions were phrased was suitable for the South African context, considering that the tools were American. Phrases and words were adjusted in order to make the instruments more suitable for the South African context (see Table 7.6); although it is acknowledged that such

adjustments may have affected the validity of the tools. Piloting the research tools was critical in order to:

- Identify barriers or aspects that may have limited potential participants' understandings;
- Ensure that the researcher was engaging with participants in a culturally appropriate manner;
- Reflect on the appropriateness of the length of the interview, especially in a phenomenological enquiry; and
- Alter the interview questions so that they were clear and concise (Kim, 2010).

The tools were pre-tested with five social workers who had left SAPS's employment. The researcher used snowball sampling in order to obtain the names of social workers who had previously been employed at SAPS. Furthermore, not using current employees in the pilot study, made it possible for all social workers employed at SAPS at the time of the study to participate in the research. Persons involved in the pilot study were excluded from participation in the final study.

After discussion with the first two participants in the pilot study two additional tools were added namely, the resilience tool and the work environment scale, as participants felt that it would not be too tiresome to complete these additional tools and these variables needed to be included in the analysis. The researcher then added these tools to the subsequent pilot studies which were conducted with three social workers. Each interview took approximately an hour and an half.

Table 7.6: Suggested Changes from the Pilot Study

Original statement	Revised statement
I find my work invigorating.	I find my work stimulating.
I take things in my stride.	I take things at my own pace.

7.7.2 Piloting the Interview Schedule in Phase Two

The qualitative interview schedule was piloted to ascertain the appropriateness and relevance of the questions. The need to pilot qualitative research tools is still not uniformly accepted as an essential requirement as some researchers argue that most qualitative designs use emergent designs, where data collection and analysis is subject to constant change. However, piloting qualitative studies has numerous advantages including highlighting ethical concerns as well as other practical aspects such as reviewing data collection procedures or accentuating any other aspects that could hinder the research process (Patton, 2002). It is possible that the use of pilot studies in qualitative studies is under-utilised and their importance not sufficiently discussed, as the tendency has been to assume that pilot studies are more in line with positivist approaches in research than naturalistic approaches (Sampson, 2004).

In order to avoid contamination, the interview schedule was tested on five social workers who had left the employment of SAPS. These social workers participated in the testing of research tools in the first phase of data collection. The piloting of the tool helped determine whether participants understood the questions and if such questions elicited the information that the researcher required to meet the aims of the study. No adjustments were made to the schedule.

7.8 THE RESEARCH PROCEDURE

The research procedure was conducted in the following sequence:

- Permission was firstly obtained from all the relevant authorities in SAPS in order to conduct the research. (This process took nine months, which is indicative of the bureaucratic environment of SAPS).
- Ethics Clearance was obtained from the university's Human Ethics Research Committee and approval was obtained from the Humanities Graduate Studies before the researcher embarked on the study (See Appendix C).
- The research tools and interview schedule were piloted with five social workers who were employed by SAPS but had subsequently left. These social workers provided the researcher with feedback about the clarity of questions and the language used. As a result of this feedback various changes were made to the questionnaires.
- The Head of Social Work Services, Director Stutterheim, informed all the sectional Social Work Heads that the researcher had obtained permission from SAPS management to conduct the research study.
- The researcher contacted each head of social work services in the different provinces and arranged a time to either attend a sectional meeting, where the researcher would be given time to invite members to participate, as well as to administer the questionnaires. Alternatively some sections held meetings solely for the purpose of the research and allowed the researcher to invite members to participate and to administer the questionnaires. Where the researcher could not be accommodated at a meeting, she couriered the questionnaires to the section head. Clear instructions about the research were included in the questionnaires and pre-paid self-addressed envelopes were provided so that members could post the completed questionnaire back to the researcher. This strategy was designed to protect participants' anonymity as the researcher was not using the SAPS structure to collect the data.
- At the meetings the researcher attended, she introduced herself and explained the purpose of her visit. A PowerPoint presentation was given demonstrating the nature and purpose of the research, explaining the research procedures as well as informing potential participants of their rights in the study. This presentation ensured that the same explanatory information was provided to all participants and that the research was uniformly conducted.

- If members agreed to participate the researcher handed them a questionnaire booklet. It should be noted that none of the social workers declined the invitation to participate.
- While participants filled in the questionnaire the researcher played calming classical music in the background to help members feel relaxed and able to focus on the task at hand.
- On average it took participants approximately an hour to complete the questionnaire booklet. The researcher was available to explain or elaborate upon any questions or any items that participants did not understand.
- Those who wished to receive feedback about the findings of the research were asked to complete the final section in the booklet that requested a physical address or email address. If participants wished to remain anonymous they could simply refer to themselves as 'the social worker'.
- Participants who were willing to participate in the second phase of the research were asked to write down their details on page two of the questionnaire booklet.
- The researcher then purposively selected 30 participants to participate in the second phase of the research.
- Thereafter, the researcher phoned these participants and arranged a suitable time to phone them for the qualitative interview.
- Suitable times were agreed upon and the researcher conducted the interviews using an interview schedule. The average time per interview was an hour.
- The interviews were then transcribed and analysed using thematic content analysis.
- Quantitative data were analysed using descriptive and inferential statistical procedures.
- Data were then presented in the form of tables and figures and illustrated with verbatim quotes.
- The final version of the study was presented in a thesis format.

7.9 DATA ANALYSIS

Various data analysis strategies were employed during the different phases of the study including the use of descriptive and inferential statistics as well as thematic content analysis and reflexivity.

7.9.1 Quantitative Data Analysis

7.9.1.1 Scoring

Data were elicited from each questionnaire and scored according to the various scoring guides. Specific scoring procedures for each questionnaire have already been elaborated upon in Section 7.6 under the explanation of the research tools.

7.9.1.2 Descriptive statistics

During the first stage of the study, the descriptive data were analysed via statistical procedures. The findings were presented through descriptive statistics whereby data were organised, summarized, described and presented as percentages; means (averages); measures of dispersal and measures of central tendency (McCall, 1990).

7.9.1.3 Inferential statistics

Inferential statistics were also utilised in order to relate variables and draw inferences from the sample to the population (Creswell, 2009). While there are numerous advantages in being able to utilise inferential statistics, Miles and Banyard (2007) identify various limitations with significance testing. Significance testing does not always reveal the exact nature of the exploration, yet it is always assumed that significance testing reveals what was under investigation. Furthermore, a finding that has statistical significance may indicate that the phenomena under examination exist, but an absence of a finding does not mean that they do not exist, but merely that they have not been discovered. Data were captured in Microsoft Excel and then transferred into two statistical software programmes for analysis. To ensure that appropriate statistical procedures were applied in this study, a statistician was consulted and the statistical programmes Statistical Analysis System (SAS) and Statistical Package for Social Sciences (SPSS) were utilised. Specific statistical procedures utilised involved a combination of Analysis of Variance (ANOVA); correlations, t-tests, chi-squared tests; and regression. Given the interval nature of the variables and the complex nature of the model, statistical analysis techniques utilised were firstly hierarchical multiple regression with moderation testing (Baron & Kenny, 1986) and secondly structural equation modelling. Data were analysed in SAS 9.4. Modules required included PROC CALIS, PROC REG, PROC UNIVARIATE, and PROC CORR.

- **Factor Structure and Aggregation of Multi-Item Constructs**

As discussed previously, all major constructs in the study are multi-item scales. This section discusses the specification and tests of factor structure. Traditional analysis of latent factors uses a *reflective* structure, that is, where the latent factor is specified as the 'cause' of the measured indicators. The logic of such a specification arises in the psychological tradition, which holds that the true measure of constructs such as satisfaction or personality is an underlying, latent construct which largely guides (causes) their manifestation in data such as answers to survey questions. In this traditional factor structure, manifest items must be highly correlated to indicate their congruent validity around a single latent factor. Some of the constructs in this thesis are specified as reflective, such as Vicarious Trauma, Burnout, and Compassion Satisfaction.

However, organisational measurement is increasingly adopting a *formative* view of some latent variables, that is, where the manifest indicators are specified as causes of the latent variable. Several

reviews have argued convincingly for this specification, which essentially suggests that the latent variable is formed by some combination of the inputs of the manifest variables (Bollen & Lennox, 1991; Diamantopoulos, Riefler & Roth, 2008; Diamantopoulos & Siguaw, 2006; Diamantopoulos & Winklhofer, 2001; Jarvis, MacKenzie & Podsakoff, 2003; Podsakoff, MacKenzie, Lee & Podsakoff, 2003; Ping, 2010; Treiblmaier, Bentler & Mair, 2011). In formative measurement, there is no particular expectation of high inter-item correlation, as individual items are contributing to the latent variable in an independent manner. In this thesis several of the constructs are approached from a formative perspective. These include:

- *Coping*: This factor is composed of items to do with cognitive, emotional, social, physical and spiritual coping resources. It seems unlikely that these are required to be consistent in score: one individual may have high social coping resources, for instance, but poor physical resources. The former would contribute to overall coping, the latter is likely to detract from overall coping. Therefore, coping was analysed as formative.
- *Resilience*: As described above, resilience is composed of sub-dimensions of self-reliance, aloneness, perseverance, equanimity and meaning. A similar argument for the formative nature of resilience is made to that of coping: it seems more likely that any combination may exist, each contributing to the overall score.
- *Work environment*: As discussed in the previous section, this factor is composed of various elements of the work environment, including supervisory and peer support, rewards, level of task-focus, autonomy, role clarity, and so forth. There is no reason to expect any given workplace to have consistent levels of these elements; there may be any combination, in which case the overall positivity of the work environment is likely to be a formative latent factor.
- *Traumatic stress*: The traumatic stress schedule is composed of many items with a yes/no answer scale to indicate exposure to certain stressful events. The total score is a sum of such exposure. This structure is formative, albeit one limited to expression through summation (Lee, 2015).

- **Multiple Regression Analysis**

In particular, the multivariate procedure employed was hierarchical multiple regression, which was used to study the complex phenomena under consideration and how they related to one another. As Tredoux, Pretorius and Steel (2006) explain, regression is a method that allows one to understand the separate and collective contributions of numerous independent variables to the variation of a dependent variable. Moreover, Punch (2014) explains that multiple correlations and regression have more than one independent variable and one dependent variable. The scores for the independent variables were obtained. These results were then used to determine how well the independent variable was able to predict the performance of the dependent variable. Firstly, this relationship was analysed using simple correlation and thereafter these findings were used to predict the scores on the dependent variable. These predicted scores were then compared with the actual dependent variable

scores. Multiple correlational analysis yielded two specific results: Firstly, the squared multiple correlation analysis was estimated. This estimate indicated the amount of variance in the dependent variable which was accounted for in the independent variables. Secondly, regression weights attached to each independent variable were estimated, indicating the percentage significance of each variable in predicting the dependent variable (Punch, 2014).

The majority of the analyses used SAS PROC REG. There are however two particular testing issues or statistics that are worth discussion. The first regards the form of the hierarchical regression used, which was hierarchical set regression (Cohen, Cohen, West & Aiken, 2003). Finally, when assessed, particular terms were added to assess the moderation hypotheses involved. At each stage in the hierarchical regression the change in R^2 was assessed for significance via the standard test as follows (Cohen et al., 2003, p. 171) where set b is added to set a:

Equation: Test for significance of change in R2

$$F = \frac{R^2_{ab} - R^2_a \big/ k_b}{\left(1 - R^2_{ab}\right) \big/ \left(n - k_a - k_b - 1\right)}$$ with degrees of freedom k_b and $(n - k_a - k_b - 1)$.

The adaptation of Fisher's protected t test for hierarchical set regression (Cohen et al., 2003, pp. 187-190) was adopted to control for Type II error. This procedure requires that generally the significance of the parameter estimates should only be considered if the set to which they belong adds significantly to R^2. Tests of moderation roles typically involve testing product terms in the relationships (Baron & Kenny, 1986; Cohen et al., 2003; James & Brett, 1984). Therefore this approach was taken, in which products of the proposed moderator and the predictor(s) are tested for significance. Moderation requires centered predictors in most cases (Lee, 2015).

- **Structural Equation Modeling Analysis**

Structural equation modeling (SEM) is a unified approach which incorporates numerous approaches including multiple regression analysis and analysis of covariance structure. According to Tredoux et al. (2006) SEM techniques can be considered a unified approach for the following reasons: SEM estimates multiple relationships and interrelates dependence relationships; this approach also represents unobserved factors in the models; and accounts for measurement error in the estimation process.

SEM is considered to be more of a confirmatory than an exploratory procedure, in that models that are constructed by the researcher are then tested with measures of the degree to which the data fit the models. Therefore SEM can be used to investigate possible causal relationships between independent and dependent variables, but it cannot sustain causal conclusions or resolve causal ambiguities (Tredoux et al., 2006).

There are two critical steps in the SEM process: firstly, the researcher needs to specify and validate the measurement model through confirmatory factor analysis. This model is built upon the researcher's hypotheses which are then expressed in the form of a structural equation model (Kline, 2010) (Figure 7.2). Secondly, the researcher needs to fit the structural model, which is accomplished primarily through path analysis with latent variables.

Several methods of Goodness of Fit were addressed. These include the Goodness-of-Fit Index (GFI) – which measures the amount of observed variance and covariance accounted for by the model, Normed Fit Index (NFI), Comparative Fit Index (CFI) – which compares the fit of a baseline model to the model (Kline, 2010) and the Root Mean Square Error of Approximation (RMSEA) – which is a measure of discrepancy per degree of freedom and incorporates the error of approximation in the population. If the model is a good fit of the data then the next step is interpretation. Causality in SEM is hypothesized by the researcher and not from the statistical test of the model (Kline, 2010). The SEM models were performed using maximum likelihood estimation in SAS PROC CALIS.

- **SEM goodness of fit tests**

An integral part of CFA as well as all other SEM analyses is goodness of fit testing. As with standard regression, the basic measure of association between variables is the covariance (although mean structures and other refinements are now commonly included), and the dynamics of actually fitting SEM models involve covariance structure modelling. The challenge in a SEM structure is therefore to fit the specified equations from those that calculate the best implied covariance matrix $\hat{\Sigma}(\Theta)$ between the observed variables, and compare this for close fit to the sample covariance matrix S (Bollen, 1989). Model respecifications would seek to minimise differences between $\hat{\Sigma}(\Theta)$ and S.

The most basic test is a test for the rejection of bad fit based on the asymptotically chi-square distributed statistic nF_{ml} where n is sample size and F_{ml} refers to the maximum likelihood fit estimator (Bollen, 1989). However, this test is in practice often ignored since it is directly based on sample size, thus indicating significant deviations from good fit based on sample alone. This dichotomy has led to a large body of work on fit estimators of varied types, which has rapidly advanced covariance structure theory (Boomsma, 2000; McDonald & Ho, 2002). These fit tests include:

1) Global fit tests based on fit between the residual matrices, notably:
    a) The Root Mean Square Error of Approximation (RMSEA), for which scores <.05-.08 are often seen as good fit (Browne & Cudek, 1993; Raykov & Marcoulidis, 2000; Steiger, 1990). It is amenable to estimation of a 90% confidence interval where researchers generally look for lower bounds < .05 and higher <.10; and

b) The Standardised Root Mean Square Residual (SRMSR; Kline, 2010), the normalised square root of average squared differences between $\hat{\Sigma}(\Theta)$ and **S**, where <.05 is often seen as acceptable.

2) Global tests of the current model compared to a 'null' or 'baseline' model that is the worst possible fit (e.g. $\hat{\Sigma}(\Theta)$ = I). There are a large number of such tests. Several of these are robust for sample size, notably:
   a) Bentler Comparative Fit Index (CFI) (Bentler, 1990), for which scores >.90-.95 indicate good fit;
   b) Tucker Lewis Index (TLI) / Non-Normed Fit Index (NNFI) (Bentler & Bonnett, 1980), again >.90-.95 is good;
   c) Model comparisons (also called predictive fit indices). These include the following:
   d) A test for comparison of nested models, most commonly involving a test of the difference in chi-squares; and
   e) Information criteria also exist, including the Akaike Information Criterion (AIC), Schwartz Bayesian Criterion (SBC) and Bozdogen Consistent AIC (CAIC). These penalise more complex models and can be used to compare non-nested models. Smaller scores are superior.
3) Local fit statistics indicating portions of the model which may contribute particularly to poor or good fit:
   a) Raw residuals which indicate fit between specific variable covariances. These are often standardised to aid in interpretation, so that residuals larger than 2-3 may indicate misspecification;
   b) Lagrange multipliers for the significance of the improvement in Chi-Square if a parameter is added (Kaplan, 2000); and
   c) Wald tests for the significance of worsened Chi-square when a parameter is restricted to zero (Kaplan, 2000).

Researchers generally report a range of these fit indices, allowing for wide evidence on fit. The rapid development of these indices has added the advantage of broad interpretability to model fitting and comparison. Paths in the structural equation models are treated as regression paths, and come in standardised beta format (β), which can be read as correlations (Lee, 2015).

- **Analysis and Inclusion of the Formative Latent Measures**

Several of the factors in the study are specified as formative, including work environment, coping, resilience, and traumatic stress. While traumatic stress is created through simple summation of binary answer items, the other formative scales are on finer measurement scales and are amenable to factor analysis-type formation.

Perhaps most commonly, formative latent variables are assessed through partial least squares (Sawatsky, Clyde, & Meek, 2015), which then may also facilitate analysis of the overall path structure between latent variables. However, this methodology then severely limits the overall modelling capability. Path analysis does not facilitate a mix of reflective and formative latent factors well, and does not enjoy the same range of fit analysis as normal theory SEM.

Formative factor fit is therefore assessed here through maximum likelihood structural equation framework. Jarvis et al. (2003) suggest that to be identified in a SEM model, formative constructs can be assessed in a SEM as long as each formative latent factor is an inferred cause of two or more reflective variables, which may be either latent or manifest. This one has generally been the approach taken in SEM implementations of formative factors. However, this approach has several limitations, most notably confused meaning of the resulting factors (Treiblmaier, Bentler & Mair, 2011).

Accordingly, the solution suggested by Treiblmaier et al. (2011) was used, in terms of which an initial methodology is used to form items into formative sets (they suggest several methods including canonical correlations, principal components and others), and a secondary confirmatory factor analysis portion loads these sets as reflective. Canonical correlations are used as the grouping mechanism, as represented in Figure 7.3 for only two of the formative factors.

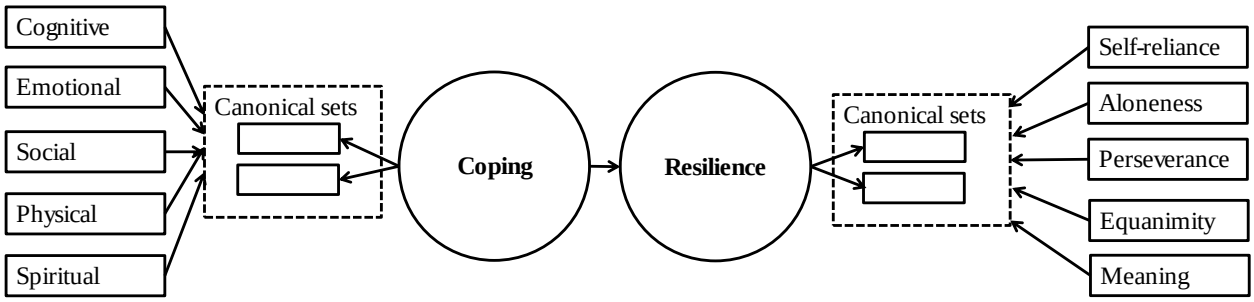


Figure 7.2: Representation of Formative-Type Structure Used in Thesis

Having established the formative constructs, an overall confirmatory factor structure can be formed from a combination of the formative and reflective structures. It can be noted from the above discussion that the manifest items in the factor analysis are usually the first-order sub-factors of each scale. As an illustration, coping's indicators in Figure 7.3 are the first-order sub-dimensions of cognitive resources, emotional resources, and the like. Each of these sub-dimensions is in turn formed from individual items. This specification is necessary due to the constrained sample size (N =128), which would not allow full second-order factor analysis in which the several hundred individual questions loaded. For identification reasons, the reduced sub-dimensions must be formed. However, these sub-dimensions are assessed for internal reliability beforehand using Cronbach alphas, and formed through averaging (except in the case of individual items comprising binary yes/no answers, in which case the sum is used).

- **Moderation and Mediation**

The approach to investigate the moderation and mediation effects followed the classic Baron and Kenny's (1986) approach, in terms of which predictors are centred and interaction term composed of the product of the independent variable and moderator are created and added to the other predictors.

Baron and Kenny (1986, p. 1174) explain what moderation variables are in the following quotation: "In general terms, a moderator is a qualitative (e.g., sex, race, class) or quantitative (e.g., level of reward) variable that affects the direction and/or strength of the relation between an independent or predictor variable and a dependent or criterion variable. Specifically within a correlational analysis framework, a moderator is a third variable that affects the zero-order correlation between two other variables. In the more familiar analysis of variance (ANOVA) terms, a basic moderator effect can be represented as an interaction between a focal independent variable and a factor that specifies the appropriate conditions for its operation". Furthermore, Baron and Kenny's (1986, p. 1176) explanation of mediating variable is as follows, "In general, a given variable may be said to function as a mediator to the extent that it accounts for the relation between the predictor and the criterion. Mediators explain how external physical events take on internal psychological significance. Whereas moderator variables specify when certain effects will hold, mediators speak to how or why such effects occur".

7.9.2 Qualitative Data Analysis

7.9.2.1 Thematic content analysis

During the second stage of the study the researcher analysed the qualitative data using thematic content analysis. Through this form of analysis data were categorised according to themes as the researcher, categorised respondents' accounts of their experiences. According to Green and Thorogood (2009), thematic content analysis is a comparative process, in which the researcher compares transcripts in order to identify themes that are prevalent. Terre Blanche, Durrheim and Kelly (2006) identify the following steps in qualitative data analysis, namely, familiarisation and immersion, inducing themes; coding; elaboration; and interpretation and checking. These steps are explained as follows:

(i) *Familiarisation and immersion* - During this initial stage the researcher needed to collate all the material (raw data: interview transcripts and field notes) and familiarize herself with the texts. She also needed to immerse herself in the data, make notes, brainstorm and begin to develop a preliminary understanding of the meaning of such data;

(ii) *Inducing themes* - The second phase required the researcher to identify themes and categories emerging from the data. During this stage the researcher identified themes and sub-themes accordingly;

(iii) *Coding* - This process entailed the researcher assigning phrases, texts and sentences to the various categories and themes that were identified. Henning et al. (2004) identify three types of coding,

namely, open coding, axial coding and selective coding. These are similar to the Terre Blanche et al's (2006) last three stages as mentioned previously. Open coding breaks data down into concepts and categories. Data are then compared and similar phrases are grouped together under a conceptual label. Categorising occurs when concepts are grouped at a higher more abstract level. Axial or theoretical coding requires the researcher to make new connections between the categories and codes that were identified in the open coding. The analysis at this stage occurs on two levels namely, the actual words used by respondents and the researcher conceptualises these words. In selective coding one main core category is identified and the other categories are related to it. During this process categories are integrated and refined;

(iv) *Elaboration* - In the elaboration phase the researcher explored the similarities and differences in responses listed under the various categories. Elaboration refers to the exploration and analysis of themes in more detail. In this stage the researcher tried to capture the finer nuances of meaning; and

(v) *Interpretation and checking* - In the final stage the interpretation was assembled and presented. The data were presented according to the themes and sub-themes identified. Further scrutiny of the data ensured that there were no inherent flaws or contradictions (Terre Blanche et al., 2006).

While thematic content analysis can be simple or sophisticated, this study incorporated the latter approach as the analysis moved beyond simply identifying themes and illustrating themes with quotations, to assessing how the codes related to each other (Green & Thorogood, 2009).

The researcher utilised a computer-assisted qualitative data management and analysis software package, Atlas.ti. This software does not analyse the data but assisted with data storage, coding and retrieval of data. As Patton (2002) points out, computer programmes can facilitate the analysis of qualitative data; however, they cannot provide the creativity, intellectual discipline and analytical rigour which are required. Essentially the researcher still has a fundamental role to fulfill in the qualitative analysis process.

In order to increase the depth of data analysis the researcher adhered to the guidelines that Green and Thorogood (2009, p. 224) identify. These included the following: The researcher *read extensively and discussed the topic widely* and attended two international conferences addressing trauma and coping, respectively. The data were assessed in terms of the historical, political, social and cultural contexts as the *context of the data* needed to be considered. This aspect was particularly relevant when assessing the findings in terms of racial classifications, considering South Africa's historical past. In addition, the researcher immersed herself in the theoretical debates revolving around trauma, evident in the literature and constantly *reviewing the theoretical assumptions embedded in the research question.* Furthermore, the researcher also *interrogated her findings with other colleagues* as

she was in the fortunate position of being employed as a lecturer at a university at the time of conducting her study and was therefore able to discuss her findings with other academics.

7.10 RELIABILITY AND VALIDITY OF THE QUANTITATIVE DATA

7.10.1 Reliability

Reliability refers to the degree of accuracy or precision of the measuring instrument (Grinnell & Unrau, 2011) or how consistently a test measures what it is supposed to measure (Huysamen, 1990). In accordance with Rubin and Babbie's (2013) recommendations for maximizing reliability, the researcher clearly defined the constructs that were measured (secondary traumatic stress, vicarious traumatisation, compassion satisfaction, burnout, coping resources, resilience and the work environment). Furthermore, the administration of the tools was conducted in a standardised manner. The researcher showed all participants at the group meeting the same presentation; all the information conveyed on this occasion was exactly the same as that conveyed by means of the information sheet for those who received the postal questionnaires. The representative sample utilised for the quantitative phase of data collection suggested that the findings could be generalized or transferred to the broader population of social workers employed by SAPS.

7.10.2 Validity

Validity addresses numerous aspects including the degree to which a research tool measures what it is supposed to measure (the internal validity) and how generalisable these results are beyond a particular study (the external validity) (Grinnell & Unrau, 2011).

7.10.2.1 Content validity

This aspect is concerned with the representativeness of the content of an instrument. This type of validity asks whether the instrument really measures the concept that it purports to measure and whether there is an adequate sample of items in the research tool to measure the concept (Delport, 2011). Each research tool contained a broad range of questions that tapped the relevant construct, thereby contributing to the content validity of the tools.

7.10.2.2 Face validity

Face validity addresses the face value of what the tool appears to measure. Despite the fact that some may claim that face validity is not a form of validation, Delport (2011) mentions how important face validity is, as without it participants would be unlikely to complete questionnaires. The questionnaires appeared to have face validity as an independent researcher was able to see the linkage between the research aims and constructs to be measured.

Other types of validity such as convergent validity, discriminant validity and factorial validity were considered in relation to the specific scales discussed under 7.4.

7.11 ENHANCING TRUSTWORTHINESS OF THE QUALITATIVE DATA

Lincoln and Guba (1985) identify four concepts that help to establish the trustworthiness of qualitative research. These include credibility, transferability, dependability and confirmability. In addition, other researchers (Green & Thorogood, 2009) have included rigour as an essential concept, adding credibility to qualitative analysis. Each of these concepts is discussed and an explanation provided regarding the procedures used in the research study application.

7.11.1 Credibility

Credibility refers to the truthfulness and believability of the findings and implies that the inquiry was conducted in a sound manner, and that the subject under study was clearly identified and accurately described (Marshall & Rossmann, 1995). Lincoln and Guba (1985) identify numerous techniques that contribute towards the credibility of research. These include, amongst other aspects, triangulation and member checking. Respondent checking or member validation/checking involves taking the findings back to participants and ensuring that they agree, with the aim of achieving an emic or insider understanding (Buchbinder, 2010). While there are numerous advantages to this approach, Green and Thorogood (2009) question if respondent checking really enhances validity, as there is no reason to presume that participants would analyse their own accounts in the same manner as the researcher would. For this reason, the researcher decided not to incorporate this aspect into the research process. As previously mentioned, triangulation was employed. In order to enhance credibility the researcher described the setting, the population and theoretical framework thereby placing boundaries around the study. She also employed triangulation in the design of the study.

7.11.2 Transferability

Transferability refers to the applicability or generalisability of one set of findings to another context. In order to strengthen generalisability, Marshall and Rossmann (1995) recommend that the researcher refer to original theoretical frameworks to show how models and concepts set guidelines for data collection and analysis. The literature framework of this study therefore guided the researcher in formulating the research design and selecting and constructing the research tools. Moreover, the literature framework guided the researcher during the data analysis phase. The representative sample utilised for the quantitative phase of data collection suggested that the findings could be generalized or transferred to the broader population of social workers employed by SAPS. However, the small non probability sample recruited for the qualitative phase, precluded generalisations of the findings – although generalisation is usually not an issue in qualitative research. In order to ensure the transferability of recommendations, the researcher highlighted several recommendations which were

context specific and others that could be applied to a wider context, i.e. social workers employed in a trauma field.

7.11.3 Dependability

Dependability refers to the researcher's attempts to explain changing conditions in the phenomena under study as changes in the design occur, and is equivalent to the positivist construct of reliability. Lincoln and Guba (1985) maintain that one of the strategies to enhance dependability is through the use of an audit trail. Accordingly the researcher kept an audit trail of the research process. Efforts were made to enhance dependability by posing the same questions to all participants.

The reliability of qualitative data is strengthened if many interviews are conducted by the same researcher with various participants, as a shared understanding of different subjects can be achieved (Henning et al., 2004). For this reason the researcher personally interviewed 30 social workers regarding their experiences of secondary trauma. Internal consistency reliability as measured by Cronbach Alpha test-retest reliability; and predictive validity are discussed in relation to specific scales described under 7.6.

7.11.4 Confirmability

Lincoln and Guba (1985) explain that confirmability refers to the positivist notion of objectivity which is enhanced through the use of an audit trail, triangulation, peer debriefing and correspondence checking. The researcher specifically maintained an audit trail (see Apprendix D), used data triangulation and correspondence checking. Correspondence checking entails the use of additional researcher/s or colleagues who analyse the data independently from the researcher. Both sets of analyses are then compared in order to check for similarities and differences; this process enhances the confirmability of the data (Townsend & De La Rey, 2008).

7.11.5 Rigour

Rigour refers to methodological thoroughness and the criteria used to judge the trustworthiness of the results (Armour, Rivaux & Bell, 2009).

In order to enhance credibility of the data analysis, Green and Thorogood (2009, p. 219) identified five fundamental aspects that need to be incorporated in the research process. These aspects are identified and explained in the first two columns of Table 7.7. An explanation as to how these aspects were addressed in this study is provided in the last column. The researcher paid particular attention to methodological stringency and accuracy of the results in order to enhance the rigour of the data (Armour et al., 2009).

Table 7.7: The Five Fundamental Aspects of Data Analysis

Criteria	Possible methods	Application to this study
Transparency	Provide a clear account of procedures used. Keep an 'audit trail' that others could follow	**A clear account of research procedures used in this study is provided in this chapter under Section 8.** **Audit Trail is included in Appendix D.**
Maximising of validity	Provide evidence from the data for each interpretation made Analysis of deviant cases and disconfirming data including enough context for the reader to judge interpretation	**Interviews were recorded and transcribed word for word, and is portrayed in verbatim quotes.** **Disconfirming data are highlighted and discussed in Part Five.** **The context of the research is explained in Part Three of the thesis.**
Maximising of reliability	Comprehensive analysis of the whole data set Using more than one analyst/ coder Compare findings to other studies	**The entire data set was analysed.** **A second researcher cross checked the coding.** **Findings were compared to results from other studies.**
Comparison	Compare data between and within cases in the data set Compare findings to other studies	**The researcher assessed and compared data from the different participants.** **Findings were compared to results from other studies.**
Reflexivity	**Account for the role of the researcher in the research**	**As explained in Section 7.5.6, incorporating reflexivity was an important aspect of the qualitative data analysis.**

7.12 ETHICAL CONSIDERATIONS

Research ethics should be an integral part of each phase of the research process. Not only should research ethics empower participants, it should benefit participants. Furthermore, ethical research requires that the researcher is technically competent (Burke, 2007). The following aspects were considered and addressed in order to ensure the ethical aspects of this study:

7.12.1 Informed Consent

The researcher needed to ensure that informed consent was obtained from all participants. In accordance with recommendations by Payne and Payne (2004), potential participants were informed about the purpose of the study. The research procedures as well as any risks and benefits that participants might incur were explained. Participants gave their consent willingly and were assured that there would be no negative consequences if they declined to participate. Participants were allowed to refrain from answering any questions they did not wish to answer; and participants could withdraw from the study at any time without prejudice.

The researcher incorporated these aspects in the Participant Information Sheet. Through the process of filling in and handing in the questionnaire, participants gave their consent. If participants were willing to participate in the second phase of the study, they were asked to indicate this willingness by completing the written consent form (See Appendix A).

7.12.2 Confidentiality and Privacy

The informed consent form specified the limits of confidentiality. Durrheim and Wassenaar (1999, p.68) stipulate that in order to respect confidentiality, "participants should be informed of how the data will be recorded, stored and processed for release". In order to respect confidentiality the personal identities of participants were concealed. Raw data were stored in a secure place and will be kept for two years following any publications and for five years if no publications emanated from the study. Anonymity was ensured in the first phase of the research as no names were required, unless participants indicated their willingness to participate in the second phase, in which case anonymity could not be guaranteed. In the second stage of the research anonymity could also not be guaranteed as the researcher conducted the interviews with those participants who had indicated their willingness to participate. However, the data did not reflect the names or specific identifying information of the participants. Instead codes were assigned to ensure confidentiality. Participants were also assured that individual responses would not be shared with management and that no identifying details would be included in the thesis.

7.12.3 Avoidance of Harm or Non-maleficence

Participants were assured that no harm would come to them as a result of participating in this study. In addition, participants were informed of any potential risks of the study so that they could decline participation. As the study addressed potentially sensitive issues, including vicarious trauma, it was considered important that participants be offered professional counselling and debriefing should they require such intervention following the interview. For this purpose the researcher arranged for participants to be provided with the name of a professional social worker, who had agreed to offer debriefing services free-of-charge for this study. However, no one made use of this offer.

7.12.4 Deception

All efforts were undertaken to ensure that participants were not deceived or misled in any manner. The researcher paid particular attention to the verbal and written instructions given and did not attempt to withhold any information or present false information in order to encourage the social workers to participate in the research (Strydom, 2011).

7.12.5 Coercion and Perverse Incentives

The participants were not coerced into participating in the study. The researcher emphasised to management that staff were not to be coerced into participating in the research. Moreover, no inappropriate or perverse incentives were offered to participants.

7.12.6 Researcher's Competence and Actions

Researchers need to ensure that they are competent and sufficiently skilled to undertake a study and that they receive the appropriate supervision of a research project. The researcher was a qualified social worker who had previously worked in the field of trauma counselling for twelve years. Durrheim and Wassenaar (1999) emphasise that competence is also enhanced by using instruments that are reliable, valid and current. The researcher therefore selected current standardised tools to measure the various variables.

7.12.7 Approval of the Study by Institutional Ethics Committee

In order to ensure that the study was non-discriminatory and protected the human rights of the research participants the research proposal was submitted to the Non–Medical Human Research Ethics Committee of the Faculty of Humanities at the University of the Witwatersrand and was approved (See Appendix C for Ethics Clearance Certificate).

7.12.8 Publication of Findings and Feedback Given to Participants

The researcher informed participants that she intended publishing the findings of the study in one or more articles in a professional journal. Confidentiality needed to be considered and for this reason, only anonymous quotations and group information were included in the findings. In accordance with ethical guidelines, if any publications emanate from this study the data will be kept for two years following publication. If there are no publications raw data will be kept for five years after completion of the study. Preliminary findings were presented to members of the SAPS at an annual conference held in Limpopo.

The researcher indicated that all social workers who participated in the study and who wished to receive feedback would receive an emailed or posted summary of the findings of the research upon completion of the research. Emanual, Wendler and Grady (2000) maintain that as part of respect for participants, participants must be informed of the results of the research. For this reason participants were asked in the questionnaire booklet if they wished to receive feedback and if they replied in the affirmative, participants needed to supply an address (either postal or electronic) to which such the information could be forwarded. If they wished to remain anonymous and writing their name on the

questionnaire would jeopardise their anonymity, participants simply needed to indicate that the correspondence needed to be sent to 'the social worker' at a particular address.

7.13 CONCLUSION

The research process is seldom one of a clear systematic progression, from start to finish, as Bak (2004) believes that the research process often doubles back on itself, goes sideways, surges ahead but eventually does reach completion. This process was reflected in the research design as the design was emergent and what was initially planned frequently had to be altered or expanded (i.e. more research instruments were added). This chapter discussed the final aspects comprising both the research design and research methodology. In order to obtain a more thorough and holistic response to the research question, a triangulated approach incorporating both qualitative and quantitative designs was selected. Strengths and limitations of this approach were highlighted as well as the steps taken to ameliorate the limitations. Ethical principles that underpinned the study were also explained. This chapter forms the backdrop to Part Five which focuses on the presentation and discussion of findings emanating from the study.

PART FIVE

THE FINDINGS AND DISCUSSION SECTION

CHAPTER EIGHT

FINDINGS AND DISCUSSION I

TRAUMA EXPOSURE AND SECONDARY TRAUMATIC STRESS

"There are wounds that never show on the body that are deeper and more hurtful than anything that bleeds". ***Laurell K. Hamilton, Mistral's Kiss***

8.1 INTRODUCTION

In the social sciences, mixed methods designs have become increasingly popular as the benefits of combining qualitative and quantitative paradigms have been increasingly acknowledged. Barnes (2012) argues that mixed methods research has a transformative function to fulfil in South African research as local theory, instruments and interventions can be explored and expanded upon. The concurrent triangulation approach is particularly useful as this model aims to compensate for the weaknesses of the one approach through the use of another approach while simultaneously adding to the strength of the other approach. Figure 8.1 is adapted from Creswell's (2009, p.210) diagrammatic concurrent triangulation design. In the present study, quantitative and qualitative data were separately collected and then analysed. The data results were then compared and contrasted with each other.

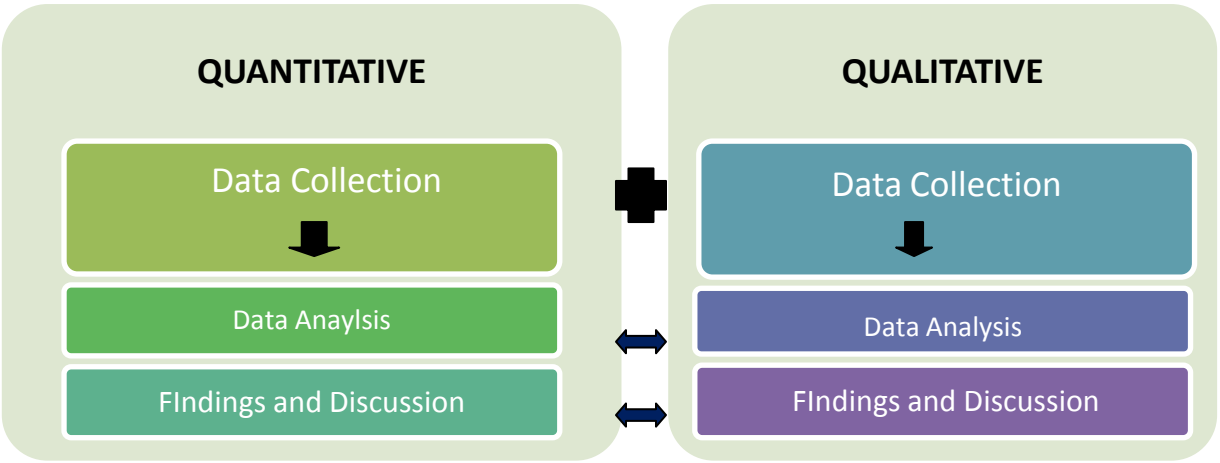


Figure 8.1: Diagrammatic Representation of the Concurrent Triangulation Design

Part five of this thesis, the findings and discussion section, is comprised of four chapters. In the first chapter, the demographics of participants are presented as well as the results for the first two qualitative and quantitative objectives of the research. In the second chapter, the results in respect of objectives three to seven (quantitative and qualitative) are discussed; in chapter three, objectives

eight and nine (quantitative and qualitative) are analysed as well as objectives nine and ten of the qualitative section. In chapter four findings from the nineth quantitative objective are presented. Both the qualitative and quantitative data are presented around the particular aims and objectives of the study. Despite the mixed-methods process being criticised as time consuming, analysing and discussing data this way has numerous advantages in that it can result in what Creswell (2009, p. 215) describes as "well-validated and substantiated findings". The results of each scale are presented and then followed by qualitative quotes in order to enrich the discussion of the findings. Limitations are also acknowledged and discussed where appropriate.

8.2 DEMOGRAPHIC PROFILE OF PARTICIPANTS

8.2.1 Areas of Social Work, Race and Gender of Survey Participants

Table 8.1: Demographic Information on the Survey Participants (N=128)

Demographic		N	%
Area of Social Work	**Forensic**	26	20.31
	Occupational	102	79.69
Rank	**Warrant Officer**	48	37.50
	Captain	67	52.34
	Lieutenant Colonel	13	10.16
Race Group	**Black**	80	62.5
	Coloured	18	14.06
	Indian	2	1.56
	White	28	21.88
Gender	**Male**	13	10.17
	Female	115	89.84
Geographical Area	**Head Office**	7	5.47
	Gauteng	40	31.25
	Free State	8	6.25
	Limpopo	15	11.72
	Mpumalanga	10	7.81
	Northern Cape	7	5.46
	Eastern Cape	1	0.78
	Kwa-Zulu Natal	9	7.03
	Western Cape	17	13.39
	North West	14	10.92

Table 8.1 contains a summary of the demographic information in respect of the survey participants, while demographic variables are explored and discussed in more detail in the sections that follow. Figure 8.2 shows the demographic breakdown of the survey participants clearly depicting that there were significantly more occupational social workers (OSWs) (102 or 79.69%) than forensic social

workers (FSWs) (26 or 20.31%) employed at SAPS at the time of the study. In keeping with the feminisation of the social work profession in South Africa (Khunou, Pillay & Nethononda, 2012), there were considerably more female social workers (115 or 89.84%) than male social workers (13 or 10.17%). OSWs at SAPS assist the police officers whereas FSWs investigate child abuse cases reported to the police (Stutterheim & Weyers, 1999). There were no male forensic social workers; all the male social workers were occupational social workers. Traditionally social work has been a female dominated profession, especially in areas of work involving children and this feminisation is reflected in the sample in that there were no male forensic social workers in the study (Mafokane, 2003; Sithole, 2010).

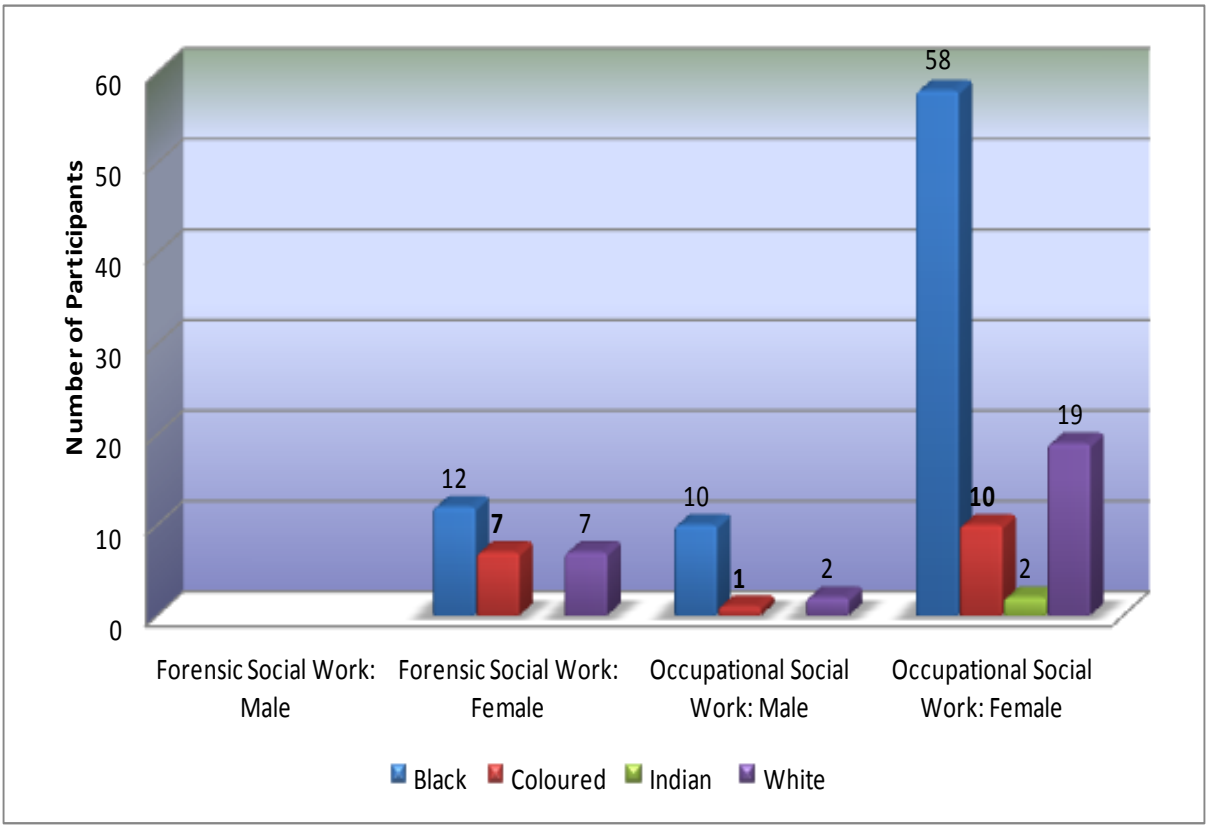


Figure 8.2: Area of Social Work, Sex and Race of Participants (N=128)

The racial distribution of the participants was as follows: the majority (80 or 62.5%) were Black, followed by 28 or (21.88 %) White, 18 Coloured[4] (14.06%) and 2 Indian (1.56%). In the national census conducted in 2015, the South African population was made up of 80.5% Black Africans, 8.8 Coloureds, 8.3% Whites and 2.5% Indian/Asian (Statistics South Africa, 2015)[5]. While the racial breakdown of the study sample was not representative of the South African population it may have been more proportionally reflective of the social workers employed at SAPS as well as the SAPS employee

[4] Meyer (2014, p. 161) explains that "'Coloured people' refer to the descendants of the Malaysian slaves in South Africa (forced migration by the Dutch East India Company) who inter-married with White farmers and local Khoi people".

[5] South African organisations are expected are expected to categorise people according to these racial groups so that the government can monitor transformation.

population. A limitation of the study was that at the time of conducting the research SAPS Head Office was not able to provide the researcher with the exact number of social workers in their employ.

8.2.2 Age Distribution, Marital Status and Family Composition of Participants

The age distribution ranged from 25 to 58 years. The majority of participants (90 or 70.31%) were between 30 and 39 years of age. More than a fifth (26 or 20.31%) of participants were aged between 40 and 49. Nine (7.03%) were between 20-29 years of age and only three participants were above the age of 50 (2.34%). The average age (mean) was 36.6 years, while the modal age for woman was 37 and for men 36. While the majority of participants were married or cohabiting (76 or 59.38%), a large proportion (52 or 40.63%) were divorced or single. However, it is not clear whether the stressful nature of police work had any impact on relationships with partners. The number of children that participants had totalled 103, with the mode being two. Thirty participants (23.44%) did not have any children, which shows that the majority (98 or 76.56%) were working parents and had to balance the demands of employment as a social worker with child rearing. Over the last few decades there has been a plethora of work and family studies on the 'spillover' between the workplace and home. The spillover model highlights the manner in which the work arena either facilitates or impedes people's ability to fulfil their responsibilities at home (Secret & Sprang, 2008). For employees with young children, demanding jobs such as those held by social workers in SAPS, may reduce the amount of time spent with their children.

What is apparent is that participants were in various stages of the life cycle as depicted by the variation in ages and family composition. Some were in the beginning of their working careers, while others were approaching retirement. According to Havighurst's (1964) model of career stages and tasks, the majority of participants (118 or 92.19%) were in the establishment phases of their careers which usually occur between 25 to 44 years of age. Key characteristics of this stage include the establishment of a more stable job or career, being productive and maintaining income, lifestyle and social roles (Bergh & Theron, 2009).

8.2.3 Participants' Ranks[6] and Geographical Location

Most of the participants held the rank of captain (67 or 52.34%), followed by warrant officer (48 or 37.50%) and then lieutenant colonel (13 or 10.16%). While there are specific ranks and designations assigned to the social workers in the SAPS, some participants felt that the job requirements of the

[6] The ranks within SAPS commissioned officers are in descending order as follows: Colonel, Lieutenant Colonel*, Major, Captain*, and Lieutenant. The ranks of the non-commissioned officers are as follows: Warrant Officer*, Sergeant and Constable. (*Indicates the ranks at which social workers are appointed within SAPS).

warrant officer and captain ranks did not always differ significantly, although the status and salary are differentiated.

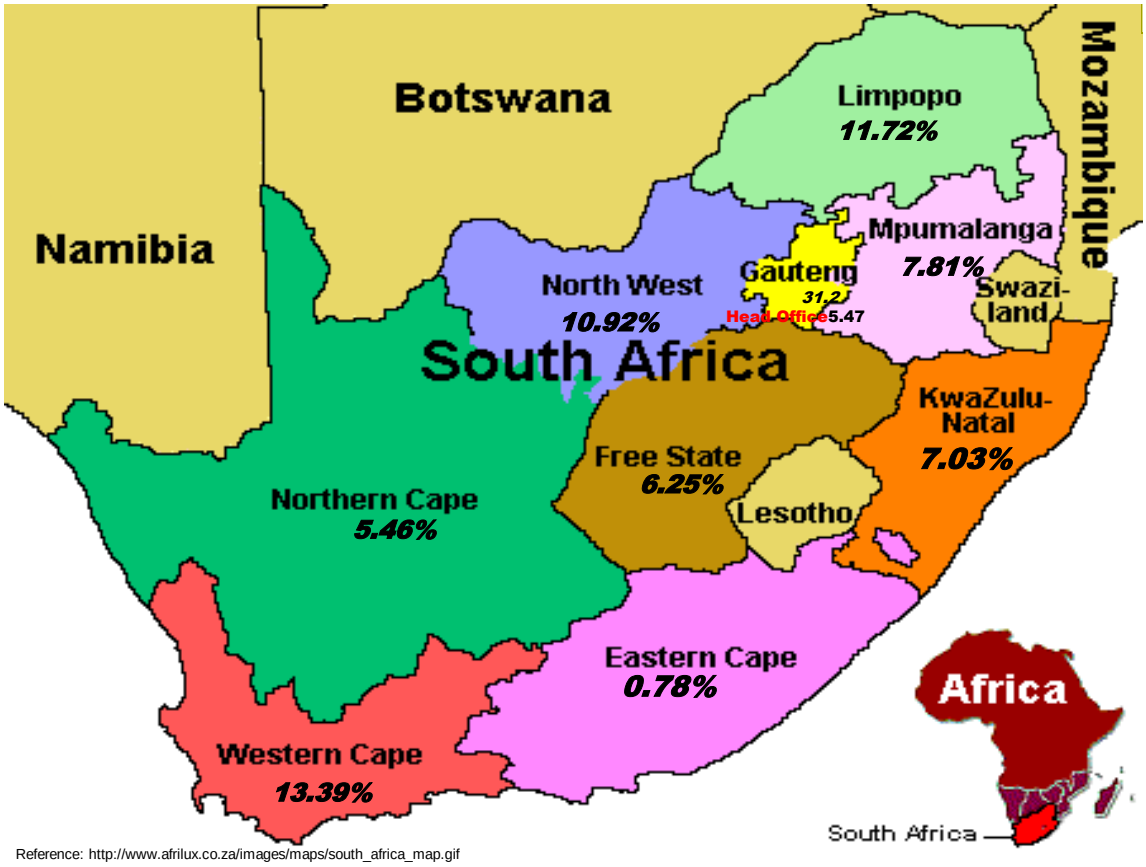


Figure 8.3: Map of South Africa Depicting Participants' Geographical Location (N=128)

Figure 8.3 shows that the majority of participants were from Gauteng (40 or 31.25%); followed by the Western Cape (17 or 13.39%); Limpopo (15 or 11.72%); North West (14 or 10.92%); Mpumalanga (10 or 7.81%); Kwa-Zulu Natal (9 or 7.03%); Free State (8 or 6.25%); Head Office in Pretoria (7 or 5.47%); Northern Cape (7 or 5.46%); and Eastern Cape (1 or 0.78%). As the researcher was unable to personally distribute questionnaires in all the rural areas due to the vast geographical expanse of South Africa, this factor may have influenced participation levels from the more rural areas, such as the Eastern Cape. However, the researcher endeavoured to overcome this limitation by posting questionnaires to the social workers in the rural areas.

Most of the participants (78 or 60.93%) were employed in urban areas; more than a quarter (35 or 27.34%) worked in peri-urban areas; and the remainder (15 or 11.72%) were located in rural areas. According to a recent survey conducted by the South African Institute of Race Relations, more than two-thirds of the South African population live in urban areas and there has been a significant decline in the number of people living in rural areas (South African Institute of Race Relations, 2013). SAPS would therefore have more social workers employed in urban areas in order to compliment the

number of police officers employed in the urban areas, as the potential for crimes in the urban areas would be higher.

8.2.4 Educational Qualifications and Previous Social Work Experience

All the social workers had obtained either a three or four year social work degree. In the past social workers only had to complete a three year degree to be registered with the South African Council for Social Service Professions (SACSSP); however this requirement was changed in the 1980s to a four year degree. Only 20 (15.62%) participants had completed additional postgraduate qualifications, including: Masters in Social Work (16); Honours in Psychology (3) and Honours in Sociology (1). Four participants did not answer this question.

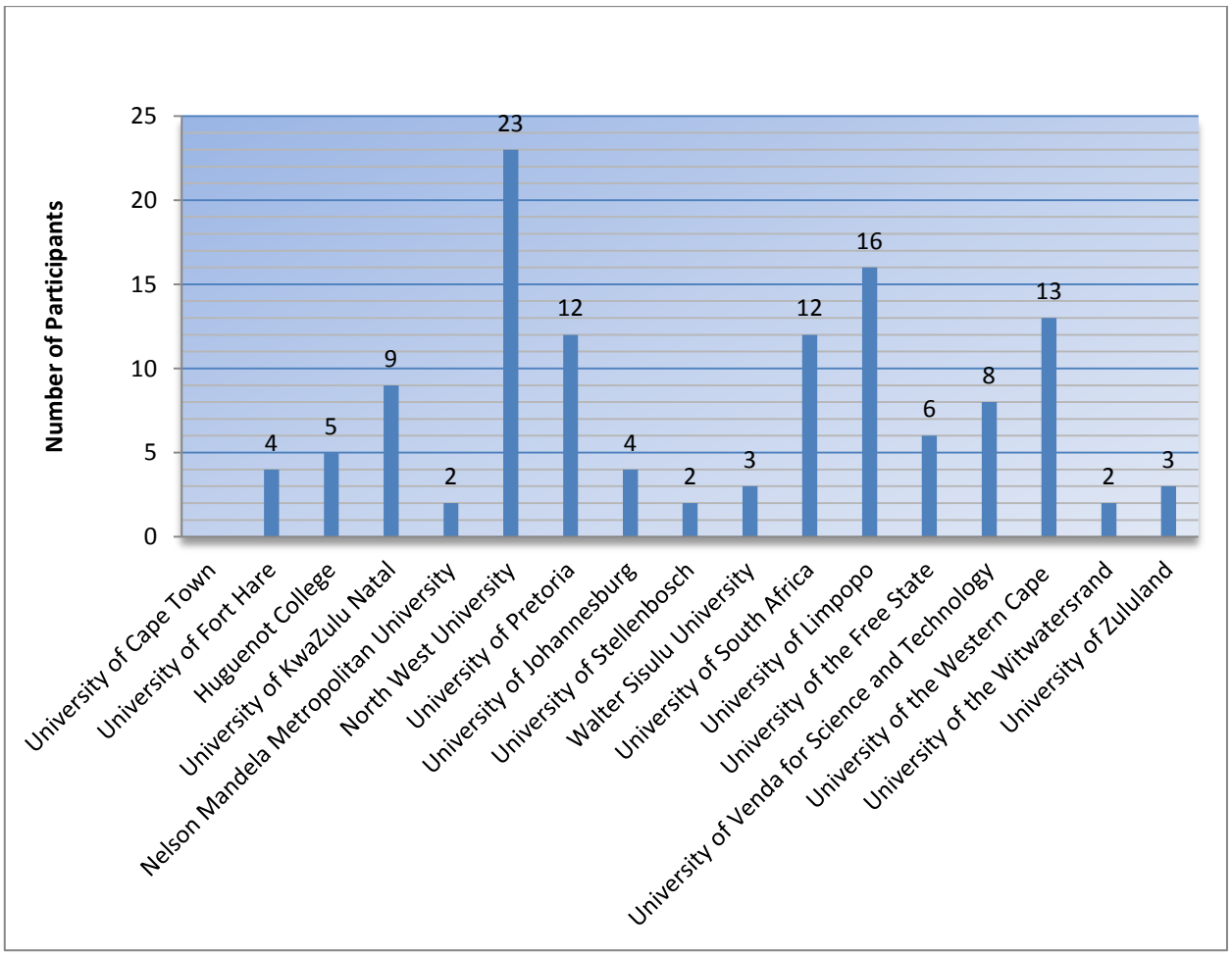


Figure 8.4: The Universities Where Survey Participants had Studied (N= 124)[7]

Figure 8.4 shows the spread of participants who had studied at the 17 South African universities offering social work training. As both the University of North West and University of Pretoria offer forensic social work (FSW) as a specialty, many participants, especially the FSWs, had trained at these two universities. What is perhaps surprising is that there were not more participants who had trained

[7] (N=124 as four people did not answer this question).

at the University of the Witwatersrand (Wits) especially considering that Wits is the only university offering the specialisation in occupational social work. Occupational social work is now a registered specialty with the South African Council for Social Service Professions. Although the social workers who were involved in occupational social work did not necessarily have the specialised university training in occupational social work, they had received their training on the job. This finding suggests that further training in occupational social work, could be beneficial for these social workers.

Participants reported having acquired experience in numerous fields of social work, with the greatest amount of experience seemingly in the child and family sector (51 or 39.84%). Considering that the social work profession originated from welfare (McKendrick, 1987; Payne, 2000), addressing child and family needs still forms a fundamental sector of the profession. Twenty participants (or 15.63%) had worked at correctional services prior to joining the SAPS, where the nature of the work environment is similar to SAPS in its bureaucratic and militarized culture. Other fields of social work where participants had previously worked included: generic practice (17 or 13.28%), disability (2 or 1.56%), domestic violence (3 or 2.34%), statutory services (13 or 10.16%), geriatrics (3 or 2.34%), medical social work (10 or 7.81%) occupational social work (4 or 3.13%), substance abuse (7 or 5.46%), and private practice (2 or 1.56%). The average number of years in social work **prior** to joining SAPS was 3.8 years (SD =4.53).

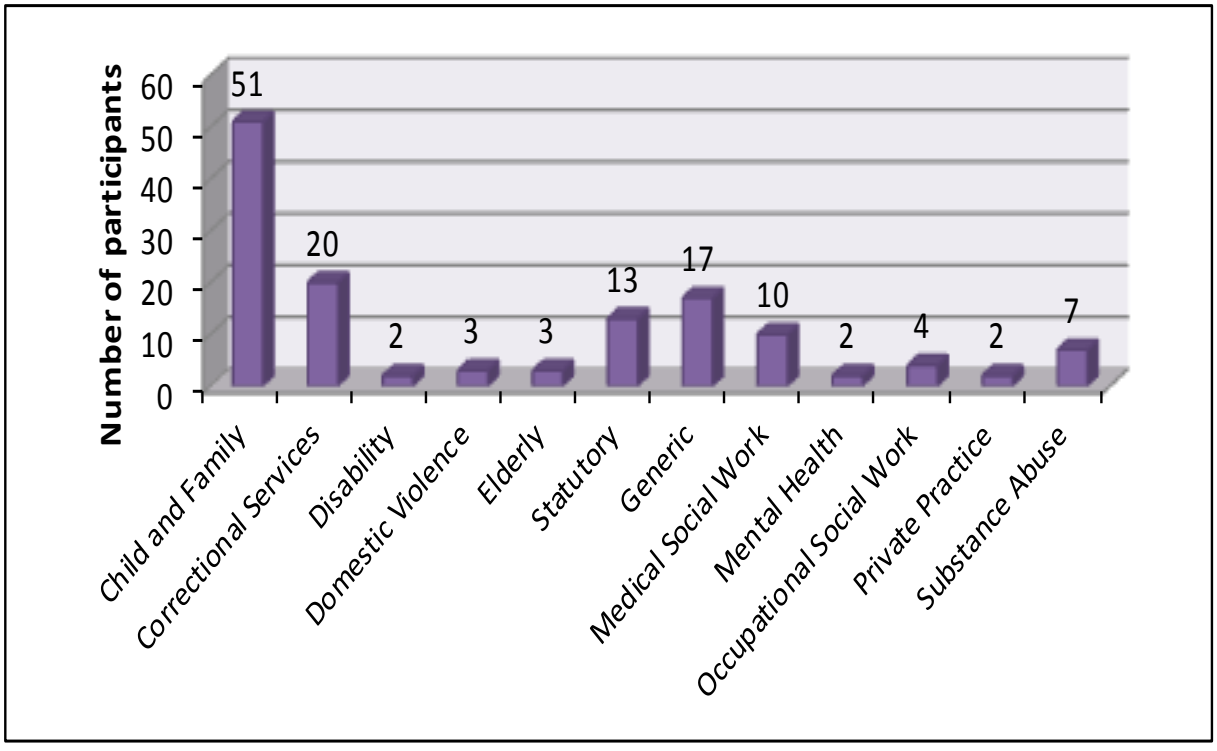


Figure 8.5: Fields of Social Work where Participants had Worked Prior to Joining SAPS (N=128)

In summary, the survey participant profile was predominantly female, Black, with a mean age of 36.5 years, holding the rank of captain or warrant officer, situated across the nine South African provinces, with the spread of training extended across almost 17 universities. Most participants had experience in working with the child and family sector with an average of 6.22 years at SAPS.

8.2.5 Demographic Profile of Interview Participants

Thirty participants were purposefully selected from the survey participants who had indicated that they were willing to be interviewed. They also agreed to allow the researcher to record the interview. In selecting interview participants the researcher considered different demographic variables including the type of social work in which they were engaged, race, gender, rank and the geographical area in which participants resided. The demographic details of the participants are displayed in Table 8.2.

Table 8.2: Demographic Profile of the Interview participants (N=30)

Demographic		N	%
Area of Social Work	**Forensic**	8	26.66
	Occupational	22	73.33
Rank	**Warrant Officer**	9	30.00
	Captain	19	63.33
	Lieutenant Colonel	2	6.66
Race Group	**Black**	20	66.66
	Coloured	3	10.00
	Indian	-	
	White	7	23.33
Gender	**Male**	5	16.66
	Female	25	83.33
Geographical Area	**Head Office**	-	
	Gauteng	10	33.33
	Free State	6	20.00
	Limpopo	3	10.00
	Mpumalanga	2	6.66
	Northern Cape	2	6.66
	Eastern Cape	-	
	Kwa-Zulu Natal	3	10.00
	Western Cape	2	6.66
	North West	2	6.66

8.2.6 Reasons for Joining SAPS and Experience at SAPS

The length of employment at SAPS ranged from seven months to 22 years, with the average length of employment at this organisation being 6.2 years (SD=4.51 years). Social work experience ranged from two to 30 years, while the average length of social work experience was 11 years.

One of the themes emerging from interviews included the reasons the participants had for joining SAPS. Some of these participants mentioned more than one reason for joining SAPS and the reasons mentioned are reflected in Table 8.3. These included: career advancement (3); change of work environment (3); opportunity to work within a specific field of social work (3); opportunity to work with adults (2); and financial incentives (3). What became apparent is that the OSWs who spoke about their motivations for joining SAPS did not mention wanting to work within the field of trauma or working with police officers per se. Conversely, the FSWs mentioned why they had joined SAPS as they specifically wanted to work with children who had been abused.

Table 8.3: Participants' Reasons for Joining SAPS (N=12)

Reasons for joining SAPS	No of participants who mentioned the theme	Selected quotations illustrating themes
Career development	3	*"Because I just wanted to grow from where I was, I was doing grant administration".* *"Uh, you know, to empower myself and greener pastures...".*
Change of work environment	3	*"I wanted to do something new, different from what I was doing".* *"I wanted just a change of scenery".*
Opportunity to work in a specific area of social work	3	*"Why SAPS? Because it was something that I long wanted to do, Employee Assistance Programme".* *"My interest was basically to work with children who were abused… at that stage the only place that I could get work in that area was with SAPS".*
Opportunity to work with adults	2	*"I was interested in working specifically more with adults and more in a therapeutic way".*
Financial incentives	3	*"…because I think coming from a NGO, I previously worked with a NGO, we have quite a lot, much more benefits, financially and security in the police service".*

Having described the profile of the survey and interview participants, the next section focuses on the first aim of the study, namely, to understand the nature of secondary trauma exposure that social workers in the police service had experienced.

8.3 DIMENSIONS OF SECONDARY TRAUMA EXPOSURE

8.3.1 The First Objective

The first quantitative objective was to determine the extent of the secondary trauma exposure experienced by the social workers employed at SAPS. The first qualitative objective was to understand the nature of the secondary trauma experienced by the social workers employed at SAPS. These objectives were investigated through the results of survey questions, the Traumatic Stress Schedule and the qualitative interviews.

8.3.2 Secondary Trauma Exposure and the Traumatic Stress Schedule (TSS)

Survey participants identified a range of traumatic cases to which they were exposed in the six months prior to participating in the research, as shown in Figure 8.6.

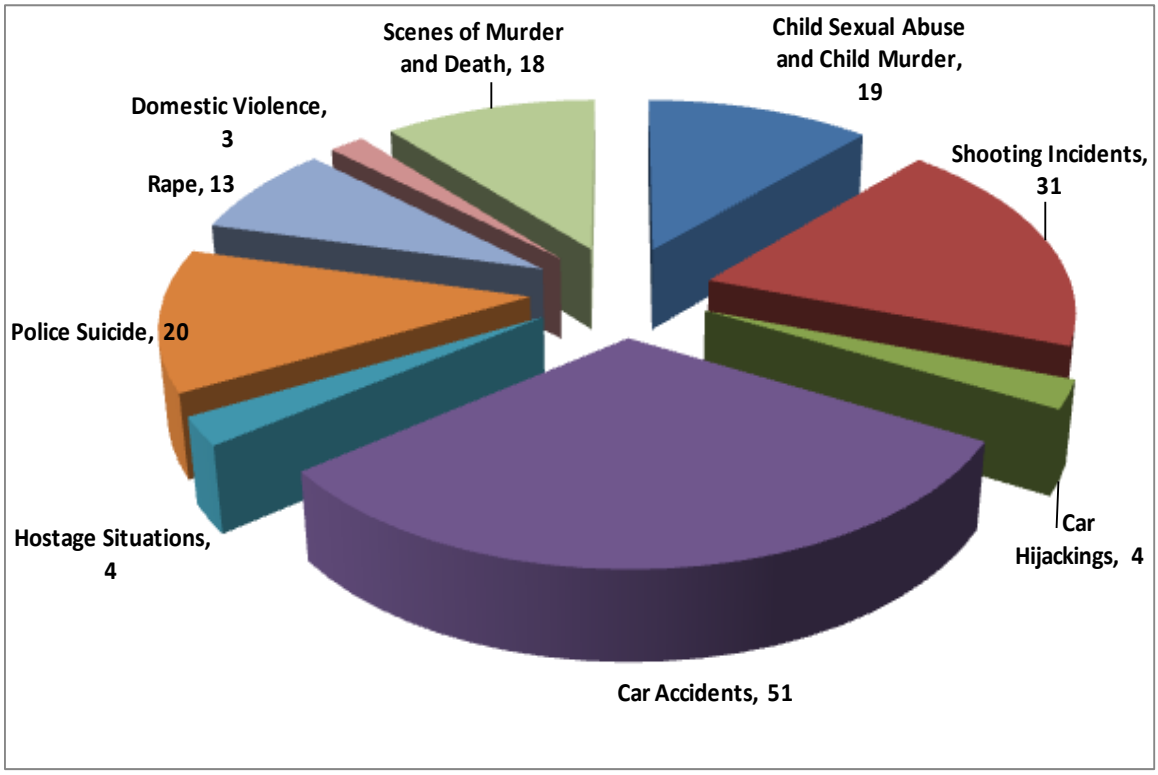


Figure 8.6: Survey Participants' Examples of Traumatic Cases in the Past Six Months (N=115)[8]

These events are recorded from the most frequently occurring to the least occurring and included: car accidents (51); shooting incidents (31); police suicide (20); scenes of death and murder (18); child sexual abuse and child murder (19); rape (13); car hijackings (4); hostage situation (4) and domestic violence (3). The high rate of accidents with police officers and shooting incidents can be attributed to police officers often being involved in high speed chases when in pursuit of criminals. A review of the recent crime statistics in SA 2014/2015 shows that in comparison to the 2013/2014 crime statistics for murder have increased by 5% (17023 in 2013/2014 to 17 805 in 2014/2015); attempted murder by 3%

[8] (N=115 as 13 people did not answer this question).

(16 989 in 2013/2014 to 17 537 in 2014/2015); common robbery by 3% (53 505 in 2013/2014 to 54 927 in 2014/2015); aggravated robbery by 9% and assault by 0.1% (182 2333 in 2013/2014 to 182 556 in 2014/2015) (South African Police Service, 2015b). For a third consecutive year the murder rates have increased resulting in South African murder rates being five times higher than the global average (Seedat, 2015). These statistics depict the levels of violent crime to which SAPS officers are exposed and as a result seek assistance from the SAPS social workers. The nature of the secondary trauma to which the SAPS social workers are exposed is therefore considerable and the different kinds of secondary traumatic exposure were further explored through the Traumatic Stress Schedule and in the interviews with participants.

The Traumatic Stress Schedule (TSS) was administered to explore the nature of traumatic events to which participants' clients had been exposed in the last six months and the results are indicated in Table 8.4. More than half the participants did not complete the section on the TSS relating to how often each traumatic stressor was experienced; therefore this data could not be adequately captured and represents a limitation in the research. What the OSW participants did indicate is that more than 50% of their time was spent counselling or in training, and that FSWs spent more than 50% of their day investigating child abuse cases, suggesting that both groups of social workers were exposed to a significant amount of secondary trauma. Reflecting on the trauma exposure which social workers in SAPS experience, Participant 2 explained, *"I think that other people only read about and hear about, what we experience".*

The most common traumatic exposures that participants' clients had experienced included: loss of a loved one (89 or 69.53%); motor vehicle accidents (74 or 58.81%); assault (70 or 54.68%); or mugging, robbery or holdup (62 or 48.44%). Due to the fact that South Africa does not experience many natural disasters, the trauma exposure relating to natural or manmade disasters was the lowest recorded exposure (31 or 24.22%).

Captains were exposed to a greater range of traumatic situations (M=3.75; SE=.27) than warrant officers (M=3.44; SE=.242) and this result was statistically significant ($t[112.62] = -.852$; $p<0.05$). As most captains have worked in SAPS longer than most warrant officers, they would have been exposed to a greater number of traumatic scenes. However, lieutenant colonels had even higher average scores than did captains (M=4.92; SE=.329) and this result was significant ($t[31.02]=-2.76$; $p<0.05$). This finding showed that the higher the rank of the social worker, the greater the secondary trauma exposure to various trauma situations. Considering that the Lieutenant colonels are responsible for a certain geographical area and number of social workers, they would be notified of all the serious trauma situations in their areas. This finding suggests that more supports should be in place, particularly for the higher ranking social work officers.

Table 8.4: The Nature of Secondary Trauma Exposure as Measured by the Traumatic Stress Schedule (N=128)

	Exposure to Secondary Trauma	SAPS Social Workers		Forensic Social Work (FSW)				Occupational Social Work (OSW)						Female SW		Rank*					
		SAPS (N=128)		FSW Male		FSW Female (N=26)		OSW Male (N=13)		OSW Female (N=89)		OSW Total (N=102)		Female SW (N=115)		1 (N=48)		2 (N=67)		3 (N=13)	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
1	Clients experienced a threat or force, such as a mugging, robbery or holdup	62	48.43	-	-	11	42.31	3	23.08	48	53.93	51	50	59	51.30	23	47.92	30	44.78	9	69.23
2	Clients were beaten or attacked	70	54.69	-	-	16	61.63	7	53.85	47	52.81	54	52.94	63	54.78	22	45.83	37	55.22	11	84.62
3	Clients were forced to have sex or were sexually abused	51	39.84	-	-	23	88.46	2	15.38	26	20.31	28	27.45	49	42.61	11	22.92	35	52.24	5	38.46
4	Motor vehicle accident with injuries	74	57.81	-	-	2	7.69	8	61.54	69	53.91	77	75.49	71	61.74	34	70.83	31	46.29	9	69.23
5	Clients had property damage because of fire, severe weather, or a natural or manmade disaster	31	24.22	-	-	4	15.38	3	23.08	23	25.84	26	25.49	27	23.48	10	20.83	17	25.37	4	30.77
6	Clients loss of a loved one because of an accident, homicide or suicide	89	69.53	-	-	11	42.31	7	53.85	71	79.77	78	76.47	82	71.30	36	75	40	59.70	13	100
7	Clients had to evacuate their home	40	31.25	-	-	6	23.08	6	46.15	28	31.46	34	33.33	34	29.57	12	25	22	32.84	6	46.15

*** Rank: 1 = Warrant Officer; 2 = Captain; 3 = Lieutenant Colonel**

8.3.3 The Nature of Forensic Social Workers' Exposure to Secondary Trauma

Inherent in the work of a SAPS forensic social worker, is the exposure to a brutal side of life, observing the manner in which some human beings exploit and violate the most vulnerable members of society. From Table 8.4 it is apparent that the FSWs were predominantly exposed to cases involving rape or sexual abuse (23 or 88.46%) or where clients were attacked (16 or 61.54%). This finding was to be expected as forensic social workers investigate cases involving children who may have been abused or neglected. The high rates of child abuse in South Africa have been attributed not only to poverty, the breakdown in social norms, family and community structures but also to poorly developed child protective systems (Meinck, Cluver, Boyes & Mhlongo, 2015). Employing forensic social workers within SAPS has been one of the government's responses to improve child protection systems and appropriately deal with the pandemic of child abuse in the country. Mathews and Benvenuti (2014) explain how the prevalence of child abuse in South Africa is not adequately recorded as there has not been sufficient systemic research on the extent and range of violence against children. The 2011/2012 crime statistics revealed that 40% of all sexual offences reported involved children (Mathews & Benvenuti, 2014).

The FSWs' caseloads appeared to differ significantly between participants. While some participants only dealt with a few new cases every month, most commented on how difficult it was to be allotted such high caseloads as each case demanded a great deal of time, as one FSW explained,

> "*Sometimes I drive the whole day to get to a case I need to investigate...a day I can get maybe 2 (new cases) per day… so ... you know I manage my cases so...you know I have a waiting list. I'm fully booked like a month or sometimes 2 months in advance. So I manage my case load…currently I can tell you I have about 20 (current) cases" (P2).*

Forensic social workers have a demanding and responsible role as they are required to conduct in-depth forensic assessments of alleged child abuse cases and then submit reports to court. If required, FSWs may need to justify their reports in court (Joubert & Van Wyk, 2014). During the process of the assessments, these social workers often have to listen to gruesome details of criminal events, especially when allegations of child abuse are investigated. Participants reflected on particular cases that they found traumatic:

> *"This child whereby exposed in terms of the setting up of the family and now she had to be the mother for her siblings you know to ...to become a wife to the father as well.... because now the child has not be a child now, to be both a child and an adult now (P18)".*

> *"…And it was so, it was so painful the way the child verbalized everything that happened, like it was you know, you know it was so painful especially when it had to urinate there was blood*

coming out. So it was so traumatic the way the child, it was so traumatic the way she verbalized the information (P21)".

"*There was a particular abuse case where the...the child died because of the abuse" (P9).*

Forensic social workers are exposed to society's failing to protect and nurture its young. The traumatic exposure to the abuse of children is compounded by the tremendous responsibility these social workers have to adequately address society's failings to protect the young and vulnerable. According to Joubert and Van Wyk (2014), forensic report writing takes a considerable amount of time and intensive mental concentration, as the social worker has to gather information appropriately, analyse the child's situation, present argument and ground the report within relevant theoretical frameworks. In addition, when forensic social workers are designated a case, they are aware that with each case they may be required to testify in court, which can be an added stressor. As one participant explained,

"The workload is of such situation that you know is difficult for me ...I will see the children and then I will compile a report and then that report goes to the docket for the criminal investigation and then, after that they will then sometimes ask me to go testify in court" (P8).

Lombard and Klein (2006) caution social workers not to abuse their statutory powers and emphasise that the decision or recommendation to remove a child from his/her family should not be taken lightly. Despite having to cope with the secondary trauma exposure from their cases, forensic social workers have significant responsibilities and experience considerable stressors in the daily execution of their duties. Considering the multi-dimensional demands on these social workers, SAPS need to ensure that adequate support mechanisms are in place so that forensic social workers have access to the necessary resources in order to function effectively.

8.3.4 The Nature of the Occupational Social Workers' Exposure to Secondary Trauma

According to the results of the TSS, the most frequent types of traumatic incidents to which the OSWs' clients (SAPS members) were exposed included: the loss of a loved one due to an accident, homicide or suicide (78 or 76.47%); clients' motor vehicle accidents (77 or 75.49%); situations where clients were attacked (54 or 52.94%); and clients were physically threatened due to robbery or assault (51 or 50.0%). Traumatic situations which were least experienced by the OSWs' clients included: evacuating their homes (34 or 33.33%); being sexually assaulted or raped (28 or 27.45%) and experiencing damage to their property (26 or 25.49%). OSW services to SAPS employees include counselling, trauma debriefing, case management and pro-active programmes. However, the OSWs did not spend all their time at work counselling as they were also required to attend meetings, conduct training sessions and attend supervision. The exposure to secondary trauma was therefore not consistent for

every participant and also varied on a daily and weekly basis. Analysis of responses revealed the following themes and sub-themes:

- **Theme one: The nature of the secondary trauma exposure**

All OSW interview participants (22 or 100%) could identify the traumatic exposure of their work and spoke about various situations that were particularly traumatic for them, which included personal and work related situations of their clients. The framework guiding OSW acknowledges how OSW should conceptualise interventions addressing the *employee as person* and the *person as employee* (Du Plessis, 2001). The incidents of secondary trauma exposure mentioned incorporated both dimensions.

- **Sub-theme one: Employee as person**

Employees are people who also may experience health problems, life challenges (marriage or divorce), go through developmental stages, and experience changes in family composition (birth or death). Five OSW participants described cases that dealt with traumatic aspects of police officers' personal lives, such as those described in the following scenarios:

> *"If I think now about one incident it was in this year…it was a police member and his child had been run over. His child was about 9 years old. and they put him on life support and they called me in because um, um, wanted him to decide, is, is he going to donate the organs or not. I had to sit with the member while he decided um, to switch off the machines because his child was brain dead. So that was, that was something, really..." (P5).*

> *"The case where the police officer... was raped" (P21).*

The occupational stress of police work may also affect police officers' personal relationships. Shift work, deployments and transfers are often disruptive for family functioning. While these aspects are not necessarily traumatic, the personal stressors combined with work stressors can produce traumatic results. Situations exposing the vulnerability of the officer may be disconcerting as the perception of police officers is often that they are tough and should be able to handle all situations. Yet police officers are also citizens who experience traumatic events in their personal capacity, such as the death of a child or being raped.

- **Sub-theme two: Person as employee**

All of the OSW participants who were interviewed (22 or 100%) spoke about traumatic situations where police officers had to be debriefed about work related incidents involving death or injury to the police officers, shootings, motor vehicle accidents or situations where police were expected to attend gruesome scenes, especially those including children.

> *"Ya, hey, very, very bad, you know I've been exposed to so many …where police were exposed to accidents where a child's head were separated from his body ...and police officers who didn't make it and I was called to the scene to do the debriefing for the members" (P5).*

> *"There was an accident and where...that people who passed away and then they, the police officials who went back, were close to those members. So they were affected" (P13).*

> *"I would say the worst for me would have been when police officers are involved in shooting incidents. Especially the armed robbers where you find that one of their colleagues is shot and they die" (P11).*

Mitchell (1983) coined the term 'critical incidents' which are situations affecting police and emergency personnel more extensively than other scenes. These include scenes where children or colleagues are involved. Police killings have become a national concern over the past few years, as the number of police killings is increasing. During 2014, 63 police officers were killed, and during the first ten months of 2015, 73 police officers had been killed. Criminals are now hunting down and chasing police in order to kill them for their weapons (Serrao, 2015; Sutherland, 2015). A South African police officer is five times more likely to be killed in the line of duty than a police officer in the United States of America (Germaner & Flanagan, 2015). The OSW is required to counsel and debrief officers who have witnessed their colleagues being killed.

In order to conduct a trauma debriefing, the counsellor ideally needs to be objective and detached from the traumatic situation that has occurred. However, as the OSWs are part of the SAPS organisation, this ideal is frequently not the reality on the ground as the OSW often knows the police officer involved. One participant explained that what makes a case particularly traumatic for her, *"It's, it's about if you know the police member. So for me it's, it's worse when I know the police member, when I know the member in, involved" (P5).* Social work professionals are normally able to create a sense of distance between themselves and their clients, as their clients are generally not employed by the same organisation as the social worker. These professional boundaries are appropriate not only for the client but are also necessary to help the social worker maintain emotional distance. However, in occupational settings such as the SAPS milieu, this dichotomous divide is not always so distinctive. In the SAPS environment, OSWs may interact with their clients frequently in various work contexts and so the death of a member is likely to have a greater effect upon the social worker, who may have worked alongside the officer in different contexts.

One of the male OSWs felt that he was required to deal with the cases that were more traumatic, as his female colleagues preferred not to deal with such cases. As he explained, *"So they become*

traumatised and mostly they are males doing that thing, that's the unfortunate part. Most of my colleagues are females and it is traumatising, so I'm the one to go out and handle the debriefings" (P3).

- **Theme two: Occupational social workers' most traumatic cases**

When talking about exposure to trauma, three themes emerged from the interviews when participants referred to these cases as their "worst cases"- police members becoming disabled and attending to police suicides and/or police family killings. Sometimes the OSW did not know the police officer who had committed suicide, but when the officer concerned was their client, it compounded the intensity of the situation. When participants spoke about these suicides, they either expressed concern for the family of the deceased or the guilt that they felt as the social worker involved in the case. Award-winning South African author Antjie Krog (2002) discusses moral guilt felt by those who do not do enough, and metaphysical guilt for having survived while the other was being killed. Dealing with police suicides and police family murders, the organisations' response to the suicide as well as the social workers' response to police suicides were sub-themes that emerged from discussing the worst calls.

  - **Sub-theme one: Police members becoming disabled**

As police officers are involved in many shooting incidents and accidents, injury on duty is a common occurrence within SAPS. According to the SAPS Annual report 2012/2013, 8310 police officers were injured on duty – 483 of whom are now permanently disabled, either through a motor vehicle accident or through being assaulted or shot at by criminals. Two participants spoke about how they found cases where officers became disabled as particularly difficult for them to deal with,

> *"Sometimes it's somebody that you know. Then the other cases that, also are somehow somewhat traumatic is disability because some of the members, you know, they lose their, their hands or their eyes" (P15).*

> *"Like, like I mentioned some of the members are HIV positive, some of the members have been amputated and it's also very difficult to work with uh, with, with, with such people because you become sometimes emotional because you know, if somebody loses a hand or a foot, a leg, you start, you put yourself in their shoes and you get affected and sometimes you are, you are empathetic, you feel sympathy. Okay, sometimes it's, how often, every month there'll be one or two" (P27).*

As Participant 27 commented above, '*you put yourself in their shoes'*, assisting someone to cope with the loss of physical functionality and permanent disability requires the social worker to have compassion and a particular strength of character. According to Ross and Deverell (2010) strong emotional reactions tend to be evoked, not only within the individual with the disabling condition but also by significant people in their environment. A social worker's intervention in this situation would

predominantly focus around the losses that the individual has suffered, as well as helping the person to adapt to his/her current reality. Not only can these functions be demanding for the social worker but they can also have a significant impact as the fragility of life is highlighted and accentuated through cases such as these.

- **Sub-theme two: Dealing with police suicides**

Ten of the OSWs identified dealing with police suicides as some of the worst (or as some explained **the** worst) case/s that they had dealt with. The high rates of police suicides in SAPS are a huge concern and are five times higher than the average rates of police suicides recorded internationally (Pienaar, Rothman & Van De Vijver, 2007).

> *"..It was especially with the families...where the member committed suicide with his firearm in the house…ya that was the worst…I have had more than one of those cases" (P9).*

> *"I wanted to really ask him, why, why did you do this? You know, I was so angry with him and I couldn't, you know, but you know, I just looked at him and said ya, no. And, we had, the worst part, we had to go and deliver the message to the wife. So that was the worst" (P16).*

> *"..It can be an officer killing himself in front of the family" (P4).*

Police officers often commit suicide at their homes and sometimes do so in front of their family members, compounding the traumatic nature of the event for family members. When a police officer has committed suicide OSWs from SAPS are required to counsel the colleagues and family members of the deceased officer. The devastating effects of the suicidal act are apparent for the OSW as such social workers are also exposed to the detrimental effects of such an event on the family members left behind and who often discover the body. Furthermore, OSWs are required to assist the surviving police officers to deal with the tragic event through individual or group counselling sessions. As a result OSWs are exposed to the devastating effects of suicide on many different levels, namely the family and the work environment. In some cases police officers commit suicide at the police station. One OSW reflected how her colleague left SAPS after a police officer committed suicide in her office,

> *"..I'm telling you some social workers in SAPS never had a person committing suicide, never. But me to the contrary, I don't know... maybe there are other social workers who had it worse. One of my colleagues actually left the police. A member committed suicide in her office. I would never have made that, I would have, never ever, I would have resigned at that moment, and I would never have made it. So there must be people who had it worse than me" (P29).*

Police officers' easy access to fire arms, is a concern when officers are suicidal, particularly when most police officers who commit suicide shoot themselves with their departmental weapons. The obvious

easy accessibility to fire arms as well as the constant exposure to death are contributing factors to high suicide rates within SAPS. However, one participant spoke about how police officers committed suicide by throwing themselves into a river and how other police officers had to retrieve the bodies of these officers.

> *"The other thing is that of a police who, I mean people who went... who committed suicide with fire arms, and some who committed suicide in the river, threw themselves into the rivers and police officers who do have a diving squad, are supposed to get inside and get those people out. And when those bodies come out, yo they are bad. And the* ***police officers*** *have to take that body, thing out and makes sure that the family gets them" (P3).*

Despite police work requiring that police officers attend to suicide scenes of members of the public; it is particularly traumatic for police officers when one of their own commits suicide. The myriad of stressors involved in South African police work is well documented and researched (Bruce, Newham & Masuku, 2007; Marks, 2005). In the case described below the officer's abuse of alcohol had detrimental results, as one participant explained:

> *"He had a state vehicle. He was drunk and then he took the state vehicle. He overturned with the state vehicle. He killed two people on the spot and then he was arrested because usually the rules say you must be arrested and then must be put in a cell and then in the next morning uh they found him, he hanged himself in the cell, he used a trouser to hang himself" (P18).*

However, there are often many factors contributing to the suicidal actions of a police officer, which may include personal or work stressors or personality dimensions (Germaner, 2013; Pienaar et al., 2007). The National Police Commissioner, Mthethwa identified the main driving factors in the high rates of police suicides as, "tensions in personal relationships, marital problems, infidelity, trauma, depression, mental health issues and poor financial management" (Mthethwa, 2013). It is of concern that Mthetwa failed to mention the occupational stressors of police work, but highlighted individual factors as the contributing causes of suicide. Mangwani (2012) found that reasons for the high suicide rates among South African Police could be attributed to personal and financial difficulties as well as work-related stress, pending disciplinary cases, the shame of misconduct and job-related traumatic incidents. The complex issue for those left behind is trying to make sense of the fatal action of another. Shneidman (1996, p. 162) asks "what is the 'psychological soil' in which the suicidal mind malignantly flourishes?" This 'psychological soil' which might be comprised of work and personal stressors needs to be further explored and understood so that more preventative strategies can be implemented at an organisational level within the SAPS.

- **Sub-theme three: Police family murders or femicide-suicides**

Three participants spoke about attending suicide scenes where the officers had committed suicide after killing their wives/partners, a phenomenon, which is known as femicide-suicide.

> *"..maybe a family member, a father or a mother shot himself in front of the children or they were involved in shooting crime, crime scene. So it happens often" (P19).*

> *"One of the cases that I attended with regards to the suicide was when a husband, uh, killed himself, a police officer killed himself and the wife… when the children come back home, they tried to knock, and they didn't succeed, after a while they checked through the window, and they find that they um, they see the body of their mother in the bathroom...and their father..they went to school without noticing that the mother passed away. It was very hard because you know, the public was there to view, the children were, you know, the, the, the case itself was emotional because now the children were alone without parents and I was just, I was just putting myself in the boots of the children and it was so traumatic" (P14).*

In a study about femicide-suicides in South Africa, Mathews, Abrahams, Jewkes, Martin, Lombard & Vetten (2008) found that 53% of femicide-suicides were committed by men in the police force, security industry and armed forces. They attribute the high levels of alcohol abuse and domestic violence in the police to be a consequence of their traumatic stress. Furthermore, police officers' displays of aggression towards their spouses or romantic partners have been linked to occupational challenges. Hakan Can, Hendy and Imbody (2013) attributed the often destructive leadership styles of police supervisors as role models for aggressive behaviour of police officers. In fact, the use of aggression as a conflict resolution strategy is often normalised. The argument has been raised that SAPS should implement more stringent personality assessments when recruiting police officers in order to ensure the correct 'personality-job fit'. However, both sides of this debate, namely work conditions and personality factors, raised concerning discourses about suicide which require consideration. Commenting on police vulnerability to mental health issues, Mahlakoana (spokesperson for Police and Prisons Civil Rights Union (POPCRU) - the police officers' union), explained, "they clean up appalling crime scenes which traumatise even the strongest of human beings on a daily basis. They bear witness to that which society only reads about in newspapers. Those and many more conditions of their employment are bound to affect them psychologically" (cited in Blinder, 2013, p.1).

- **Sub-theme four: SAPS's response to police suicide**

Four participants (13.33%) spoke about the manner in which they felt SAPS management and other police officers blamed them for the suicide of a police officer. One participant, who felt blamed for the suicide of one of her clients, shared her story:

> *"I had a client, he wanted a transfer in those days and... the Commander said no he couldn't get the transfer and I went back to him and told him. And then it was finished you know that's why he was on my case register, and then he committed suicide and they phoned me and said I had to come and do the debriefing and I had to do it in the house where he committed suicide. So during that debriefing there was a... had to go through to do that debriefing. And it was his colleagues who was there, and so was the family...and when I got there and I started the whole process… his colleagues told me "why do you come here now? It's too late. You should have helped him earlier"... and oh yes the next time when I came to my office someone put a newspaper on my desk... the report on his suicide and it was marked in red, with a red pen. I don't know who put it there… but it was on my table. So that just strengthened the fact that I thought they were blaming me" (P29).*

Defensive–attribution theory suggests that the need to blame others is a defensive position that individuals assume in order to avoid situations where they can be blamed for an event or experience a similar misfortune themselves (Finchilescu, 1991). In the case of suicide, many feel the need to hold someone accountable for the event, minimising the relevance of agency (the individual's choice) in the structural problem. Blaming the social worker for adverse situations is a discourse that is prevalent in society. This often misplaced blame does not rectify the situation but appeases the conscience of others or the organisations concerned. White-Bowden (1985, p. 12) posits that "the truth of suicide lies with the victim. The survivors can only guess. They must put the pieces of life together to try to come up with reasons for an unreasonable death".

Moreover, there is often a great deal of media attention given to the suicide of police officers, as the public are reminded of the reality of work stressors experienced by those who maintain the law and order of the country. One participant spoke about how focus of the media on a police suicide results in more questions being raised about the suicide and what attempts were made to assist the individual by the social workers.

> *"Where the media noticed about a murder or say a policemen had murdered his wife and then himself and a big hoo-ha is made about where were we and why didn't we prevent it and the whole suicide issue, they don't understand that suicide is not a single dimension problem" (P16).*

Often, the individual factors contributing to the suicidal action of a person are emphasised and explained in terms of psychological disturbance and/or severe personal stressors. One of the fathers of sociology, Emile Durkheim's ground breaking work on suicide, challenged society's understanding of suicide and the individual pathological framework through which it has been understood. Durkheim emphasised how poor levels of societal integration contribute to high rates of suicide (Durkheim, 1979). His work highlighted the fact that suicide 'is not a single dimension problem' and that factors

contributing to suicide are far more systemic in nature. The occupational stressors of police work are well-known internationally; in addition SA police officers work in one of the highest crime-ridden countries in the world, where violence is endemic to all sectors of South African society.

- **Sub-theme five: OSWs' feelings of guilt after police suicide**

One participant (as mentioned earlier) felt angry with her client for committing suicide. However, guilt was the predominant emotion that the OSWs identified when working with police suicide cases. The act of suicide evokes different emotional responses from those left behind. Typical responses can include negative identification with the suicide victim, shock, anger and guilt (Firestone, 1997). In particular, participants spoke about how they felt they had not done enough to assist the client as expressed by the following quotations:

> *"..sometimes I feel guilty about it...why the member has not come? Are we not good enough? We ask those questions… not that you are not good, I mean not good enough but you asking why the member has not used the resources" (P10).*

> *"And I think he made his decision (to commit suicide) long time ago, so although he made his burden, still felt, you know, I felt I didn't do my work properly" (P24).*

> *"I had a client. He was having medical problems and uh, I did a session with him and then, you know, you cannot predict….and I felt stupid also, and I felt like I didn't do my work…. that has affected me" (P8).*

> *"He used a trouser to hang himself. And it affected me a lot because now, the, it was a question for me to say, didn't I do enough to convince this person" (P16).*

Counsellors often experience a profound legacy of guilt, doubt and fear when a client commits suicide. These emotions can result in therapists feeling confused and unsettled by their responsibilities, as well as plagued by life and death understandings (Roussouw, Smythe & Greener, 2011). The tragic event may result in both a personal and professional crisis for the therapist which may culminate in an existential search for meaning and a phenomological inquiry into life. Survivor guilt may occur when an individual cannot rescue someone from a tragedy. For the social worker this guilt may occur as they were unable to stop or influence the client contemplating suicide. Survivor guilt is a complex phenomenon and may serve to protect or mask other emotions but can also immobilise an individual. Unresolved guilt can become problematic not only for the individual concerned but for others in that individual's life (Schiraldi, 2000). Fox and Cooper (1998) explain that therapists' fear of being blamed and the sense of shame that they have failed may result in the practitioners isolating themselves from the very sources of support necessary to help them resolve the trauma. The importance of

organisational support is necessary not only for the police officers but for the OSW as well. The impact of suicide on SAPS social workers needs to be further researched and the necessary provisions put in place to help social workers effectively navigate these tragic circumstances.

8.4 SECONDARY TRAUMATIC STRESS

8.4.1 The Second Objective

The second quantitative objective was to measure the prevalence of secondary traumatic stress according to Bride, Robinson, Yegidis and Figley's (2004) Secondary Traumatic Stress Scale and the second qualitative obejcteive was to explore the phenomenon of secondary traumatic stress among SAPS social workers.

8.4.2 Secondary Traumatic Stress Levels

According to the DSM IV-TR, PTSD is diagnosed when the individual's exposure to a traumatic event evokes a response of fear, helplessness or horror – Criterion A (American Psychiatric Association, 2000). This criterion was explored in section 8.3 where participants identified a traumatic event to which they had been exposed, and responded to the event either with fear, helplessness or horror. There has been significant debate about criterion A and the requirement for a single acute dramatic episode to have occurred in order for PTSD to be diagnosed. (As discussed in chapter two this criterion has been modified in the DSMIV, IVTR and V). In addition, for a diagnosis of PTSD an individual must meet the following criteria: Criterion B stipulates that the individual must show at least one **re-experiencing** symptom; Criterion C stipulates that three **avoidance** symptoms must be present and Criterion D requires two **arousal** symptoms to be evident (American Psychiatric Association, 2000). Furthermore, Criterion E stipulates that the symptoms must have been present for more than a month and Criterion F that these symptoms have significantly impinged on an individual's personal and/or occupational functioning. Criterion A (exposure and response); Criterion E (the duration of symptoms) and Criterion F (impairment) of PTSD are not assessed in the STSS. As Bride, Smith Hatcher and Humble (2009) explain, Criteria B, C and D of PTSD are the core symptoms of PTSD and as a result most trauma measures focus on the measurement of these criteria. However, as criteria E and F were not assessed in this study, this lacuna is acknowledged to be a limitation of this research.

Participants were asked to indicate how often they had experienced various secondary traumatic stress symptoms in the previous seven days and their responses are presented in Table 8.5. Almost all (108 or 84.38%) of the participants had experienced at least one secondary traumatic stress symptom in the preceding seven days. According to Bride et al. (2009) a symptom is considered to be endorsed if participants indicated that they had experienced the symptom occasionally, often or very often in

the previous seven days. Most (108 or 84.38%) participants met at least one diagnostic criterion; at least 74 (or 57.81%) met two diagnostic criteria; and more than a quarter (37 or 28.91%) met all three diagnostic criteria. The intrusion criterion was the most experienced criterion (108 or 84.38%), indicating that the traumatic nature of the participants' work was constantly in the thoughts and physiological responses of participants. For only 8 (or 6.25%) participants, none of the criteria B, C, or D was endorsed.

Table 8.5: Participants' Endorsement of Diagnostic Criteria B, C and D of PTSD (N=128)

Criterion Assessed	Number of participants	%
Criterion B: Intrusion	108	84.38
Criterion C: Avoidance	48	37.50
Criterion D: Arousal	85	66.41
Intrusion and Avoidance (B and C)	42	32.81
Intrusion and Arousal (B and D)	74	57.81
Avoidance and Arousal (C and D)	37	28.91
Intrusion and Avoidance and Arousal (B and C and D)	37	28.91
None	8	6.25

The impact of STS on the counselling relationship is well documented (Bride, 2007b; Figley 1995; Pearlman, 1999) as the counsellor may become detached, avoidant and struggle to maintain appropriate boundaries with clients. The results in Table 8.4 show that experiencing one or more secondary stress symptoms was a common response for social workers in SAPS and implies that these social workers should be proactively educated regarding the signs and symptoms of secondary traumatic stress.

Saltson and Figley (2003) caution that counsellors with unacknowledged STS can be particularly harmful, as they might not realise how inattentive or avoidant they may have become with clients. Empowering social workers with knowledge about STS can help them develop greater insight into, and understanding of their own responses.

Table 8.6: Correlation Matrix

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1	Age	1	.203*	.116	.098	.018	.114	.093	.206*	.084	.163	-.035	-.049	.120	.208*	-.047	.078	.018	.057	.093	.767**
2	TSS	.203*	1	.252**	.144	-.071	.307**	-.078	.063	-.082	-.049	.084	.022	.048	.213*	-.059	-.043	.102	.093	.051	.223*
3	STS	.116	.252**	1	.449**	-.331**	.597**	-.332**	-.203*	-.216*	-.241**	-.112	-.099	-.088	-.034	-.244**	-.236**	-.229**	-.097	-.273**	.179*
4	TABS	.098	.144	.449**	1	-.310**	.483**	-.589**	-.443**	-.093	-.113	.011	-.039	-.013	-.100	.047	.006	-.176*	.020	-.072	.085
5	Compassion S	.018	-.071	-.331**	-.310**	1	-.585**	.512**	.450**	.306**	.182*	.182*	.285**	.243**	.124	.177*	.325**	.331**	.232**	.409**	-.145
6	Burnout	.114	.307**	.597**	.483**	-.585**	1	-.497**	-.313**	-.259**	-.145	-.150	-.110	-.233**	-.030	-.120	-.276**	-.302**	-.062	-.289**	.191*
7	Coping	.093	-.078	-.332**	-.589**	.512**	-.497**	1	.557**	.169	.213*	.141	.089	.161	.121	.204*	.138	.215*	.012	.251**	-.023
8	Resilience	.206*	.063	-.203*	-.443**	.450**	-.313**	.557**	1	.119	.237**	.052	.124	.170	.197*	.082	.179*	.203*	.112	.249**	.096
9	Involvement	.084	-.082	-.216*	-.093	.306**	-.259**	.169	.119	1	.259**	.349**	.269**	.391**	.104	.327**	.250**	.318**	.316**	.610**	.035
10	Cohesion	.163	-.049	-.241**	-.113	.182*	-.145	.213*	.237**	.259**	1	.263**	.253**	.282**	.138	.302**	.236**	.247**	.234**	.558**	.115
11	Support	-.035	.084	-.112	.011	.182*	-.150	.141	.052	.349**	.263**	1	.366**	.404**	.277**	.338**	.288**	.191*	.408**	.676**	-.185*
12	Autonomy	-.049	.022	-.099	-.039	.285**	-.110	.089	.124	.269**	.253**	.366**	1	.305**	.121	.328**	.236**	.270**	.230**	.610**	-.105
13	Task Orientation	.120	.048	-.088	-.013	.243**	-.233**	.161	.170	.391**	.282**	.404**	.305**	1	.312**	.422**	.277**	.260**	.276**	.684**	-.031
14	Work Pressure	.208*	.213*	-.034	-.100	.124	-.030	.121	.197*	.104	.138	.277**	.121	.312**	1	.165	.121	.186*	.171	.420**	.091
15	Clarity	-.047	-.059	-.244**	.047	.177*	-.120	.204*	.082	.327**	.302**	.338**	.328**	.422**	.165	1	.372**	.113	.254**	.635**	-.121
16	Managerial	.078	-.043	-.236**	.006	.325**	-.276**	.138	.179*	.250**	.236**	.288**	.236**	.277**	.121	.372**	1	.171	.227**	.545**	-.019
17	Innovation	.018	.102	-.229**	-.176*	.331**	-.302**	.215*	.203*	.318**	.247**	.191*	.270**	.260**	.186*	.113	.171	1	.172	.494**	.008
18	Physical Comfort	.057	.093	-.097	.020	.232**	-.062	.012	.112	.316**	.234**	.408**	.230**	.276**	.171	.254**	.227**	.172	1	.556**	-.057
19	Work Environment	.093	.051	-.273**	-.072	.409**	-.289**	.251**	.249**	.610**	.558**	.676**	.610**	.684**	.420**	.635**	.545**	.494**	.556**	1	-.056
20	SAPS	.767**	.223*	.179*	.085	-.145	.191*	-.023	.096	.035	.115	-.185*	-.105	-.031	.091	-.121	-.019	.008	-.057	-.056	1

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

8.4.3 Hypothesis Testing

Hypothesis one stipulated that secondary traumatic stress levels in SAPs social workers would be higher in social workers who were exposed to a greater range of traumatic cases. The null hypothesis stipulated that no relationship existed between STS and trauma exposure (TSS). A positive and significant relationship was found to exist (Table 8.5) between trauma exposure and secondary traumatic stress ($r=.252$; $p<0.01$), thereby rejecting the null hypothesis and accepting hypothesis one. Although this correlation was significant, it was weak, suggesting that there were other factors also influencing the development of STS. Authors such as Baird and Kracen (2006) found that greater exposure to traumatic material is positively correlated with higher STS levels. Large caseloads, long work hours and increased time spent with traumatised clients have all been found to be related to STS (Bourke & Craun, 2014; Pearlman & Mac Ian, 1995). In addition, personal attributes of the counsellor (such as gender, ethnicity, psychiatric history and age) can cumulatively increase the risk of STS (Figley, 1995; MacRitchie & Leibowitz, 2010). Through further analysis, factors such as race, gender and type of social work were explored in relation to STS levels and these findings are discussed in the following section.

Table 8.7: Means, Standard Deviations and Ranges of STS (N=128)

	Category	N	Mean	SD	Min	Max	Range
STS Total	All SAPS SW	128	40.27	14.31	17	85	68
	Forensic SW	26	43.12	17.18	17	85	68
	Occupational SW	102	39.54	13.49	17	81	64
	OSW: Male	13	38.77	18.15	17	76	59
	OSW: Female	89	39.65	12.78	18	81	63
	Female	115	40.43	13.89	17	85	68
	Rank: W/ Officer	48	36.83	11.73	17	58	41
	Rank: Captain	67	40.19	53.31	17	76	59
	Rank: L/Colonel	13	53.31	18.40	17	85	68
	Race: Black	80	36.35	12.20	17	76	59
	Race: Coloured	18	41.06	10.49	25	58	33
	Race: White	28	50.46	16.84	17	85	68
	Race: Indian	2	44.50	10.51	30	59	29

Table 8.7 shows the mean scores of participants as depicted by type of social work, race, rank and gender. In order to obtain interpretive categories Bride (2007b) suggested the use of percentiles. STS scores ranged from 17 to 85 for all participants, the mean score was 40.27 (SD=14.31), indicating mild STS levels within the SAPS social workers. Using the percentiles as interpretative levels (Table 8.8) analysis of the different sub groups revealed that lieutenant colonels (M=53.31; SD=8.40) and White participants (M=50.46; SD=16.84) had average scores indicating moderate levels of STS. The average scores for Indian (M=44.50; SD=10.51); forensic (M=43.12; SD=17.18); female (M=40.43; SD=13.89); occupational (M=39.54; SD=13.49); and female OSWs (M=39.65; SD=12.78) indicated mild levels of

STS. In comparison, male (M=38.77; SD=18.15); warrant officers (M=36.83; SD=11.73) and Black participants' (M=36.35; SD=12.20) average scores indicated little to no STS.

Table 8.8: STS Percentiles and Interpretations

Percentile Range	Score	Interpretation
≤50	39.00	Scores at 50th percentile and below indicate little to no STS
>50	39.01	Scores above 50th percentile and below 75th percentile indicate mild STS
≤75	47.75	Scores at or above 75th percentile indicate moderate STS
≤90	58.00	Scores at or above 90th percentile indicate high STS

These findings indicate that there were average differences in the levels of secondary traumatisation of participants, depending on their race and rank. Levene's test for equality of variances showed that lieutenant colonels (M=53.31; SE=5.10) had higher average STS scores than warrant officers (M=36.83; SE=1.93) and that this result was statistically significant ($t[14.74] = 4.68$; $p < 0.05$). These differences in average scores was further explored in a linear regression model with STS as the dependent variable and this model accounted for 15.4% of the variance in STS scores. When controlling for other variables, lieutenant colonels scored an average of 12.65 points higher on STS in comparison with warrant officers (Table 8.9). As lieutenant colonels had been employed in SAPS for an average of 13 years, whereas warrant officers had on average been employed in SAPS for 4.6 years, lieutenant colonels would have been exposed to a greater number of traumatic cases and therefore had a greater chance of experiencing secondary traumatic situations than warrant officers. Length of time at SAPS was weakly but positively correlated with STS ($r=.179$; $p<0.05$). An individual has a greater risk of developing PTSD, the more severe and longer the duration of the trauma exposure (Friedman, 2006; Matsakis, 1994). Although counsellors may desensitise over time through the development of defences, this finding provides support for the literature suggesting that the cumulative nature of the trauma exposure can be considered a risk factor for STSS (Bride, 2007a; Figley, 1995; Hudnall Stamm, 1999).

Table 8.9: Linear Regression Model with STS as Dependent Variable

Model		Unstandardised Coefficients		Standardised Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	34.516	2.690		12.830	.000
	Forensic	1.130	3.297	.032	.343	.732
	Male	-.016	4.016	.000	-.004	.997
	Married /In Relationship	-1.405	2.530	-.048	-.555	.580
	Captain	2.758	2.730	.096	1.010	.314
	Lieutenant Colonel	12.650	4.752	.268	2.662	.009
	Peri Urban	1.191	2.777	.037	.429	.669
	Rural	1.882	3.817	.042	.493	.623
	Coloured	3.731	3.589	.091	1.040	.301
	Indian	-1.260	10.460	-.011	-.121	.904
	White	12.078	3.212	.345	3.760	.000

$P < 0.05$

Lieutenant colonels also have greater work responsibility and accountabilities than the warrant officers or captains, which may adversely contribute to greater vulnerability to STS. Furthermore, most of the lieutenant colonels were White and the regression analysis showed that Whites scored an average of 12.078 higher on STS in comparison to Black social workers (Table 8.9), suggesting that race was a significant factor in STS levels. Considering South Africa's discriminatory past based on racial segregation and discriminatory ideologies, it is not surprising that there were significant racial differences. White South Africans grew up with a sense of privilege, having access to more resources and living in safer areas (Steinberg, 2008), unlike Black South Africans who predominantly lived in areas characterised by violence and crime. As a result White South Africans generally have not been exposed to the same levels of violent crimes as other racial groups and hence one could speculate that they may experience greater levels of traumatisation when exposed to traumatic material.

8.4.4 Secondary Traumatic Stress Symptoms

The results of the STSS are grouped according to the three sub-scales that the STSS measured, namely: intrusion, avoidance and arousal symptoms and are displayed in Table 8.10.

The mean summary scores for all SAPS social workers were: intrusion (M=12.47; SD=4.30); avoidance (M=16.48; SD=6.18); and arousal (M=11.32; SD=4.73). Occupational male social workers scored on average lower on every sub-scale than the female occupational social workers, suggesting that females showed greater susceptibility to STS than males. Baum (2015) attributes these gender differences to physiological differences between genders and believes that the tendency to report emotional distress is greater in females than in males.

Table 8.10: Mean, Standard Deviations and Ranges of STS Sub-Scales

	Category	N	Mean	SD	Min	Max	Range
Intrusion	All SAPS SW	128	12.47	4.30	5	25	20
	Forensic SW	26	12.62	5.01	5	25	20
	Occupational SW	102	12.43	4.14	5	24	19
	OSW: Male	13	12.08	5.22	5	22	17
	OSW: Female	89	12.48	3.98	5	24	19
	Female	115	12.51	4.21	5	25	20
	Rank: W/ Officer	48	11.50	3.64	5	20	15
	Rank: Captain	67	12.63	4.29	5	22	17
	Rank: C/Colonel	13	15.23	5.51	5	25	20
	Race: Black	80	9.65	3.70	5	21	16
	Race: Coloured	18	12.22	2.96	8	19	11
	Race: White	28	14.46	5.23	5	25	20
	Race: Indian	2	13.00	4.24	10	16	6
Avoidance	All SAPS SW	128	16.48	6.18	7	35	28
	Forensic SW	26	18.04	7.31	7	35	28
	Occupational SW	102	16.08	5.84	7	33	26
	OSW: Male	13	15.69	8.06	7	33	26
	OSW: Female	89	16.13	5.49	7	32	25
	Female	115	16.57	5.97	7	35	28
	Rank: W/ Officer	48	15.04	4.91	7	25	18
	Rank: Captain	67	16.45	6.24	7	33	26
	Rank: C/Colonel	13	21.92	7.44	7	35	28
	Race: Black	80	14.89	5.45	7	33	26
	Race: Coloured	18	16.5	4.82	7	25	18
	Race: White	28	21.00	6.92	7	35	28
	Race: Indian	2	21.00	6.93	11	22	11
Arousal	All SAPS SW	128	11.32	4.73	5	25	20
	Occupational SW	102	11.03	4.49	5	25	20
	Forensic SW	26	12.46	5.50	5	25	17
	OSW: Male	13	11.01	5.52	5	22	17
	OSW: Female	89	11.03	4.36	5	25	20
	Female	115	11.36	4.67	5	25	20
	Rank: W/ Officer	48	10.29	3.82	5	19	14
	Rank: Captain	67	11.12	7.44	7	35	28
	Rank: C/Colonel	13	16.15	4.26	5	23	18
	Race: Black	80	11.81	4.04	5	22	17
	Race: Coloured	18	12.33	3.46	7	18	11
	Race: White	28	15.18	5.43	5	25	20
	Race: Indian	2	15.00	8.49	9	21	12

Therefore interventions should not only be focused on ensuring the appropriate support systems for female social workers but should also encourage self-awareness and the use of appropriate emotional release techniques for male social workers. Forensic social workers scored on average higher than occupational social workers on every sub-scale indicating that FSWs experienced greater secondary

traumatic stress symptoms, although these average differences were not significant. White social workers scored the highest average scores on every sub-scale, whereas Black social workers scored the lowest on every sub-scale.

There was a significant difference ($t[36.17]=5.20$; $p<0.05$) in the mean levels of arousal symptoms between Black ($M=9.95$; $SE=0.414$) and White ($M=15.18$; $SE=1.03$) social workers, indicating that White social workers experienced greater arousal symptoms. White social workers also experienced higher intrusion symptoms ($M=14.46$; $SE=0.98$) than Coloured social workers ($M=12.22$; $SE=0.698$) and this finding was statistically significant ($t[43.47]=4.24$; $p<0.05$). As discussed previously, White social workers were more susceptible to STS: hence these racial differences should be interrogated and explored. It is possible that differentially certain cultures condition a person's perception of shame or willingness to admit certain symptoms (Shah, Garland & Katz, 2007). Due to the sensitivity around racial issues in South Africa, there is also a culture of silence around any differences in race which may occur. This concealment of issues does not dissipate these matters but instead can conversely entrench differences. Opportunities therefore need to be created where social workers can begin to sensitively open up and engage in dialogue around some of these relevant issues.

The following items on the STSS were recorded occasionally, often or always (Figure 8.7) by the SAPS social workers:

- I thought about my clients when I didn't intend to (65.01%).
- I was less active than usual (56.73%).
- I felt discouraged about the future (52.62%).

Items that were experienced the least frequently by participants included:

- I had disturbing dreams about my work with clients (28.09%).
- I avoided people, places, or things that reminded me of my work with clients (30.71%).
- I expected something bad to happen (30.93%).

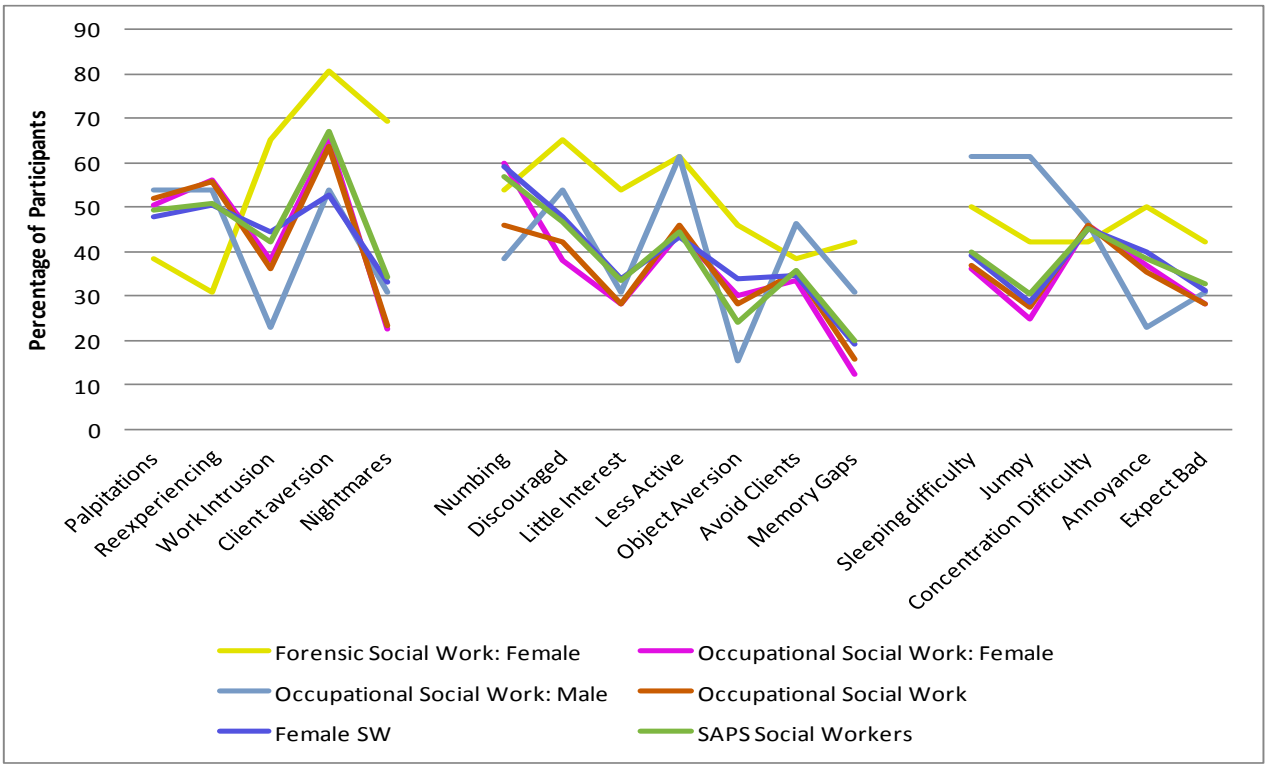


Figure 8.7: STS Symptoms Experienced Occasionally, Often or Always by the Participants (N=128)

The item experienced most frequently by FSWs (80.7%) and female OSWs (60.2%) was that they thought about their clients when there was no intention to do so. The second highest item/s for the FSWs included being less active (65.4%) and feeling discouraged (65.4%), whereas for female OSWs this item was feeling numb (56.8%). The items male OSWs experienced the most included: being less active (61.5%); and difficulty sleeping (61.5%). From the findings, males reported physical symptoms as the symptoms experienced most often, whereas for females the symptoms experienced the most were cognitive, emotional and physical symptoms. Items that were the least experienced were recorded as follows: FSWs - re-experiencing (30.8%) and nightmares (30.8%); Female OSWs – gaps in memory (25%) and feeling jumpy (23.9%); and Male OSWs - Avoiding places or things that reminded them of clients' traumas (15.4%); expecting something bad to happen (23.1%); annoyance (23.1%); and avoiding clients (23.1%). Training programmes about STS should therefore educate social workers about the symptomology of STS, with particular emphasis placed on detailed explanations about the most frequently experienced symptoms. Greater awareness and normalisation of symptoms can potentially help to reduce a sense of being overwhelmed and feelings of inadequacy (Allen, 2005; Ringel & Brandell, 2012).

8.4.5 Interview Participants' Experiences of Secondary Traumatic Stress

Acknowledging the effects of traumatic stress may be easier for some participants than others. When exploring the effects of STS, four themes became apparent: acknowledgment of the effects of secondary trauma; STS symptoms experienced; desensitisation to secondary trauma and the impact of attending traumatic scenes.

- **Theme one: Acknowledgement of the effects of secondary trauma**

Listening to traumatic narratives of clients can be particularly difficult for social workers. Most (26 or 86.66%) of the interview participants acknowledged that they sometimes felt traumatised by their work. All the forensic social workers could easily identify the personal effects of traumatic exposure, while some of the occupational social workers did not perceive their work as traumatic. As one FSW explained, almost every case was traumatic for her,

> *"For me, I think it means that more like taking the trauma that someone else experienced and as they tell you... that you get traumatised yourself. Ya, and I think this was basically happening almost, in every case, new case that's coming in because they, they just say it out and they give so much details that it's like you were there watching sometimes and it feels like that you're traumatised" (P16).*

> ***"****I think, when I came here, before I used to know, this is happening, people are dying, do this and that and that and then it was not easy because some of the time, going back home, you sleep and then it's like I think about all this experiences and this thing and it was like, affecting me" (P11).*

However, four occupational social workers felt that they were not adversely affected by the trauma to which they were exposed through assisting their clients. (One participant explained that she had not been allocated any trauma cases as she had not completed the trauma training course and therefore as she had not personally listened to a traumatic narrative, she was not affected). The responses of these participants could be explained as denial, which is a common defence associated with trauma exposure (Briere & Scott, 2006; Courtois, 2010) or as a result of participants' ability to dissociate or distance themselves from the trauma (Herman, 1997; Kirmayer, Lemelson & Barad, 2007). As Participant 6 explained, she was not affected as she was able to maintain emotional distance,

> *"It (secondary trauma exposure) doesn't affect me that much because I feel that I don't have to be emotionally involved with the issues so it's easy for me to do counselling them" (P6).*

McDougall (as cited in Ringel & Brandell, 2012) believes that it is not the absence of emotional response to trauma which becomes an issue but rather the inability to contain and truly reflect on

emotions relating to the traumatic experience. Upon reflection another participant acknowledged that she was initially affected by the trauma when she started at SAPS but she felt that she was no longer affected. Experiencing secondary traumatic stress in the initial years of employment was another theme that emerged and is explored in the following section. It is possible that more of the participants felt that they were not adversely affected by the trauma and were concerned as to how they would be viewed as counsellors if they were not affected by someone else's suffering.

- **Theme two: Secondary traumatic stress symptoms experienced**

Most participants (26 or 86.66%) had experienced STS symptoms, although some were not aware that these were STS symptoms as they were not familiar with the concept of STS. Bride (2007b) maintains that social workers engaged in direct practice are likely to experience at least one symptom of STS as a result of their work with traumatised populations. Matsakis (1994) explains that the fundamental dynamic underlying PTSD is the cycle of symptoms experienced when the trauma is re-experienced, followed by attempts at blurring or avoiding trauma memories and then periods of increased physical and psychological alertness.

- **Sub-theme one: Intrusion or re-experiencing the trauma**

Participants' experiences of intrusive thoughts, flashbacks and nightmares were shared in the following quotes,

> *"When you experience trauma…. physically, you might lose weight, you might eat too much, or not eat too much, when you can, you can have flash backs (P16)".*
>
> *"There are those specific cases where you feel that even before you sleep, like, you just thinking about this person" (P24).*
>
> *"It was starting to affect my personal life now because it's like, this was, I was now starting to think about it at night" (P13).*
>
> *"Can't sleep, can't eat, getting nightmares" (P5).*

Memories and emotions associated with the traumatic event emerge either consciously or unconsciously during the recall phase. Intrusive symptoms occur when traumatic and painful material needs to be processed. Often these intrusions are unwelcome and uninvited as they elicit feelings of fear and vulnerability (Matsakis, 1996; Schiraldi, 2000).

- **Sub-theme two: Avoidance**

Participants were more likely to describe intrusion and arousal symptoms than avoidance symptoms. However, as shown in Table 8.7, the results of the STSS showed that the average score for intrusion

was the highest score in comparison to the other two sub-scales. Two participants explained how they had experienced avoidance symptoms,

> "*Ya, don't go, I don't go near um, anybody else with anybody else with emotions and things. Almost as if I, if I don't need to I don't want to hear it" (P5).*

> *"I couldn't see a police van; I couldn't see a police member. Up till today sometimes when I go shopping and I see certain people, I just leave everything and I leave the shop. Because I'm too scared they going to come and talk to me. I don't want to see them, I don't want to hear them, I don't want anything to do with them. So I've got this thing of hiding a bit, erm from certain people who comes in the vicinity. My friends who know me, they'll phone me and say listen this guy is here so lock your door. So I'll lock my door, I won't answer it, I won't answer the phone I won't answer anything until these people have left. (LAUGHS) it's not normal I know..." (P26).*

As avoidance symptoms help the individual to suppress traumatic thoughts and feelings it may have been easier for interview participants to admit to experiencing intrusive and arousal symptoms.

- **Sub-theme three: Arousal symptoms**

These hyperarousal symptoms can give rise to feelings of anxiety and fear, and even result in a change to the body's chemistry (Friedman, 2006; Matsakis, 1994). Symptoms of hyperarousal can include insomnia, irritability, difficulty concentrating, startled responses and outbursts of anger. Three participants shared their experiences,

> *"..sweating at certain stages, exaggerated startled response. I had such a fight with my kids about balloons because I cannot handle a loud sound near me, in jump out of my skin. Ja (Yes), it's like that" (P8).*

> *"Sometimes, you can have loss of concentration" (P6).*
> *"Okay, so then when I came here, um, working, working with the children then, my stress level definitely went up. Um, so for the last few years, I was very, very anxious. Not working with the children specifically" (P2).*

Rousseau and Measham (2007) caution that it is clinically naive to evaluate the health of a trauma survivor either by the absence of symptoms or by a return to a previous state. Instead these authors attribute the waxing and waning of trauma symptoms over time to be part of the transformative process occurring as the individual develops a new state of equilibrium. Instead of conceptualising health and disability to be a dichotomy, it is imperative that understandings of traumatic stress move beyond this polarised view. This process requires a move away from pathological labelling and instead greater emphasis needs to be placed on adaptation. Although this more diverse understanding of mental health may contradict traditional social work approaches, practitioners need to deepen their

knowledge of traumatology, not only to be able to understand their own reactions but also to be able to offer more holistic services to their clients.

- **Theme three: Desensitisation to secondary trauma**

Four participants (13.33%) spoke about how they initially had experienced secondary trauma symptoms when they joined SAPS, but how these symptoms had dissipated over time. As two participants explained,

> *"I think when I started it was just, sleeping patterns, I could say it affected that because I was instead of sleeping I would be thinking about what was happening during the day, like, just like thinking about that, so it affected my sleeping because instead of sleeping I'd be thinking about the experience I had during the day but as time goes on, it's work, I come to work, I do it and after that its fine" (P18).*

> *"I think I'm used to it now, like, it's like there's something that is, if somebody was involved in a shooting, I don't have a problem with it, I'll, I'll go and do the debriefing with the group or individual, the family or whatever but I, I don't have a problem, like it's different, like when I come here, for me it's like, it was too much, every month, it's this then that but for now,* ***it's like it's a job****" (P15).*

Many posttraumatic therapeutic approaches such as flooding or implosive therapy, in vivo or imaginary exposure techniques expose the individual to imaginary traumatic stressors, in order to reduce arousal symptomology from reoccurring. Desensitisation helps to modify and reduce emotional and psychological responses to trauma, as one participant explained, "I just got used to it" (P1). However, although this desensitisation may not be a conscious process, the concern is that the long-term effects on the practitioners' ability to empathise may be negatively impacted which ultimately can affect not only the counselling relationship but all aspects of their lives.

- **Theme four: The impact of personally attending traumatic scenes**

Five OSW participants (16.66%) who spoke about the experience of secondary trauma mentioned that having to attend the scene where the incident happened (i.e. suicide or accident scene) as well as debriefing members involved, added to their traumatic exposure. The following two quotations reflect this theme:

> *"I think a difficult case that happened recently is when like, they called, they called me to, a member shot himself, they called me and the member was still there and the family was still there because usually they remove them, everything, they do everything and call us in" (P27).*

> *"I can handle anything but walking on the floor when somebody has been shot in the mouth and all the teeth are lying on the floor and hearing the 'crack', 'crack', 'crack' as you are*

> *stepping on the teeth you know - things like that and when you get home you have to wipe the soles of your shoes and its actually the blood from the scene" (P6).*

Another participant, who had not attended an incident scene, described herself as lucky, *"I've never seen like the bodies not just been exposed to the blood or even the accident you see".* It appears that it used to be SAPS's policy for social workers to attend the scene, but this requirement appears to have changed over the years and so consequently attending the scene was not always required. One participant who was not adversely affected by hearing about the trauma attributed this experience to the fact that she did not have to attend the scene,

> *"Although maybe it's because I don't go and see the scene, so they come to us and tell us what happened and all that so - it's not that much traumatic" (P1).*

Intensity of the traumatic exposure has been found to be associated with increased STS levels. Exposure to intense graphic details of a situation has been found to increase STS symptoms (Bourke & Craun, 2014). Traumatic memories are easily triggered as these memories remain near the forefront of awareness and are easily triggered by cues in the environment. These triggers can be visual, auditory (sound), olfactory (smell), gustatory (taste) or kinaesthetic (body movement) (Schiraldi, 2000). The practitioner has to deal with the traumatic exposure on numerous levels when attending traumatic scenes where officers have killed themselves and the ensuing counselling of officers about the event. This increased exposure also increases the number of traumatic memories and subsequent triggers. SAPS social work management should therefore consider the extent of trauma exposure to which the social workers are subjected. Where possible practitioners should not be required to attend traumatic scenes and be responsible for counselling personnel regarding the same traumatic event.

8.5 CONCLUSION

Anthony Altbeker refers to South Africa as a country at war with itself as he explains that South Africa has a 'crisis of crime' (Dixon, 2012). The interaction of trans-historic, cultural, structural, psychological and physical violence (Henkeman, 2013) makes policing in South Africa a particularly challenging task, one that is frequently acknowledged by researchers, criminologists and the South African society at large. However, under-acknowledged and almost hidden within the policing system are the social workers who try to assist the police through either forensic or occupational social work services. The extent of trauma exposure, occupational challenges and lack of recognition are factors that need to be acknowledged, explored and spoken about. This chapter has highlighted the nature of SAPS social workers' traumatic exposure, and the subsequent levels of secondary traumatisation which these

practitioners experience. The long term effects of this exposure, both personally and professionally are explored in the following chapter.

CHAPTER NINE

FINDINGS AND DISCUSSION 2

VICARIOUS TRAUMA, TRANSFERENCE AND COUNTER-TRANSFERENCE, COMPASSION SATISFACTION, BURNOUT AND THE WORK ENVIRONMENT

"Whoever fights monsters should see to it that in the process he does not become a monster. And if you gaze long enough into the abyss, the abyss will gaze back into you"

Fredrich Nietzsche.

9.1 INTRODUCTION

In the last few decades the adverse effects of assisting traumatised individuals has received a great deal of attention as the research interest in trauma associated psychological sequelae has significantly expanded (Kazantizis, Flett, Long, MacDonlad, Millar & Clark, 2010). Despite the tremendous rewards that practitioners may experience as a result of helping a trauma victim, Valent (2002, p. 17) cautions that helpers may be the "next dominoes who follow primary victims and suffer themselves". Using Constructivist Self-development theory as a framework, Pearlman and Saakvitne introduced the concept of **vicarious trauma,** explaining how one's beliefs, worldviews and memories can change over time through repeated traumatic exposure. This chapter explores the vicarious trauma levels of the SAPS social workers, through listening to interview participants' narratives and analysing changes in beliefs about trust, safety, esteem, intimacy and control. The impact of secondary trauma on the therapist was initially understood in traumatology through the framework of transference and counter-transference; accordingly interview participants' utilisation of these concepts was explored.

Understandings of the positive growth opportunities and increased work satisfaction levels have burgeoned in recent years. Against this backdrop, the results of the compassion satisfaction and burnout scale as measured by Hudnall Stamm's (2010) Professional Quality of Life Scale (PRoQOL) are presented and discussed. Taking into account that working conditions have a potentially significant influence on the development of vicarious trauma and burnout, participants' experiences of the work environment at SAPS were measured using Moos's Work Environment Scale. Lastly, survey participants identified specific aspects within the SAPS work environment that could be improved and these suggestions are presented.

9.2 VICARIOUS TRAUMA (VT)

9.2.1 The Third Objective

The third quantitative objective was to ascertain levels of vicarious trauma experienced by practitioners, as measured by Pearlman's (2003) Trauma and Attachment Belief Scale (TABS). The third qualitative objective was to ascertain whether participants' worldviews have changed as a result of secondary trauma exposure and to explore the phenomenon of vicarious trauma with practitioners.

9.2.2 The Trauma and Attachment Belief Scale (TABS)

The TABS was administered to measure levels of vicarious trauma and negative disruption of the five need areas that are often affected by the exposure to trauma, namely: safety; esteem; trust, intimacy and control. According to the guidelines specified in the TABS manual (Pearlman, 2003), total raw scores were converted to T-scores for interpretative purposes and these results were presented in Figure 9.1.

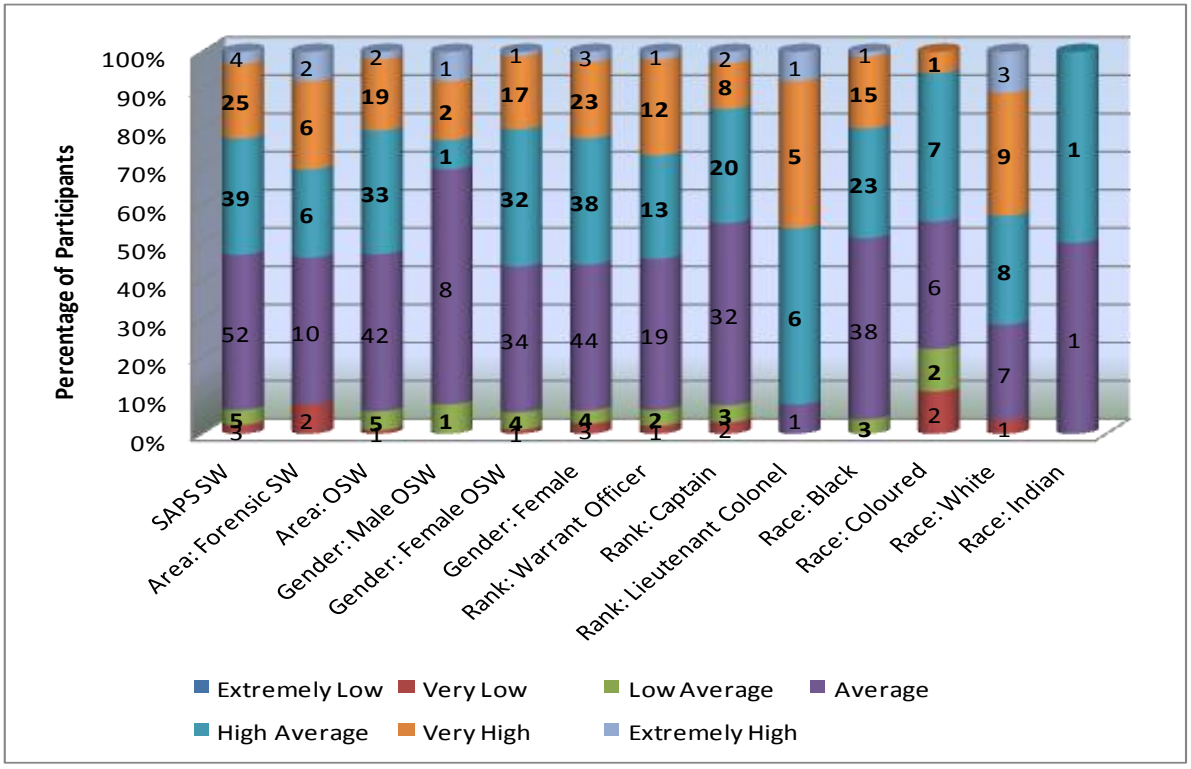


Figure 9.1: Interpretation of TABS T-Scores (N=128)

T-scores ranged from 118.9-320.9, with a total mean score of 210.43 (SD=36.02) which suggested a high average level of vicarious trauma (Pearlman, 2003). Almost a quarter (29 or 22.66%) of the participants had T-scores above 60, which suggested relative disruption as these results indicated very high and extremely high levels of vicarious trauma. Pearlman (2003, p. 13) explains that the term

disruption refers to "a restriction of one's belief that affects his or her ability to relate to others in a healthy manner". These high levels of disruption were evident in the following groups of participants: lieutenant colonels (6 or 46.15%); Whites (12 or 42.86%); forensic social workers (8 or 30.77%); males (3 or 23.08%) female occupational social workers (18 or 20.22%) and Black social workers (16 or 20%). Only captains (10 or 14.93%) and Coloured participants (1 or 5.56%) scored less than 20% with high vicarious trauma scores – although none of the Indian participants had high scores. However, it is acknowledged that due to the small sample size of Indians these results need to be interpreted with caution. Most participants (91 or 71.09%) had results indicating average or high average levels of vicarious trauma and only 8 or 6.25% had low or very low average scores for vicarious trauma. These results show that vicarious traumatisation among SAPS social workers is of particular concern.

Table 9.1: Regression Model with Vicarious Trauma as Dependent Variable

Model		Unstandardised Coefficients		Standardised Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	208.122	6.720		30.969	.000
	Forensic	8.335	8.237	.096	1.012	.314
	Male	2.259	10.033	.020	.225	.822
	Married/ In Relationship	2.865	6.321	.040	.453	.651
	Captain	-9.762	6.820	-.139	-1.431	.155
	Lieutenant Colonel	15.532	11.871	.135	1.308	.193
	Peri Urban	-1.152	6.938	-.015	-.166	.868
	Rural	-21.189	9.535	-.196	-2.222	.028
	Coloured	-20.268	8.965	-.202	-2.261	.026
	Indian	-25.519	26.130	-.091	-.977	.331
	White	15.298	8.024	.179	1.907	.059

P <0.05

A linear regression model with vicarious trauma as the dependent variable explained 11.6% of the variance in vicarious trauma scores and this model is depicted in Table 9.1. When controlling for other variables, social workers working in rural areas scored 21.189 lower than social workers in urban areas. Although crime in South Africa is a national problem, crime levels in urban areas are higher than rural areas (South African Police Service, 2015b) and therefore social workers in urban areas are expected to have been exposed to higher levels of trauma in their work, which can result in higher levels of vicarious trauma.

It is of interest that Coloured social workers scored 20.268 lower than Black social workers. The issue of 'Coloured' identity is one that has possibly not received as much attention in the transformation of South Africa as it should have. McKaiser (2015, p.32) speaks about how the Coloured population is

"still moored between the binaries of Black and White". In the old South Africa Coloureds were not White enough and in the new South Africa they are not Black enough as encapsulated in the title of Adhikari's (2005) book "Not Black enough, not White enough". As race in South Africa is a social reality along which identity is created, so Coloured communities have a separate identity from other race groups, and religious identity has also played an integral role in the assimilation of identity. The two main religions observed by Coloured people are Islam and Christianity: the Coloured Malay, a Coloured sub-group that initially originated from Malaysia, traditionally followed the Islamic faith; and with the advent of colonialism the Dutch Reformed Church was established in South Africa. Many missionary stations were established in the Cape and a separate branch of the church was established for the Coloured community as they converted to Christianity. The significant differences between Black and Coloured participants as displayed in Table 9.1 suggests that the Coloured people have a different identity to Black people and that although Coloured people are often stereotyped and identified as Black in South Africa (Adhikari, 2005), they have their own history and identity. Religious beliefs can help to provide a person with purpose and these beliefs can help to sustain them through difficult experiences. As vicarious trauma highlights changes in beliefs and understandings of the individual (Pearlman & Saakvitne, 1995a), so religious beliefs can help to sustain an individual through traumatic times, reducing the level of vicarious trauma experienced. A tentative explanation for the differences in levels of vicarious trauma for Coloured participants in the study is that traditional religious affiliations of the Coloured community are still evident and influence the beliefs and views held by this community. However, there is a paucity of research in this area and further research needs to be conducted which could potentially contribute to the discourse of trauma in South African society.

TABS measures beliefs about safety, trust, esteem, intimacy and control in relation to self (Figure 9.2) and others (Figure 9.3). These five need areas are sensitive to the effects of traumatic experiences (Pearlman, 2003), and high scores on these sub-scales indicate negative schema and possible disruption. Figure 9.2 shows that forensic social workers and lieutenant colonels obtained the highest scores for most of the sub-scales, whereas males and Coloured social workers tended to obtain the lowest average scores.

The highest scores overall were for Whites (M=20.68; SD=4.7227); lieutenant colonels (M=20.26; SD=2.82); and forensic social workers (M=19.67; SD=4.757), indicating the most disruption to beliefs about self. The lowest average overall scores were obtained by Coloured (M=17.12; SD=3.95) and Indian (M=17.80; SD =3.9598) participants, although the Indian scores need to be interpreted with caution due to the small sample size. Whites had the highest average scores for the self-intimacy scale

(M=23.29; SD=6.40); self-trust (M=17.57; SD=5.6) and self-esteem (M=20.04; SD=5.85), indicating the highest levels of distortion in these belief areas. Lieutenant colonels had the highest mean scores for self-control (M=21.62; SD=3.3) and forensic social workers for self-security (M=22.85; SD=5.46), indicating high levels of distortion in these areas.

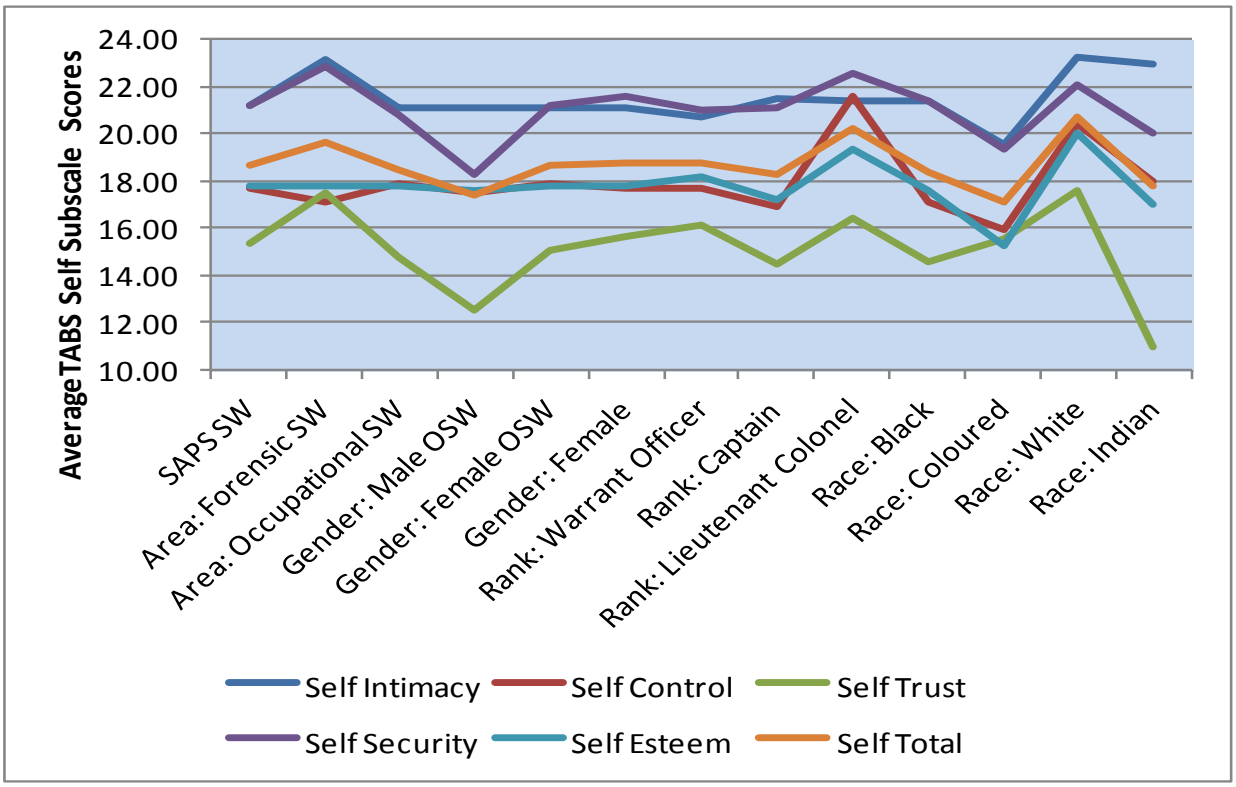


Figure 9.2: Average TABS Self Sub-Scale Scores (N=128)

Females (M=15.63; SE=0.47) had higher mean scores on the self-trust scale than males (M=13.23; SE=0.73) and this result was statistically significant ($t[23.65]=4.2$; $p<0.05$), indicating that females had greater distortions in self-trust than males. Forensic social workers scored higher on the self-intimacy sub-scale (M=23.15; SE=1.26) than occupational social workers (M=21.14; SE=0.456), and this result was statistically significant ($t[31.87]= 4.38$; $p<0.05$), showing that forensic social workers had greater distortions regarding self-intimacy than occupational social workers. Although working with traumatised individuals, whether they are adults or children, can have a significant impact on any counsellor, working with potentially abused children highlights a particular cruelty that exists within human nature. It is therefore not surprising that the forensic social workers would experience significant levels of mistrust, more so than occupational social workers who deal predominantly with the effects of trauma on police officers.

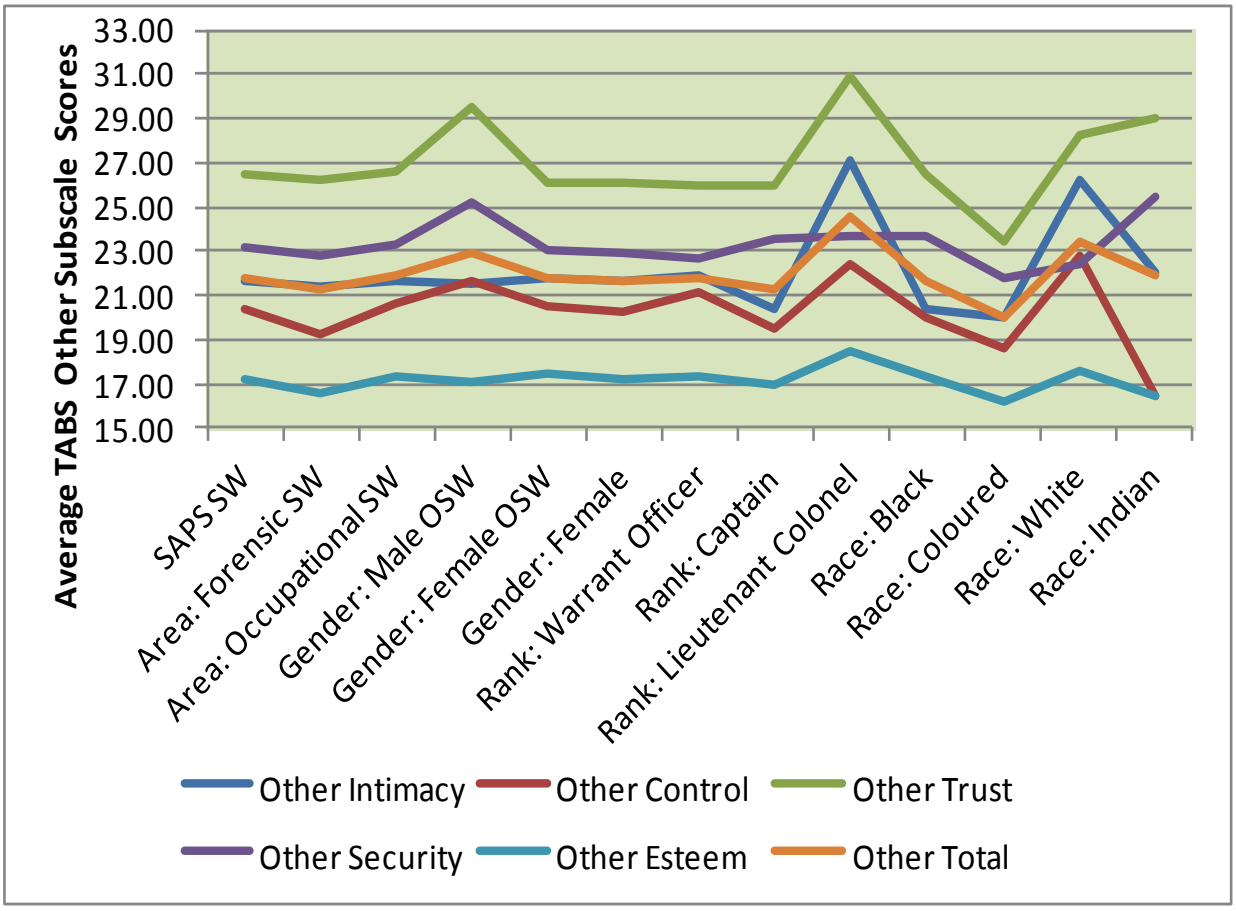


Figure 9.3: Average TABS Other Sub-Scale Scores (N=128)

Black social workers scored lower (M=26.40; SE=0.668) than White social workers (M=28.46; SE=1.64) on the sub-scale that measured other trust and this result was statistically significant (t[36.38] =4.46; p<0.05), indicating that Whites had greater distortion in trusting others than Black social workers. A possible explanation is that traditionally, White culture has had an individualistic focus and therefore relying on or trusting in others is perhaps not as prominent whereas in Black cultures the sense of extended family and community is much better acknowledged, possibly resulting in a greater belief and trust in others.

9.2.3 Hypothesis Testing

Hypothesis 2 stipulated that vicarious traumatisation was positively correlated with STS. Conversely, the null hypothesis indicated that there was no significant correlation between VT and STS. Pearson product-moment correlation coefficient showed that there was a significant positive relationship with STS (r=.449; p<0.01), therefore the null hypothesis was rejected and hypothesis four was accepted. The more secondary traumatic stress an individual experiences, the higher their level of vicarious traumatisation is likely to be. Although some of the symptoms of VT and STS may overlap, such as negative feelings about the future, the two constructs do have different areas of focus.

What this finding suggests is that these two constructs are related, although STS can be experienced suddenly and VT occurs over time. Although some of the symptoms of VT are the same as STS, the symptoms of VT are predominately manifested in cognitive, emotional or spiritual changes. Participant 3 explained how she was affected by the trauma, *"Physically I was not so worse off…. It was more emotional".* Proactive support strategies are therefore necessary to try to ameliorate the development of either STS or VT.

According to the null hypothesis 3 there was no significant difference in the average level of vicarious traumatisation experienced by forensic and occupational social workers employed at SAPS. Therefore hypothesis 3 proposed that there was a significant difference in average vicarious traumatisation scores experienced by forensic and occupational social work. Levene's t-test was used to test this hypothesis and showed that forensic social workers experienced higher levels of vicarious trauma (M=207.19; SE=9.18) than occupational social workers (M=205.04; SE=3.12) and this result was statistically significant (t[31] =0.222; $p<0.05$). The null hypothesis was therefore rejected, and hypothesis 3 accepted indicating that there was a difference in average levels of vicarious traumatisation experienced by forensic and occupational social workers suggesting that the type or area of social work engaged in can influence the level of vicarious traumatisation. The implication of this finding is that social workers in SAPS need to be educated about vicarious traumatisation and particular emphasis should be given to promoting awareness about vicarious trauma among the forensic social workers.

9.2.4 Understanding Vicarious Trauma in SAPS Social Workers

In the interviews participants were asked if they felt that the way in which they understood the world had changed due to the constant exposure to trauma. Despite the results from the TAB scores showing that vicarious trauma is a concern for SAPS social workers, most (19 or 63.33%) participants did not feel that their understandings about life had been negatively influenced as a result of their work. The responses from the 11 participants who felt that their beliefs had changed were analysed according to the five schema areas identified in the TABS scale. Selected quotations were incorporated within Table 9.2 to illustrate the five areas, namely; intimacy; control; safety; trust and esteem.

Table 9.2: Quotations to Illustrate Vicarious Trauma (N=11)

	Sub-theme	No	Selected quotations to Illustrate themes
Vicarious Trauma	**Intimacy**	**5**	• *"I think it (trauma exposure), I think it's really, I think it made me, I'm very afgesond in Afrikaans, you call it. I'm very numb. It's as if nothing can shock me, and I think it's my way of also defending myself otherwise I won't be able to cope, I would need to, I need to pick myself up to put myself through it to show some emotion..to drag some emotion out because it, it's, even though I feel it I can't express it" (P9).* • *"If you are in SAPS, it's like you are in another, another world. Like things are no longer the same but maybe, I don't know, maybe it's like; I don't know whether it's SAPS or whatever. With the people you are working with say, it's like, maybe it's due to trauma ...It's like for them, they always need something to do, it's difficult for some, most of them like, to be faithful or to be committed, maybe because most of the time they are far from home, they get bored, they get frustrated and then they have affairs.. Because mostly I'm dealing with the ones of uh, marital cases and whatever, and I think to myself... you just find out that like, marriage is unpredictable, life is unpredictable. So you end up like, not getting involved due to, to experience" (P15).*
	Control	**2**	• *"The need for control definitely, like with one of the specific topics that I spoke to him about, with the psychiatrist, I told him that I feel out of control... especially with the cases, I think you know... I don't have control about the outcome on the case, so no matter how hard I work or how much effort I put in, I don't... I still don't have any control about the outcome, and if these children go back to their homes, to the perpetrator, or the accused I feel very powerless, because you know, and out of control because I did everything I could and still it didn't help. So control yes, it did have an impact" (P9).*
	Safety	**6**	• *"So immediately, it's not someone else anymore, it's, it can happen to me also and um, so, what else? Ya, but the usual things that the members experience like stress symptoms um, being emotional, not there while I'm there but afterwards being emotional, can't sleep, can't eat, getting nightmares, um feeling a bit paranoid about my child, so, being run over some things like that" (P6).* • *"Safety it's a big one because now, I would think that oh my god, and sometimes it is not easy because we are unsafe. We are unprotected, we are not been trained as police officials" (P16).* *"I don't even know how I see the world now, because the thing is, I'm only concerned about me and my family. How safe are we. Because I don't know the other person is safe but just me, just thinking of me and am I safe… Am I safe in my own country? If I do leave to go to another place, will it be safe?" (P14).*

	Trust	***4***	• *"Because you can't trust anybody, you can't even trust a neighbour, you can't trust your brother, you can't trust your uncle, you can trust no one but yourself" (P12).* • *"No, I think it's just that area of abuse with kids and not being able to trust people with my own kids" (P13).*
	Esteem	**2**	• *"So I've gained a lot of weight also um, when I'm in stress situations So that then indirectly has influenced my self-worth because at this stage I'm over weight and I don't feel that much self-confident but I know, I definitely know it has to do with my weight consciousness" (P5).* • *"That I must say I get quite a lot. People acknowledge quite a lot what I do. So, um, and that drives me. Sometimes I get negative, when the case is, is, you know, thrown out, or withdrawn or whatever. It does influence me negatively" (P2).*

Vicarious Trauma is a process that occurs not only over time, but also across clients and therapeutic relationships (Steed & Downing, 1998). Counsellors may find it difficult to be alone and avoid self-awareness opportunities as it may be frightening and anxiety-provoking to deal with feelings and emotions (Pearlman, 2003). Experiencing a traumatic event can result in difficulty in intimacy resulting in alienation from others, avoidance of personal conversations or emotional closeness. Five participants (16.67%) spoke about how they felt their personal connections with others had changed since joining SAPS.

Due to the excessive levels of violent crime in the country, personal safety is a concern for every South African. Not only are crime and safety incidents being reported on a daily basis in the media, the very organisation where participants were employed, is mandated to ensure the personal and community safety of all South African citizens. For the SAPS social worker, assessing children who may have been abused or counselling an officer, whose life was threatened during the execution of his or her duties, may result in these social workers developing negative beliefs about trusting others and experiencing an increasing concern about their safety. Concerns about safety may also result in counsellors increasingly wanting to ensure control over aspects of their life that they can control. Feelings of helplessness may be exacerbated when the counsellor has limited influence or control over the outcome which may often be the situation with the forensic social workers, as Participant 2 explained in Table 9.2.

Vicarious traumatisation might result in the counsellor experiencing difficulty with social intimacy and relating to others. The quotations in Table 9.3 show how participants acknowledged that safety and trust were areas in their lives that had been adversely affected through the constant exposure to traumatic material. Pearlman and Saakvitne (1995a) explain how self-confidence and esteem issues can be a particular concern for a novice trauma counsellor. A counsellor is faced with two particular challenges, the development of a professional identity and the development of self-confidence. Young counsellors may have high expectations and unrealistic beliefs in their own abilities and those of others to overcome adversity. When these expectations are not met, it can result in the counsellor experiencing feelings of frustration, resentment and anger. If these feelings are not dealt with, they can lead to the counsellor experiencing long-term effects on self-esteem, self confidence and belief in the therapeutic process. This change of belief in the counselling process was apparent in Participant 28,

> *"Only now - I think there's always been hope, I've always said I can manage my own work and do things I need to do but I've lost hope in.. in what we doing - I really have" (P28).*

These findings indicate that SAPS practitioners experienced relatively high levels of vicarious trauma and highlighted the need for counsellors to be attuned to their own dynamics and not only those of their clients. The need for introspection and self-analysis is further explored in the following section.

9.3 TRANSFERENCE AND COUNTER-TRANSFERENCE

9.3.1 The Ninth Qualitative Objective

The ninth qualitative objective was to elicit information on practitioners' awareness of transference and counter-transference and whether they recognise the impact of these factors on the counselling relationship. (Although this objective is the ninth qualitative objective, the researcher deemed it appropriate to incorporate this section after vicarious trauma and hence the section on transference and counter-transference has been inserted after objective four).

9.3.2 Understandings of Transference and Counter-transference

Of paramount importance in trauma counselling is being aware of the transference and counter-transference reactions, as discussing traumatic material can have significant implications for both the client and the counsellor. Most of the interview participants (23 or 76.66%) were not aware of the meanings of the terms transference or counter-transference, which implied that these participants did not use these conceptual understandings to analyse the development of the counselling relationship.

The researcher provided the same explanation of the terms transference and counter-transference (Chapter 1, p.15) to the participants who were not aware of these concepts. After these explanations were provided, it was apparent that these participants were still not familiar with these terms. The following participants acknowledged their confusion in their responses:

> *"I haven't experienced that. I might but I haven't experienced it" (P22).*
>
> *"I try always not to do that. Although sometimes it comes, ne, but I don't, I don't show it, you know, I ignore it and go, and continue with what I'm supposed to do" (P8).*
>
> *"Yes transference, I do that I move one police officer from one station to another" (P18).*

One could perhaps attribute the lack of familiarity to memory decay as participants may have learnt about these techniques during the course of their undergraduate training. Alternatively, since English was not the first language of most of the participants, this factor could account for their unfamiliarity with these terms. However, what was apparent was that participants were not familiar with the practical application of these terms, as one participant explained,

> *"Ah - I remember those terms but I don't remember their definition - but I remember them - I don't remember if the other one had to do with, I'm not sure if I'm right or wrong - maybe when the client is crying you also feel like crying, ... you empathise. I'm not sure if I'm correct" (P1).*

Although the terms transference and counter-transference emanate from psychoanalytic paradigms, most counselling approaches emphasise the importance of the counselling relationship. Cartwright (2011) argues that these terms are helpful for therapists, particularly cognitive therapists, to consider during reflective practice and that the potential application of these concepts should not be dismissed, purely because of their psychoanalytic origins. Cartwright (2011) explains how Winnicott (1949) spoke about the subjective and objective aspects of counter-transference. The subjective aspect refers to the therapist's own personal issues, whereas the objective refers to how the therapist responds to the client's behaviour. Although this delineation may seem superfluous as ultimately the subjective and objective are intertwined, this delineation may be useful in helping therapists to achieve greater insight into their own responses. Leahy (2008) speaks about the "emotional philosophy" of the counsellor and emphasises how important it is for counsellors to be aware of their own emotional philosophies. Counsellors need to give credence to the client's emotional condition, and not impose their own emotional philosophy on the client (counter-transference). Two participants spoke about how they were aware of these concepts and acknowledged how important they were when dealing with client interventions,

> *" I do think they do, because maybe I might have issues, maybe for that day about another case or something and I might end up transferring all those issues towards the case or that particular child or the parent because I had things that I haven't resolved and they may be doing that because sometimes you get a reaction and not because they want to, but it just happens sometimes.. and all you need is just to be aware. If you're aware it's much better than when you're not because you can try and minimise that" (P6).*

> *"Transferring is, I knew that, transferring and counter-transferring, isn't it about taking the person's situation, nearly getting into the situation with the person, or counter-transferring is to let a person, I don't know, get to you, get too near to you, whereas the boundaries, the boundaries are overstepped, need to be careful of that" (P5).*

Whereas counter-transference was initially conceptualised by Freud to refer to the analyst's unconscious processes, a more systemic understanding of the term, according to the person-practice model, incorporates conscious and unconscious material (Baldwin, 1987). Social workers need to constantly strive to increase their levels of self-awareness and learn to understand how their own responses affect the counselling process.

What these findings also highlighted was that some of the participants had limited knowledge and understanding of trauma theories and specific trauma counselling approaches and techniques. Two of the participants explained how they did not focus on trauma counselling but instead used their generic social work counselling skills whenever they had to counsel a traumatised client. As these participants explained,

> *"No, not really, because counselling I think is counselling, the issue doesn't affect it because I still follow the same, uh, principles, doing the same counselling as a social worker" (P18).*
> *"So, my focus is not only on trauma, as I've said to you, there's a lot to do...so trauma I don't just do trauma, trauma cannot just affect my counselling style" (P3).*

Although a social worker is always guided by the techniques, values and principles of generic social work, advanced knowledge and skills need to be developed in specific areas of practice such as family therapy, substance abuse and trauma. Briere and Lanktree (2012) identified specific intervention techniques when assisting an individual with complex trauma including: distress reduction/affect regulation training; exposure therapies; cognitive processing; relationship building and support; psycho education; as well as trigger identification/intervention. Most of these techniques are not taught in social work undergraduate training as they are beyond the scope of generic social work training and would require social workers to attend additional more advanced training courses.

Participants spoke about how they had attended trauma training and learnt to conduct debriefings using a particular model. However, it appears that social workers who were interviewed had only been trained in one debriefing model and this model was applied to every situation and client. This finding

raises two points for consideration: firstly, clients are all different and as social workers we should have an individualised and culturally sensitive approach when counselling clients. The practice of rigidly utilising only one approach to trauma counselling, brings into question whether the principle of individualisation is being appropriately applied. Secondly, the effectiveness of group debriefings has often been questioned during the past decade. It is therefore recommended that SAPS should conduct longitudinal studies to assess the effectiveness of mandatory debriefings and whether these debriefings are effective when coping with the continual exposure to traumatic situations. Considering the stressful work environment in which these social workers practise, it is imperative that they are equipped with the necessary skills so that they can provide quality services to clients.

9.4 COMPASSION SATISFACTION

9.4.1 The Fourth Objective

The fourth quantitative objective was to measure the levels of compassion satisfaction as determined by the Professional Quality of Life Scale (Hudnall Stamm, 2010) and the fourth qualitative objective was to explore whether participants experience compassion satisfaction in their work.

9.4.2 The ProQOL's (2010) Measurement of Compassion Satisfaction

The mean score for compassion satisfaction was 51.35 (SD=7.614) corresponding with the 49th percentile of the reference group. When compared with the cut scores that are included in the concise ProQOL manual (Hudnall Stamm, 2010), the reference group mean for this scale which was 50, indicating that participants experienced average levels of personal reward from their work as social workers. The mode for this scale was 59, the median was 53 and the scores ranged from 13-66.

The highest proportion of participants experienced average levels of compassion satisfaction (60 or 46.88%), whereas 55 (42.97%) experienced high levels of compassion satisfaction and 13 (10.16%) experienced low levels of compassion satisfaction. These results indicated that most participants experienced an average level of compassion satisfaction in their work, only deriving an average level of fulfilment through their work as a social worker. Figure 9.4 displays the different levels of compassion satisfaction for the various categories (type of social work, gender, rank and race).

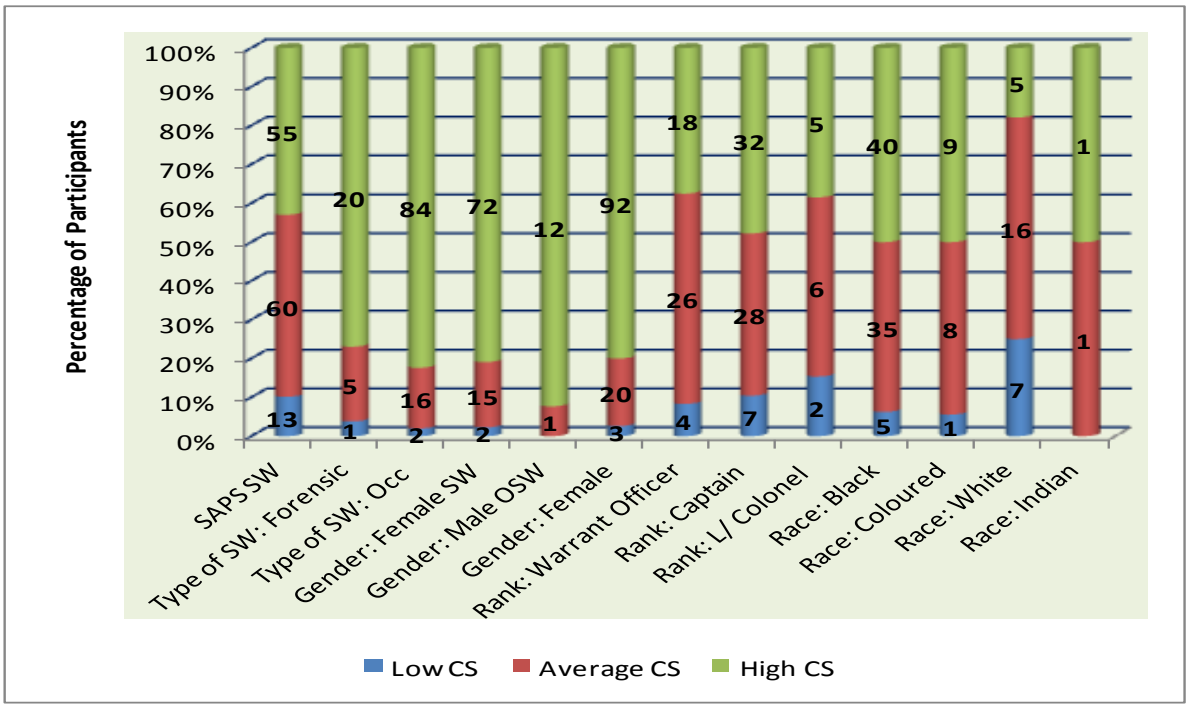


Figure 9.4: Levels of Compassion Satisfaction (N=128)

There was a significant difference (t[125]=3.117;p<0.05) in average scores of compassion satisfaction between those who were in a relationship and those who were not. On average, those who were not in a relationship scored higher on compassion satisfaction (M=40.37; SE=0.804) than those in a relationship (M=36.49; SE=0.952). Social workers, who were not in a relationship, may have derived a greater sense of meaning and purpose from their work as opposed to those who were married or in a relationship. For those social workers who were not in a relationship, work may have fulfilled many more of their needs and helped to provide a greater sense of belonging, resulting in participants who were single experiencing higher levels of compassion satisfaction.

Black social workers (M=40.19; SE=.685) scored on average higher than White social workers (M=32.86; SE=1.69) and this result was significant (t[36.20]=7.33; p<0.05), indicating that Black social workers were more fulfilled by their work than White social workers. In Table 9.3, a linear regression model that accounted for 19.2% of the variance in scores, participants in a relationship scored on average 3.061 lower on satisfaction that those participants who were not in a relationship. White social workers also scored 5.578 lower than Black social workers, indicating that White social workers found less satisfaction in their work than Black social workers.

Table 9.3: Regression Model with Compassion Satisfaction as the Dependent Variable

Model		Unstandardised Coefficients		Standardised Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	41.764	1.391		30.025	.000
	Forensic	-1.766	1.705	-.094	-1.036	.302
	Male	3.941	2.077	.158	1.898	.060
	In Relationship	-3.061	1.308	-.198	-2.339	.021
	Captain	.525	1.412	.035	.372	.711
	Lieutenant Colonel	-2.490	2.457	-.100	-1.014	.313
	Peri Urban	.014	1.436	.001	.010	.992
	Rural	-3.110	1.974	-.133	-1.576	.118
	Coloured	-3.434	1.856	-.158	-1.851	.067
	Indian	5.787	5.408	.095	1.070	.287
	White	-5.578	1.661	-.301	-3.359	.001

P<0.05

A possible explanation is that White social workers who are unable to speak the home languages of their Black clients may feel less competent and not derive as much compassion satisfaction from their professional engagement with clients as Black social workers do. However, this assumption would need to be subjected to more rigorous research. Supervision and personal counselling can be instrumental processes in helping the practitioner to experience greater levels of compassion satisfaction in their work, establish realistic goals and expectations and where disappointments can be acknowledged and worked through.

9.4.3 Hypothesis Testing

Hypothesis 4 stipulated that there was a negative correlation between vicarious trauma and compassion satisfaction. The null hypothesis stipulated that there was no correlation between vicarious trauma and compassion satisfaction. A negative and statistically significant relationship ($r=-.310$; $p<0.01$) was found to exist between vicarious trauma and compassion satisfaction, therefore the null hypothesis was rejected and hypothesis 6 accepted. Similarly, compassion satisfaction was negatively but significantly correlated with STS ($r=-.331$; $p<0.01$). This finding implies that practitioners should be encouraged to find fulfilment and explore the positive outcomes of working with trauma, as this process may help to reduce levels of vicarious traumatisation and secondary traumatisation.

9.4.4 Understanding Compassion Satisfaction

Compassion satisfaction was explored through both the survey questions and the interviews that were conducted with participants. Three themes about aspects of compassion satisfaction emerged, namely: feeling fulfilled through one's work; growth in professional knowledge and posttraumatic growth.

- ***Theme one: Feeling fulfilled through one's work***

Social work is not typically known to be a financially lucrative profession; however, the ability to positively contribute to an individual's life or for the greater good of society often creates rewards of a more personal or spiritual nature. Participant 18 explained how knowing that she was making a difference kept her going,

> *"Ya, yes, that keeps me going. It, and it, especially if somebody comes to me and say, you know, thank very much, you have done a wonderful, you have made a difference, I feel positive, and I go on" (P18).*

Participant 36 viewed her work as *"…a privilege and honour to work for SAPS and trying to make a difference in members and their families' lives" (P36).* Although the quantitative results showed that most participants (115 or 89.85%) had an average or high level of compassion satisfaction, the majority of the interview participants (18 or 60%) did not easily identify many aspects of their work that made them feel satisfied. However, participants could easily identify the professional growth that they had experienced since joining SAPS.

- ***Theme two: Growth in professional knowledge***

For 15 participants (50%) the growth that they identified related to their growth in knowledge and skills as a social worker. Six participants (20%) mentioned how they had learnt to facilitate training workshops; four participants spoke about how they had learnt how to conduct trauma debriefings; and only two participants mentioned how they had improved in their counselling skills. As two of the interview participants explained,

> *"Yes, they are equipping us with knowledge, they give us some training and all that so there's no confusion you go outside and they train you to help the police - every year they give us a certain code and then you go and present it to the member"(P1).*

> *"Yes, I'm starting to, I've changed a lot and I have gained a lot, you know. I have gained a lot of experience in the field of trauma and I have, you know, I have, those people who are, you know the people who are affected or infected have a way of relating to me. If I meet somebody with disabled, it's very, it's very easy for me to relate to that person...like I have that confidence in*

myself that I can tackle anybody who is experiencing HIV or who has had an amputation because I have experience in working with those people" (P19).

For Participant 19 one of her main learnings was how to empathise and relate to clients who had particularly difficult issues, such as HIV or disability. Four participants mentioned how they had acquired specialised social work knowledge in either occupational or forensic social work, "*I have gained much knowledge and insight into occupational social work as a* specialised *field of social work"* (P65). Three participants spoke about how they had learnt to work independently and to work under pressure. Participant 96 mentioned how she had learnt about *"working in a team; patience, some things are done slowly; and how important it is to stay abreast with new information".*

- ***Theme three: Posttraumatic growth***

Assisting clients through traumatic experiences often challenges many philosophical and spiritual understandings of the social worker. Just as social workers help traumatised clients to initially focus on survival strategies and to use the situation as a transformation opportunity, they are also personally and professionally confronted by these challenges and opportunities. Fourteen participants could identify areas in which they felt they had personally grown as a result of the constant trauma exposure and working at SAPS. Participant 2 could identify her growth as a process occurring over the years that she had been employed at SAPS, *"So, the positive thing about that is that um, everything that I'm doing now I knew, you know, if I go back five years ago, how much I've learned so it was also a growing process"(P2).*

One of the most prominent growth areas that these participants identified was the importance of putting their needs first and looking after themselves. Participant 27 explained how police officers see a negative side to life, "*SAPS members mainly work with the bad things in life (rape, murder etc). They offer service to the community and forget about their own wellbeing*" and by the same token the social workers in SAPS are constantly exposed to the harshness in life and not only do they teach their clients to look after themselves but they first need to learn about the importance of their own self-care.

"Yes, I have changed a lot. I have learnt to look after myself" (P7).

"M*y family first and then others can follow" (P4).*

"I love the SAPS and the members but now I am tired because all these years I have learnt that if you don't care about yourself no one else will" (P111).

Social workers often have 'rescue personalities' where they will place others' needs before their own. *"Working within boundaries*" (P48) may come more naturally for some than others. Learning to develop boundaries can be an essential survival technique that some social workers acquire over time. Learning the importance of establishing boundaries and promoting self-care habits are life lessons needing to be learned, particularly from working with traumatised clients. Two participants described how they felt they had grown and that they had developed their coping skills,

> *"I've learnt a lot, it (SAPS) equipped me in many ways, my coping skills developed very well - because you need to cope to stay alive" (P122).*

> "*SAPS exposed me to situations that made me stronger than before; I can now cope with serious incidents that I am exposed to on a daily basis" (*P38).

Njabulo Ndebele (1991) and Sampie Terreblanche (2012) have both described South Africa as a racially polarised and divided society. Consequently, many social workers may not have significantly interacted with people of other races, until they enter the workforce. One participant powerfully acknowledged that his greatest learning was that "*working with different ethnic groups builds strength"* (P46). Learning to appreciate the diversity and differences of another's culture is imperative for any social worker intending to be relevant and effective. Although social workers speak about the importance of culturally sensitive practice (Zastrow, 2013), until social workers learn to acknowledge their own biases and prejudices, the notion of culturally sensitive practice is purely a theoretical ideal. In a society like South Africa where race has been the defining characteristic, acknowledging one's discriminatory perceptions of others from a racial perspective, requires self awareness and possibly a maturity of character. Only in honest reflection of who we are can we create true opportunities for growth as individuals and professionals. Four participants (13.33%), identified areas of personal growth they had experienced through working at SAPS and encountering consequent levels of trauma:

> *"To be independent when working and achieve against opposition" (P42).*

> *"Problems are a way of life but the important thing is how you handle them" (P51).*

> *"Despite difficulties life goes on" (P49).*

> *"Accept the things I can't change and change the things I can - I choose how I think, feel and react" (P63).*

Personal growth of the counsellor can be ignited through the connection that we have with our clients. As Pearlman and Saakvitne (1995, p. 403) explain,

> Sharing in the growth and development of another person is an honour. Participating in the transformation of a client's despair is a life-altering, spiritual experience for those therapists who are open to it. Our clients' resilience and capacity to heal and grow are powerful antidotes to the creeping cynicism that characterizes vicarious traumatisation.

Social workers also need to be taught about the opportunities for posttraumatic growth, so that they can consolidate their own growth opportunities. Hearing about how other social workers have grown, both personally and professionally, through the constant exposure to trauma may inspire and motivate social workers to understand and view the challenges of their work through a different lens.

9.5 BURNOUT

9.5.1 The Fifth Objective

The fifth quantitative objective was to measure the levels of burnout as measured by Hudnall Stamm's (2010) Professional Quality of Life Scale (ProQOL) and the fifth qualitative objective was to explore participants' experiences of burnout.

9.5.2 ProQOL's (2010) Measurement of Burnout

Hudnall Stamm understands compassion fatigue to be comprising secondary traumatic stress and burnout levels (Hudnall Stamm, 2010); it was therefore necessary to explore burnout levels of the participants. Only four participants (3.13%) scored high levels of burnout, with most participants (78 or 60.94%) obtaining moderate or low (46 or 35.94%) levels of burnout (Figure 9.5).

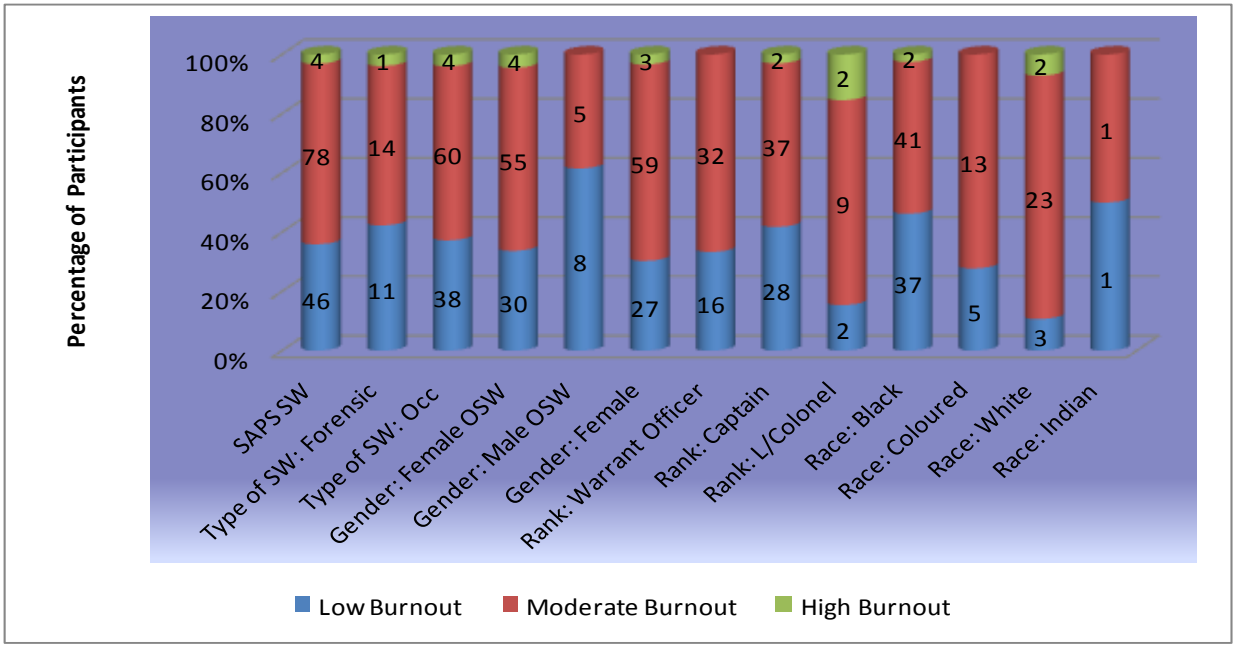


Figure 9.5: Levels of Burnout (N=128)

The mean score for burnout was 54.42 (SD=6.772), which corresponds to the 70th percentile of the reference group. Scores ranged from 35-73, with a mode of 48 and a median of 54.51. The majority of participants (85 or 66.4%) scored above the group's reference norm for this scale (50), while 56 (43.75%) scored above the 75th percentile, indicating that a substantial portion of the participants had a relatively high risk for burnout.

A linear regression model (Table 9.4) accounted for 10.7% of the variance in scores. When accounting for other variables, lieutenant colonels scored on average 4.95 higher than warrant officers, showing that lieutenant colonels had higher burnout levels than warrant officers. Considering that lieutenant colonels have more work responsibilities than the other ranks, one could expect that they would also have higher burnout rates.

Table 9.4: Regression Model with Burnout as the Dependent Variable

Model		Unstandardised Coefficients		Standardised Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	22.402	1.304		17.180	.000
	Forensic	-1.076	1.598	-.064	-.673	.502
	Male	-3.677	1.947	-.165	-1.889	.061
	Married /In Relationship	1.600	1.226	.116	1.304	.195
	Captain	-.093	1.323	-.007	-.070	.944
	Lieutenant Colonel	4.955	2.303	.222	2.151	.034
	Peri Urban	.282	1.346	.019	.210	.834
	Rural	.234	1.850	.011	.127	.900
	Coloured	.135	1.739	.007	.078	.938
	Indian	-7.456	5.070	-.138	-1.471	.144
	White	3.627	1.557	.220	2.330	.022

P<0.05

Coloured participants (M=23.56; SE=.933)) had higher average scores than Black (M=22.80; SE=.691) and Indian participants (M=21.50; SE=7.5) but neither of these results was significant, (t[59]=.248; p>0.05) and (t[18]=.156; p>0.05). However, in the regression model White social workers scored 3.627 points higher than Black social workers, indicating that there were significant average differences on the burnout scores based on race and that higher burnout levels were evident in the White participants. This finding is consistent with earlier findings in this study which showed that White participants were more susceptible to negative aspects of the work environment and to the trauma exposure than Black participants. White participants may have greater expectations of personal

fulfilment and work satisfaction than Black participants. Moreover, with less community support structures in place, Whites may consequently be more vulnerable, and experience more symptoms of burnout.

9.5.3 Hypothesis Testing

The null hypothesis 5 stipulated that there was no significant positive correlation between burnout and secondary traumatic stress; accordingly hypothesis 5 predicted that there was a significant negative relationship between STS and burnout. Pearson's product-moment correlation coefficient showed that there was a strong positive relationship between STS and burnout ($r=.597$; $p<0.05$), suggesting that those who experience high levels of secondary traumatic stress are likely to experience high levels of burnout. If practitioners experience secondary trauma symptoms they may be more vulnerable to feelings of exhaustion and depersonalisation and consequently their work may be adversely affected. Galek, Flannelly, Greene and Kudler (2011) raise the question whether institutional variables that contribute to burnout, also, to some extent, contribute to STS. Although these two constructs, burnout and STS are distinctively different phenomena, and burnout is understood to happen over time, in comparison to STS which can have a sudden onset, researchers (Figley, 1995; Galek et al., 2011) maintain that these concepts are somewhat related. Therefore, it is important to ensure that there are adequate workplace supports established so that practitioners feel supported and mentored during stressful periods, reducing the potential for both secondary traumatic stress and burnout.

9.5.4 Understanding Participants' Experiences of Burnout

Four of the interview participants attributed the burnout they had experienced to having worked at SAPS. While these four participants specifically used the word **burnout,** many other participants mentioned various symptoms they had experienced and which could be classified as signs and symptoms of burnout. The dimensions comprising the burnout syndrome, namely; emotional exhaustion; depersonalisation as well as a reduced sense of accomplishment and decreased work performance (Maslach, 1986) were identified as themes.

- ***Theme one: Emotional exhaustion***

Six participants could easily identify feelings of exhaustion within themselves. Participant 16 explained "So, it was like, this work has also drained me emotionally" (P16). Another participant shared how burnt out and depressed she felt in the following quotation:

> *"Yes…I've had depression - you know I - you get to the stage where you can't sleep and what really got to me was after I left the scene... It was explained again to me in the debriefing and I*

> *would be much more traumatised, do you know what I'm saying? You look at the scenes and you don't notice every detail but listening to the details they explain to you it's like a you would take the video at the scenes…(crying) they just replay everyday in my mind... and you know things like that and with the depression I've been in I've been to various psychiatrists and they don't really, they can't understand the secondary trauma impact you know people say if you weren't at the scene then people say you can suffer from posttraumatic stress" (P8).*

Maslach (1986, p.3) painted the image of burnout as she explained, "The word evokes images of a final flickering flame, of a charred and empty shell, of dying embers and cold grey ashes". Miller and Baldwin (1987) predict that burnout levels will be higher in mental health practitioners who adopt problem-orientated or technique-orientated approaches in counselling. If counsellors do not place significant emphasis on their own vulnerability and do not focus on the synergy occurring in the helping relationship, they are likely to experience a loss of professional energy and effectiveness. In the following three quotations the participants' levels of emotional exhaustion are apparent:

> *"Ya, I don't go near anybody else... with anybody else with emotions and things. Almost as if I don't need to ...I don't want to hear it" (P12).*

> *"But it's getting difficult, sometimes it's difficult, sometimes I feel you know what I just don't give a damn" (P9).*

> *"Ya, really too tired, or to care for colleagues, that's one of the bad things... that's also something, I was never like that... a colleague of mine had a heart operation and I didn't have the strength to just call him and say I'm thinking about you because I don't have the energy" (P11).*

Clients can pick up on a counsellors' lack of interest and care and this attitude can be extremely damaging to the client especially if the client is attending counselling, being in a vulnerable space. The cycle of emotional exhaustion can be perpetuated as clients may leave counselling and the counsellor may feel ineffective and incompetent in his/her counselling ability.

- ***Theme two: Depersonalisation***

When interview participants were asked if they felt that over time their ability to empathise with clients was compromised or reduced, most (20 or 66.66%) felt that that their ability to empathise with clients had not been compromised due to excessive exposure. As Participant 18 explained,

> *"No, I treat them as individually, if a person comes, I will, I will treat her, like it's a person, even if, this, the same thing happened to the next person, I won't like use a, like use the, whatever, maybe the method that I used before. I will know that that is another case with a new person and then I will treat that person as an individual, as, and I won't like, that is what I'm trying to do, like to, to, to, to treat them as, as, as, as new client with a new case but I don't just generalise just because oh, I knew this, this has happened before and I did deal with this, like this way. With this one I know, I just treat as individual" (P18).*

However, a third of the interview participants (10 or 33.33%) acknowledged that due to the constant exposure to trauma their ability to empathise with clients was affected. The words of Participant 10 were echoed by these ten participants, "*It's, sometimes ya it, it affects me. So it also, you find that I don't empathise that much with them"* (P10). Participant 28 explained that feeling a reduced sense of empathy towards her clients was particularly evident when she felt overworked as she explained,

> *"Yes… when I'm overworked, then, ya....and empathy-wise it's not there, where usually it was. I'm not crying anymore. I don't get angry, I just keep everything inside and I'm not a person like that".*

Participant 9 was extremely honest when she shared about how tired she was of having to cope with suicidal clients as she explained,

> *"Yes, very much so, very much so, but as far as possible I try not to, not to show anything but afterwards I would say something to myself or think by myself ... you are on the 7th floor, why don't you just jump? ... Well that, that I say in my, in my thoughts to the other person".*

Detached and even callous and inhuman responses are all evidence of the first dimension of burnout, termed depersonalisation. The importance of empathy in the counselling relationship is generally not disputed, yet Figley (1995) cautions that increased empathy levels are positively correlated with burnout levels. Wilson and Lindy (1994) refer to *'identificatory empathy'*, where the counsellor grieves not only for the burdens and suffering other human beings may experience in a traumatic event, but also for themselves within this context. At times these levels of exposure to human suffering, may result in counsellors feeling emotionally overloaded, depleting their energy and empathy levels and thereby increasing their levels of depersonalisation. Participant 2 spoke about how her empathy levels had reduced not only in her professional life, but in her personal life as well,

> *"And I feel guilty about that because I have a friend who's going through a difficult relationship um, now and I told my husband, I don't feel sorry for her anymore because I told her what I think and if she doesn't want to listen or whatever, then she must just go ahead and then, you know, I will give her support afterwards. So I'm not that empathetic any more" (P2).*

The researcher was aware that many more of the participants may have experienced changes in their ability to feel or experience compassion with their clients; however they may not have wanted to admit these changes to the researcher for fear of being judged and thought of as a social worker who lacked compassion. Hence it is acknowledged that social desirability responding may have influenced some of the responses. Arising from the findings, it is important that social workers are educated about depersonalisation, so that they can learn to recognise these characteristics in themselves.

- ***Theme three: Decreased work performance***

The third dimension to burnout is decreased work performance, motivation or effort placed into task completion. Two participants acknowledged how their work performance had declined as a result of feeling exhausted,

> *"So if someone keeps on nagging me for a report, I would just say okay, fine, and I would write the damn report and give it in, just to get the person off my back and I'm not like that" (P9).*

> *"So it's, sometimes it affects me. So it also, you find that I don't empathise that much with them. But it's getting difficult, sometimes it's difficult, sometimes I feel you know what I just don't give a damn... Ya, ya, it's been compromised. I think, ya, I think clients sometimes pick it up if you not as um, empathic as, empathic as you usually are... so yes, I think they sometimes pick it up... then if it's voluntarily, then 95 just don't come back" (P6).*

Decreased levels of work performance may be apparent not only through reduced quantity and quality of work or reduced levels of empathy with clients but through other aspects of employee behaviour such as late-coming, avoidance of tasks, presenteesim (being present at work physically but not fully engaging mentally in tasks) and excessive absenteeism. Only two participants spoke about taking more sick days, although the researcher is aware that participants whose sick leave had escalated may not have wanted to admit that fact in the interviews.

- ***Theme four: The organisation's response to burnout***

Participants, who spoke about experiencing burnout, did not feel supported by their superiors at SAPS. The following participant spoke about how she felt unsupported by her superiors as well as guilty for having taken time off work, which required her colleagues to assist with her work,

> *"Um, you know what happened is - when you gone X the rest of the people, but although verbally they said they support me, I know that there were two or three social workers that had to do more work because I was off, so um ja…it made me feel even more guilty - and I mean to this day, they haven't approved my incapacity leave - I've still got to write reports and get reports from my psychiatrist explaining why, you know - according to there is them there is no burnout, there's not an illness like that" (P6).*

Initial understandings of burnout emphasised the individual aspects as contributing factors. However, the role that organisational factors play in burnout subsequently became more apparent (Maslach & Leiter, 1997). In particular, the level of social support in the workplace has been found to be inversely correlated to burnout (Galek et al., 2011). The organisation's negative response to employees who are experiencing burnout can further exacerbate the situation, resulting in the employee feeling more exhausted and incompetent. Management therefore needs to be educated about the causes and

consequences of burnout so that they can demonstrate the appropriate responses and help the employee to return to effective levels of functioning.

9.6 THE WORK ENVIRONMENT

9.6.1 The Sixth Objective

The sixth quantitative objective was to measure the 10 work dimensions identified in Moos's (2008) Work Environment Scale and the sixth qualitative objective was to explore participants' experiences of the SAPS work environment.

9.6.2 Moos's (2008) Work Environment Scale (WES)

Figure 9.6 shows the total work environment score for the various categories (type of social work, gender, rank and race), with the higher scores indicating greater satisfaction with the work environment. Overall the average score for participants was 47.97 (SD=1.86), which is below the standard norm (50) indicating that participants experienced below average levels of satisfaction with the work environment at SAPS. Men (M=52.1; SE=1.97) had higher average scores than women (M=46.6; SE=.843) although this result was not significant (t[126]=1.441; p>0.05).

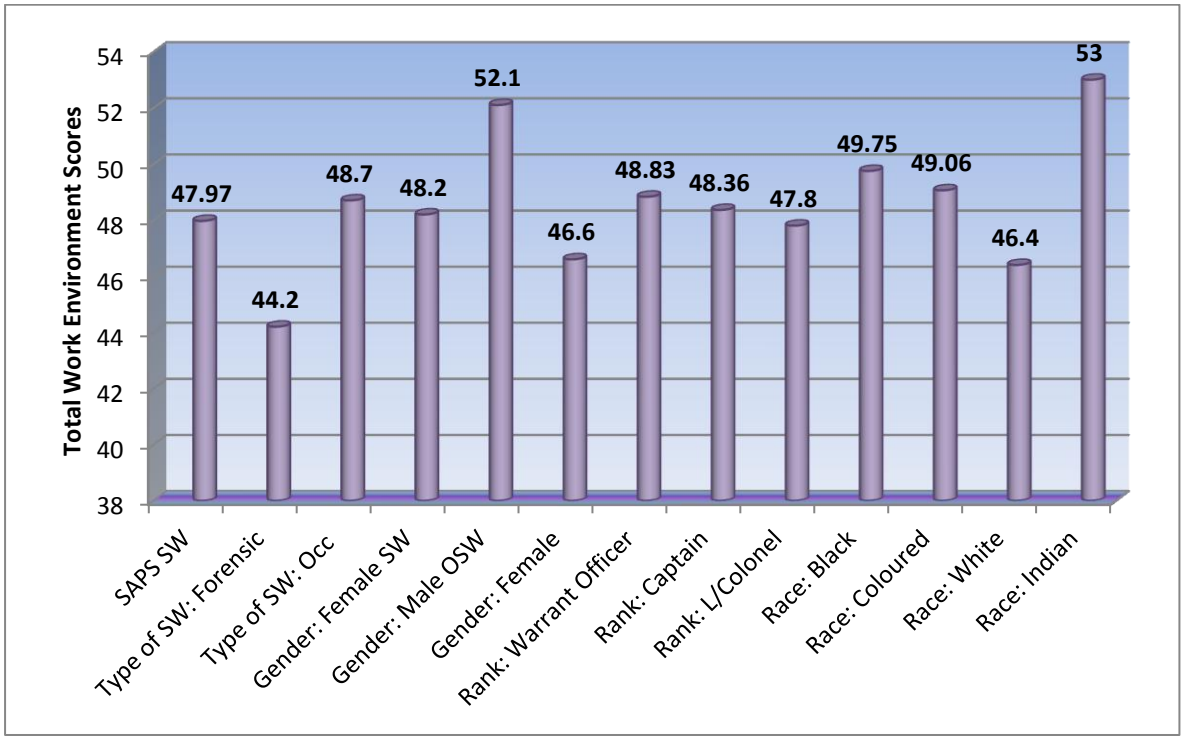


Figure 9.6: Work Environment Scale Total Scores (N=128)

Whites (M=46.4; SE=1.474) had lower average scores in comparison to Coloured (M=49.06; SE=1.805) and Indian (M=53.00; SE=2.0) participants, although not one of these results was statistically

significant ((t[126]=1.441; p>0.05) and (t[126]=1.441; p>0.05). A linear regression model (Table 9.5) indicated that findings were significant (p=0.028) and accounted for 8.2% of the variance in scores. When controlling for other variables, Whites scored on average 5.498 lower than Black social workers, indicating that Whites were less satisfied with the work environment than Black participants.

As previously mentioned Whites generally come from a more privileged background than Black participants, and so they might have had greater expectations of the work organisation than Black social workers who have learnt to survive despite difficult circumstances. Furthermore, promotion opportunities for Whites are limited due to employment equity policies and programmes aimed at redressing past inequalities in the country by giving preference to Black persons, which may have contributed to the lower work environment scores of Whites.

Table 9.5: Linear Regression Model with Work Environment as Dependent Variable

Model		Unstandardised Coefficients		Standardised Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	53.671	3.212		16.707	0
	Forensic	-3.168	2.144	-0.143	-1.478	0.142
	Male	3.464	2.612	0.118	1.326	0.187
	In Relationship	-0.533	1.645	-0.029	-0.324	0.746
	Captain	0.075	3.019	0.004	0.025	0.98
	Peri Urban	0.959	1.806	0.048	0.531	0.597
	Rural	-5.378	2.482	-0.194	-2.167	0.032
	Coloured	-3.047	2.334	-0.119	-1.306	0.194
	Indian	-0.137	6.802	-0.002	-0.02	0.984
	White	-5.498	2.089	-0.252	-2.632	0.01
	Inspector	-0.387	3.09	-0.021	-0.125	0.901

P <0.05

Participants who worked in the rural areas scored 5.378 lower on the WES than those who worked in urban areas. Historically, rural areas are particularly under-resourced since during apartheid most rural areas were not developed or provided with basic infrastructure and resources, as rural areas were predominantly inhabited by Black South Africans. Due to the vast geographic locations and distances between police stations, social workers in rural areas often work in far more isolating conditions than urban social workers. As a result rural social workers may feel less supported by colleagues and management and perceive the SAPS work environment to be less satisfying than that for social workers employed in urban areas. Despite the South African government's attempts to

develop rural areas, and making rural development a national priority, significant development of these areas will take a considerable amount of time. In the meantime, specific strategies need to be introduced to ensure that rural social workers receive the necessary support from their superiors.

9.6.3 Hypothesis Testing

Hypothesis 6 predicted that a negative relationship existed between the work environment and burnout scores. The null hypothesis stipulated that there was no statistically significant relationship between the work environment and burnout levels. Pearson's correlation coefficients were calculated and showed that there was a weak but statistically significantly correlation ($r=-.289$; $p<0.05$), between the work environment and burnout. Hypothesis 6 was therefore accepted and the null hypothesis rejected. Task orientation, managerial control and innovation were inversely correlated with burnout and these results were found to be statistically significant ($p<0.01$). Other work variables such as autonomy, involvement, work pressure, clarity and physical comfort all had nonsignificant correlations with emotional exhaustion (Table 8.6). These findings suggest that the system maintenance and change dimension, as both managerial control and physical comfort are allocated in this dimension, can significantly influence the levels of burnout experienced and when addressing workplace burnout, management needs to place particular emphasis on these aspects.

9.6.4 Exploring the Work Dimensions of SAPS

According to Moos (2008), the Work Environment Scale comprises ten sub-scales and these results are presented in Figure 9.7 for all the social workers, type and gender of the participants. The highest scores were for control ($M=57.01$; $SD=6.239$); physical comfort ($M=53.75$; $SD=7.243$) and innovation ($M=52.24$; $SD=6.599$), indicating above average levels of managerial control, constant changes and the implementation of new changes as well as the degree of physical comfort in the work environment. Above average levels of managerial control could be expected form a highly bureaucratic and hierarchical organisation such as SAPS. The constant implementation of changes may have been related to the frequent changes in senior leadership of SAPS over the past decade. Furthermore, scores for colleague support ($M=47.98$; $SD=7.622$) and cohesion ($M=48.07$; $SD=8.209$) were below average, indicating that the relationship aspects in the work environment were problematic.

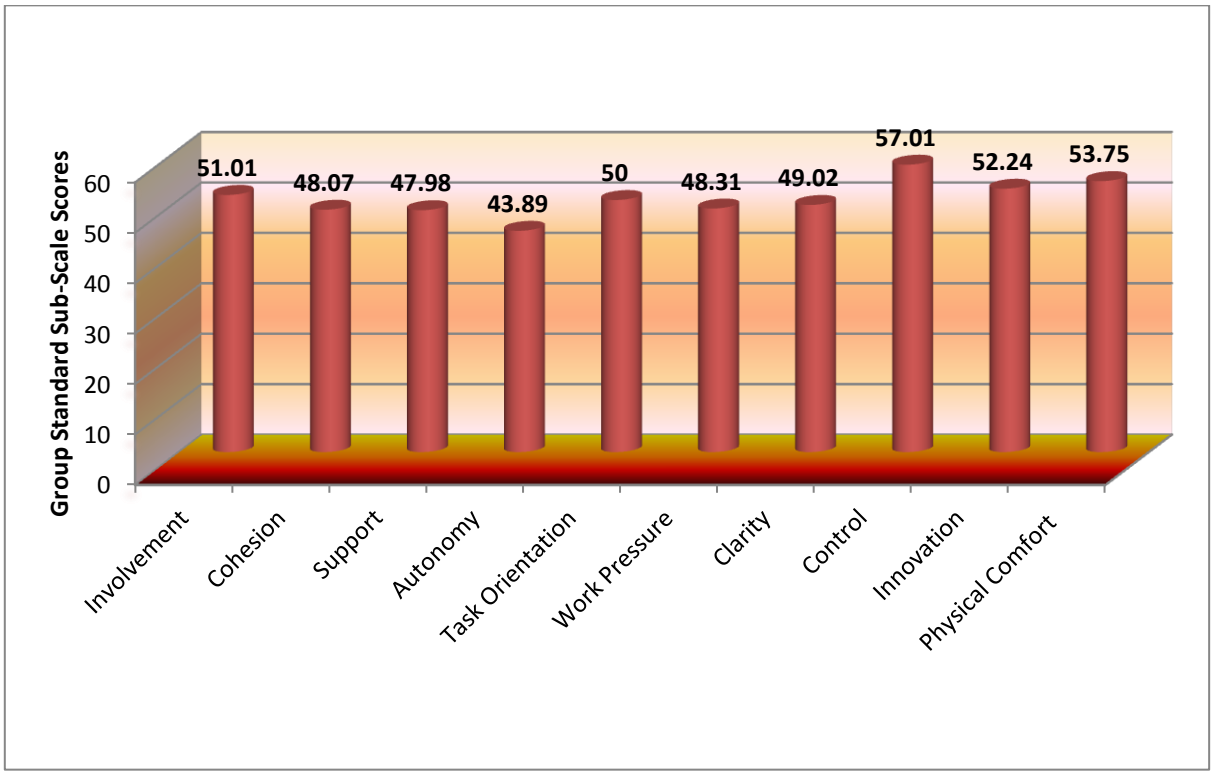


Figure 9.7: WES Standard Sub-Scale Scores (N=128)

Furthermore, the level of autonomy was the lowest score (M=43.89; SD=9.80), which was not surprising considering that participants had to adhere strictly to protocol and procedures and they were not always encouraged to make their own decisions. While these rules may be necessary in a policing environment, there is also the potential to reduce the personal growth dimension. The WES scale has three underlying dimensions, namely: the relationship dimension; personal growth or goal orientation dimension; and the system maintenance dimension. The following section utilises these various dimensions as a framework within which both the quantitative and qualitative findings are presented.

9.6.4.1 The Relationship Dimension

The relationship dimension incorporated involvement, co-worker cohesion and supervisor support, and these results were displayed in Figure 9.8. In Figure 9.8, the raw scores were converted to standard scores (Moos, 2008) and one can see that the support scale had the lowest mean scores for almost every group. In order to determine which results were statistically significant the raw data were analysed using Levene's test for equality of **variance.** The only significant findings were that captains (M=3.96; SE=.180) felt significantly less supported than warrant officers (M=4.29; SE=.279), ($t[83.77]=5.077$; $p<0.05$). Captains officially have more responsibilities and are fewer in number than warrant officers and they therefore may not feel adequately supported by colleagues.

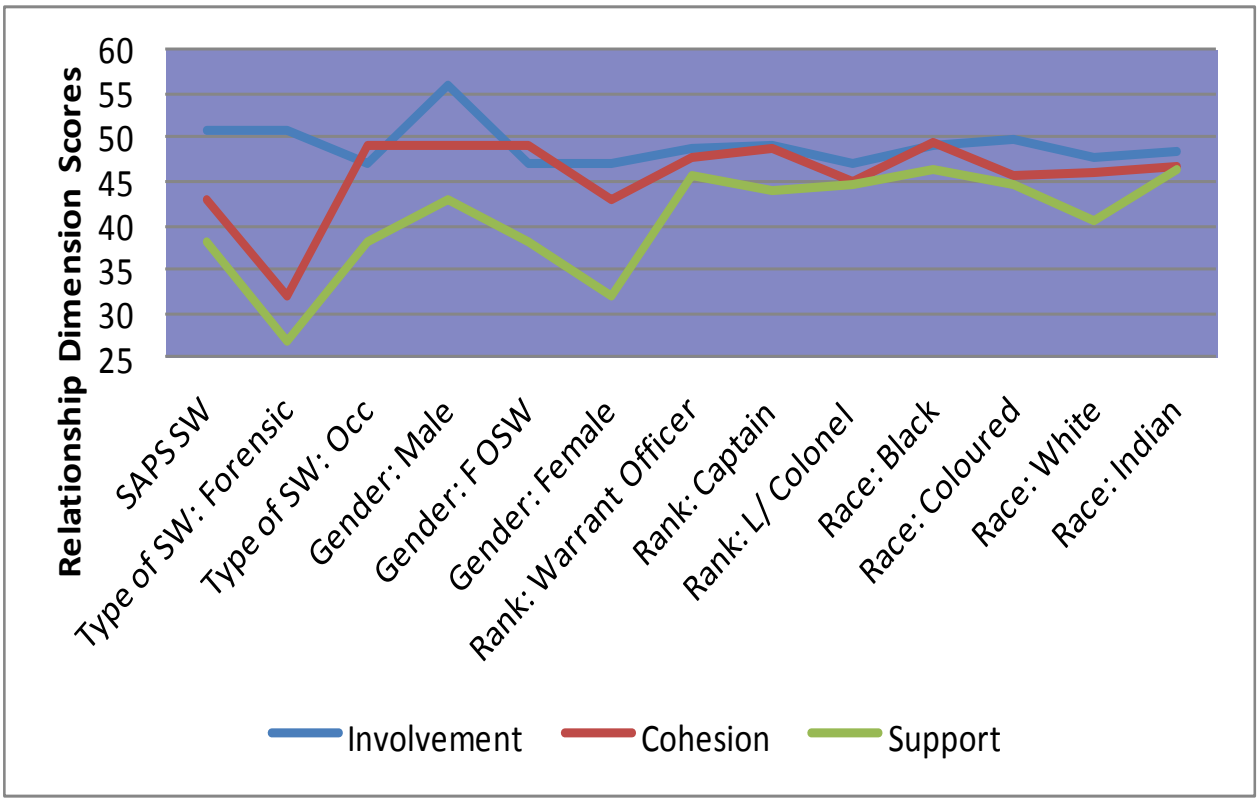


Figure 9.8: WES Sub-scales Depicting Relationship Dimension Standard Scores (N=128)

Black participants (M=4.4; SE=.186) had higher mean scores for colleague support than White participants (M=3.14; SE=.234) and this result was significant t[63.32]=4.89; p <0.05), indicating that Black social workers experienced greater support from their colleagues than did White social workers. In Black cultures the concept of community and team work, is far more prevalent than in White cultures. As a result Black participants may have been more familiar with asking for and receiving support from others, than White participants who might consequently not have felt the same measure of support.

In the interviews, the relationship dimension was explored and two themes that emerged included employee involvement and commitment as well as supervisor support which are discussed in the following section. Although worker cohesion was also a theme emerging from the interviews, this construct is discussed at length in the following chapter on coping and resilience.

- ***Theme one: Employee Involvement and commitment***

Despite the often adverse and demanding working conditions to which social workers within SAPS were exposed, most employees still presented the same degree of concern about their jobs and committed to offering clients the best service that they could. One participant spoke about how

"*working within the Police is a calling" (P19)* and that not everyone would be able to endure all the demands made of them, with often little recognition. Participant 28 explained that she felt honoured to be able to work within the SAPS as she felt she could make a difference*, "It is a privilege and an honour to work for SAPS and trying to make a difference in members and their families' lives".* Many social workers joined the profession to be able to assist others and to know they were making a significant contribution to enhancing society.

- ***Theme two: Supervisor support - supervision***

The nature and extent of supervision opportunities provided in SAPS were explored in the interviews. Four sub-themes emerged which included: supervision opportunities provided; addressing trauma reactions in supervision; participants' willingness to attend supervision; and attendance of supervision with a social worker external to SAPS.

  - ***Sub-theme one: Supervision opportunities provided***

Inherent in the social work profession is the practice of supervision which is often provided on either a group or individual basis. Supervision has numerous purposes and should not only address administrative procedures, but rather supervision should also create educational opportunities in order to promote the employee's knowledge and skills as well as provide emotional support for the employee (Kadushin & Harkness, 2014). Only 13 (43.33%) of the participants interviewed indicated that they had attended supervision sessions at SAPS. For some of the participants these sessions were particularly beneficial, as Participant 11 explained in the following quotation:

> *"Yes...I attend supervision, they (supervision sessions) are very helpful. We have supervision twice a month. Ya, it, I can say it assists because supervision, our supervision as we take all the files and we discuss work. All the clients for that month then if, maybe I'm struggling with one person, two, whatever, then in the supervision we decide what to do" .*

Forensic social workers who were interviewed and who worked in urban areas alongside other forensic social workers attended group supervision sessions and found these sessions to be beneficial and enjoyable. In contrast, forensic social workers who worked alone in rural or urban areas indicated that they did not receive any supervision from SAPS social workers, and this lack of supervision contributed to feelings of isolation in their work. Participant 1 explained that although she had attended supervision, she had only attended a few sessions, "*Yes - supervision we do it but not that much ... I only attended two supervision sessions, I think, one individual and one group" (P1).* The reflective approach to supervision goes beyond only focusing on task aspects during supervision sessions, and instead creates opportunities for emotional expression. Truter and Fouche (2015) believe that reflective supervision, particularly with social workers engaged in child protection, can

create opportunities to nurture resilience in these social workers which, in turn, can ultimately be of benefit to the children and communities they serve. While numerous models of supervision may be adopted within SAPS, adopting a reflective supervision approach could have long-lasting benefits for all. Participant 26 spoke about how the supervision sessions appeared to have been more of a consultative nature than one of supervision,

> *"I do have a supervisor. Ya, I wouldn't call it supervision sessions, more like consultation and talking about work and so forth. For me, supervision is what, on my work, bring my dockets if you are a detective or bring my files if you are a social worker. It's more like consultation" (P26).*

Consultation in social work is generally focused around guidance or assessment of a task. Consultation which generally occurs at the request of the supervisee, is generally not focused around the supervisee's support or developmental needs (Howe & Gray, 2013). Another participant did not feel that the supervision sessions she attended were beneficial,

> *"The only time when all of us get together is when they ask us about the statistics and um, what we don't do, but there's not positive feedback, I feel" (P2).*

Most of the interview participants (17 or 56.66 %) indicated that they did not receive supervision and instead were required to cope on their own. As Participant 12 explained, *"We also don't get supervision...No, we don't get it".* Participant 24 explained that she used to receive supervision from which she felt that she benefited but when the supervisor left SAPS, the situation changed and she no longer felt supported,

> "*No, no, there are no support structures. There's not even supervision. When we started in 2002, there was a little bit of supervision but that person left in 2000, end of 2004".*

What was apparent was that the nature and extent of supervision sessions offered to social workers differed substantially. Furthermore the type of supervision provided differed, as some of the social workers attended group supervision while others had individual supervision sessions. Three participants who attended supervision sessions spoke about the fact that they would prefer to attend individual as opposed to group supervision, as this approach would afford freedom of expression in how they were affected by their work,

> *"Ya, group supervision session is also right but uh, sometimes it is not uh right, especially if one needs to express her emotions and feelings you know for, for him or her to be uh, to personally grow, because sometimes it is not nice, let's say for instance you are in a group you don't want to share how you really feel or that you don't know something" (P6).*

From the interviews it appeared that social workers in the more rural areas appeared to receive less supervision than those working in urban areas. One social worker engaged in a deep rural area, explained that she had telephonic supervision and found this experience extremely beneficial. Supervision does not need to occur face-to-face; with the technological advances over the last few decades, there are numerous ways supervision can be conducted, i.e. telephonic, teleconference or Skype.

- ***Sub-theme two: Addressing trauma reactions in supervision***

Of concern was that four participants who attended supervision, specifically mentioned that they did not discuss secondary trauma exposure during supervision. As Participant 1 said, *"at the supervision...we don't talk about trauma" (P1).* Not only do trauma counsellors need special education in the role they play, they also require opportunities to review their cases in the context of selected intervention approaches, as well as their own personal responses to these situations. Exposure to secondary trauma is inevitable in the police environment and supervision is an acknowledged and recommended practice for practitioners who work in the trauma field. Some of the participants who had received supervision found these sessions beneficial. Hence it is recommended that SAPS management review the supervision policies and procedures currently in practice in order to ensure social workers receive the necessary support and education, particularly to minimise the effects of secondary trauma.

- ***Sub-theme three: Willingness to attend supervision sessions***

Those who indicated that they did not attend any supervision sessions were asked if they considered supervision necessary. All of these participants (17 or 56.66%) indicated their willingness to attend supervision sessions if SAPS offered them. As Participant 15 enthusiastically explained, *"Yes I would attend, I love the sessions as supervision for me, I like supervision very much".* The educational importance of supervision was highlighted by Participant 17,

> *"Because I might think that I am doing the right thing, whereas I need some improvement somewhere. At least a little advice from someone else can also help me to update my knowledge".*

Three participants mentioned how important it was that the supervisor had particular attributes, in particular, the supervisor should be both knowledgeable and approachable. Two social workers who acknowledged the importance of supervision, expressed their concerns about being allocated a supervisor who did not have these attributes, as Participant 2 explained,

> *"Supervision would be beneficial but if it is by someone that um, knows about forensic social work...It won't help me at all if they say I must get supervision by EAS (Employee Assistance*

> *Services) member here...they don't even know what is my task but um, as I said if it's someone that, that I trust, someone I feel comfortable... but that's difficult.. in one sense, it benefits but then again, I don't know who will, who will do the supervising and then I will rather say I'll do it privately ...Ya, I know it sounds very silly but speaking to someone that I trust, would rather, about a case someone that I feel comfortable with, it helps me much more because I can ask questions that, that I won't be able to usually ask someone else" .*

The appointment of supervisors needs to be carefully considered. According to the guidelines of ethical supervision and consultation provided by the Department of Social Development (2011, p.9), "Social workers who provide supervision or consultation should have the necessary knowledge and skill to supervise or consult appropriately and should do so only within their areas of knowledge and competence". While knowledge and experience are prerequisites for a supervisor, it is not necessarily these attributes alone that make supervisors effective in their role; personality characteristics such as warmth, sensitivity and patience also play a significant role. According to Aristotle, the Greek philosopher who lived during the third century B.C. virtue ethics comprise both intellectual and moral ethics. Moral ethics include character traits such as patience, kindness, loyalty, humility and wisdom (Ross & Deverall, 2010). It is important that these moral virtues are also considered when supervisors are appointed.

- ***Sub-theme four: Attending supervision with a social worker external to SAPS***

Three of the social workers interviewed mentioned that as there was no supervision provided for them through SAPS; instead they attended supervision sessions with someone privately for which they paid themselves. As one participant explained, "*I had to find my own supervisor or else I would not have survived at SAPS" (P18)*. A forensic social worker sought the advice of her former lecturer as she felt that she needed guidance,

> *"I went to consult with, with one of my lecturers last week for a big, big case. He went through my report uh, and told and provide me with, or help me with the case, um, maybe gaps in my report, that things that I have, what, what, where can I do some more research or what to do but um, they specifically told us and there was a specific person that said, um, forensic social workers is not supposed to have supervision if you're on this level um, then you're supposed to um, I don't know what I, I can't remember the direct words but it came down to the point that um, it said that um, if you're a forensic social worker you, you know, you're up, you're supposed to cope on your own because you, you're like an expert".*

As both types of social work practised in SAPS, namely occupational and forensic social work, are specialised areas of social work, it is particularly important that SAPS social workers receive adequate supervision. There are evidently differences in supervision opportunities provided to social workers

and this inconsistency needs to be reviewed by management in order to ensure that social workers are afforded the necessary support and guidance they require.

The researcher did not specifically interview supervisors and so was not able to gain insight into supervisors' experiences of offering supervision to social workers. Suraj-Nrayan (2005) found that social work managers experienced numerous occupational stressors, including logistical constraints; role conflict, work overload, career development concerns, techno stress (lack of computer training), and work-life balance. Dealing with other social workers' stress and anxiety may take its toll on supervisors, who may also exhibit and experience signs of burnout, consequently with adverse repercussions on the quality of services they provide. Specific support structures should therefore be in place for supervisors, so that they in turn may provide support to others.

9.6.4.2 The Personal Growth Dimension

According to the WES, the personal growth dimension includes participants' autonomy, task orientation and the levels of work pressure.

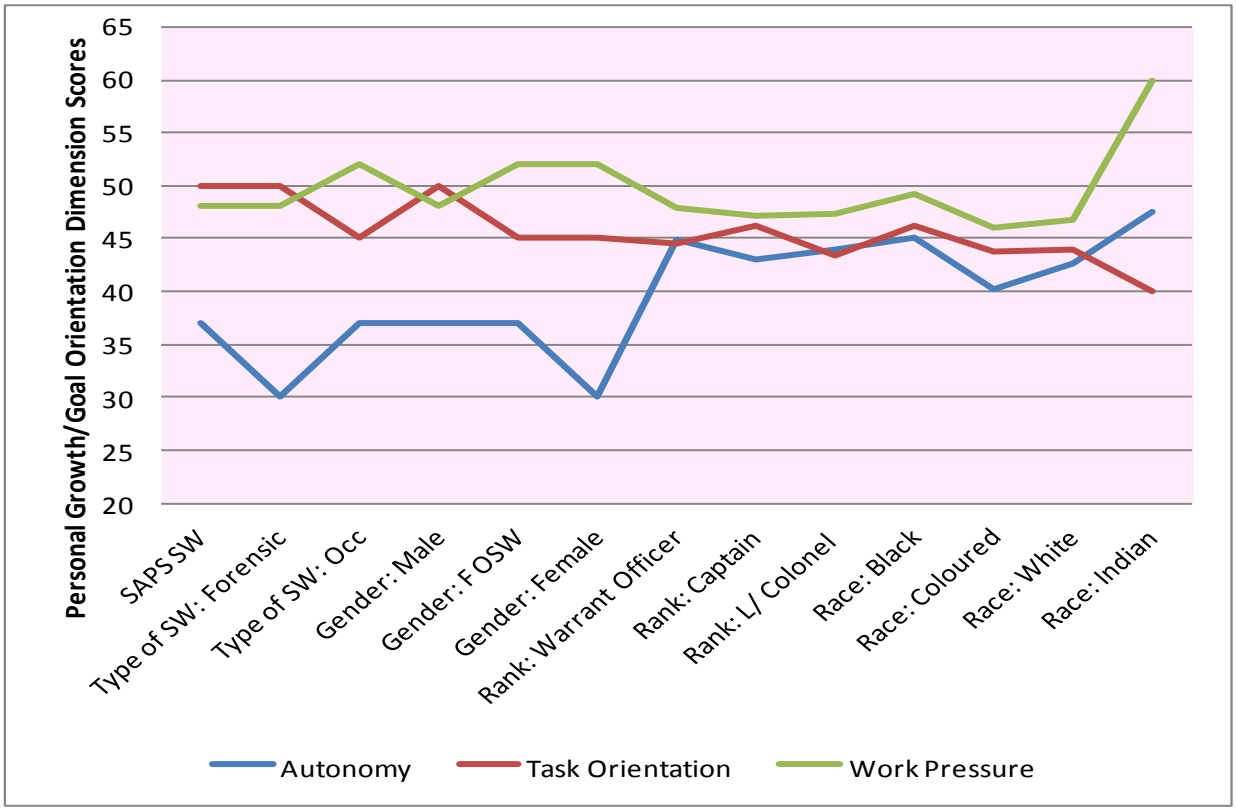


Figure 9.9: WES Sub-Scales Depicting the Personal Growth Dimension (N=128)

Figure 9.9 shows the three sub-scales of the work environment scale relating to personal growth, the raw scores were converted to standard scores (Moos, 2008). Participants' experiences of autonomy

were below the mean average for the scale, indicating that employees were not encouraged to be self-sufficient and to make their own decisions which may have been related to the hierarchical structure in SAPS. On average, the work pressure experienced by participants was lower than the standard score (50), indicating that work demands and time pressures were not that high. The results for task orientation were average (50) indicating an expected degree of emphasis upon planning, efficiency and ensuring completion of tasks.

When exploring personal growth opportunities in the interviews three themes emerged, namely, work pressure, professional recognition and support and professional ethical dilemmas that social workers experience.

- ***Theme one: Work pressure***

Only a few (6 or 20%) of the interview participants mentioned that they felt pressurised by the amount of work for which they were responsible. Three of these participants commented that they only felt high work pressure when they wanted to take a break and realised that other colleagues would then be required to carry their load, as Participant 19 explained,

> *"Ya, at times, uh, the workload or whatever, is, is high, and you are the only social worker around, so you feel like you know, you have to be at work, even though you feel like you need to take a break but at times if there's, you under pressure, then you just have to work" (P19).*

Work pressure and workload have been shown to contribute to burnout. Galek, Flannelly, Green and Kudler (2011) caution how practitioners' sense of self-efficacy may be reduced when demanding workloads and bureaucratic organisations restrict counsellors' ability to complete their work tasks effectively. Work pressure appeared to be more of a concern for forensic social workers who had to work according to specific court timeframes in comparison to occupational social workers. There were also a greater number of occupational social workers employed at SAPS compared with the number of forensic social workers, which could account for the apparent differences in work pressure.

- ***Theme two: Professional recognition and support***

Working within a secondary social work setting can have inherent challenges for social workers. Any programme that is implemented to address employee wellness requires sanction and support from both management and staff. Two participants spoke about how management did not support the programme and therefore did not make the necessary and appropriate referrals for staff to participate in the programme as Participant 6 reflected,

> *"I think the support that I can identify at the base here in Mpumulanga is the commanders because they usually don't refer the members, when they experience trauma - even when we were not employed here they were not debriefed, they were told that fighters don't cry so they really don't, for some members they really need it" (P6).*

Five of the interview participants spoke about the limited career opportunities within SAPS and how they did not feel acknowledged or supported as professionals by the management of SAPS. Two participants expressed their anger at the way social workers were treated in SAPS,

> *"It just goes on and it's as if we just comply, comply, comply and I'm, I'm angry because nothing's changing...we are, we are, we are abused here...So if I want to, actually want to survive, I must get out of the police, because, because, because they don't change the things. They don't appoint more people, they don't promote people. So ya. It's, the work itself, I love the work itself but, but the way they are treating the social workers and the way they are treating us, um, it's not acceptable for me anymore. I would leave for a job but, that I like less, just to get out of the police" (P13).*

> *"It makes me very angry, at management level I was at a meeting one day with the divisional commissioner, we were trying to explain um under what pressure we all are, in the sense of we've got little resources, vehicle wise, cell phone wise, personnel wise, and why everybody's burnt out - he called us together and basically disciplined us because with all the provincial commissioners they send him to explain to them... and I remember him saying I've had enough of the social workers going to the provincial commissioners um, crying to them about their work circumstances - I've always felt that the policemen had more empathy with us than our professional supervisors but I remember a woman breaking down in the middle of the meeting and he zoomed in on her and told her to take her bags and go if she can't cope with the work and that kind of stuff" (P8).*

According to Coulshed, Mullender, Jones, and Thompson (2006), allowing staff to voice their concerns and worries in an environment where these concerns can be addressed is an essential component of a healthy workplace culture. If social workers themselves do not feel acknowledged and appreciated within the work environment, this lack of appreciation is likely to adversely affect how they are able to assist and motivate police officers. Social work management personnel have a tremendous responsibility to educate and advocate for the rights and responsibilities of the social workers in their employ. Without sufficient voice and representation, these social workers will not adequately perform their duties. Moreover, social work managers themselves need to show adequate planning and consideration towards the social workers. One social worker explained the frustration she experienced due to information only being communicated to her at the last minute,

> *"They (Head Office) phoned me and told me I need to be in Johannesburg the next day for a three day workshop where we going to sleep over - now my whole situation is that I'm a single parent of four children...You can't tell me 12 hours before that I need to go away for 3 days because it's not possible".*

Social work management has a particularly difficult mandate to fulfil in SAPS. Not only do they have to constantly ensure that they comply with senior management's requests but they also have to ensure that they communicate effectively with the social workers employed under their leadership. This dual role raises the issue of dual loyalties which is discussed in the next section.

- ***Theme three: Professional ethical dilemmas***

In a secondary setting it is essential that the social worker's role is clarified and that adherence to social work values and principles is emphasised. Encountering ethical challenges within a secondary work setting is inevitable for any social worker. One social worker whose client, a police officer, committed suicide after finding out about his HIV status, spoke about how difficult it was to then counsel his wife, who was battling to understand why her husband had killed himself,

> *"And you know I was like, I tried to counsel the lady, talk to the lady, but I was just thinking was I there, but I talked to the lady that she must go for the HIV test as then you are prepared.. but that was one of the cases that exhausted me emotionally because the people were talking about it and as a social worker, I didn't have to comment, even if I knew I tended the case, I even didn't associate myself with the case but they were talking about it and they were talking lots of lies and I know the truth. So, as a professional sometimes we just have to keep quiet, even if you know the truth" (P19).*

According to the South African Council for Social Service Professionals' (SACSSP) guide on handling HIV cases, social workers are obligated to inform clients about their partners' HIV status if the partners do not disclose their HIV positive status (South African Council for Social Service Professions, n.d.). However, although the SACSSP guidelines stipulate this requirement, many social workers are not aware of this expectation and have not also been adequately prepared for this task. Complicated ethical issues require the social worker to carefully consider what the appropriate plan of action should be, and in these situations supervision fulfils an essential function.

Maintaining confidentiality is a professional ethic to which social workers subscribe when they take up their professional registration. In a secondary setting one may frequently be placed in ethically compromising situations, which highlights the need for adequate social work collegial support processes to be established so that the social worker can receive assistance, support and guidance

when required. Skovholt (2001) maintains that when participants directly engage in discussions regarding stressful professional dilemmas, these discussions can be viewed as protective factors in that participants learn to identify and review challenges. In consulting with others and assessing appropriate strategies, participants can learn to become more resilient.

At times it may feel as though the social workers in SAPS are serving two masters, and ensuring that they achieve a professional balance, may be a seemingly insurmountable task with challenges that are neither understood nor acknowledged. This dual loyalty, involving allegiance towards SAPS management on the one hand and loyalty towards fellow social workers on the other, may be an ethical dilemma that is frequently experienced, particularly for the social work managers. Dhai and McQuoid-Mason (2011, p.66) explain dual loyalties as, "simultaneous loyalties, expressed or implied, to a patient or to a third party resulting in a clinical role conflict between professional duties to the patient and the interests of the third party". The issue of dual loyalties is not only applicable to healthcare settings but can be applicable to many secondary settings where social workers are employed. This ethical challenge may not always be easy to navigate for social workers and the social work management in a setting such as the SAPS and highlights the need for constant co-worker collaboration and supervision in order to navigate often conflicting loyalties.

A further ethical issue that emerged from the interviews cantered around the use of weapons. As social workers are employed under the Police Act they are required to attend training as police officers and have to learn how to use a fire arm and when it is appropriate to do so. Many of the social workers in the interviews mentioned how this requirement made them feel ethically compromised. As Participant 11 explained, *"if there's special duty, you have to go, you have to go for shooting, you have to do those things that you don't even want to do" (P11).* Participant 18 appealed to management to *"Clarify our role, don't try to change social workers into becoming police personnel",* and this request was reiterated by Participant 26 who stated, "S*ocial workers should remain social workers not other things, e.g. Expected to wear uniforms and be police".* Requiring a social worker to learn to use a gun, to shoot and kill a person if required could be considered a paradoxical situation as it goes against the ethical imperative to 'do no harm' or exercise 'non maleficence'. Social workers inherently are meant to empower people and believe in an individual's capacity to change, yet they are being trained to kill. While there are benefits to the social worker if they are employed under the Police Act (particularly pertaining to rank and salary), perhaps the compromise that social workers are required to make is too high a price for their personal and professional integrity. This issue is an ethical one necessitating requires further investigation and exploration, so that the appropriate recommendations can then be provided and such discussion beyond the scope of this research.

At times it may feel as though SAPS social workers are serving two masters; therefore, ensuring that they achieve a professional balance may seem like an insurmountable challenge that few may understand or acknowledge. The director of employee health and wellness was not interviewed in this research, which may be considered a limitation of this research. Although the researcher had various meetings with her about this research study, her experiences of the successes and challenges of the social workers in SAPS were not explored and this exploration would be recommended for future research.

9.6.4.3 The System Maintenance and Change Dimension

The four aspects encompassed within the system maintenance and change dimension are clarity, managerial control, innovation and physical comfort. The standard score results of these sub-scales are depicted in Figure 9.10. Levene's Test for Equality of Variance showed that there were significant differences in variance for two of the scales, namely, managerial control and physical comfort. Males scored higher (M=6.00; SE=.277) than females (M=5.73; SE=.142) on managerial control and this result was statistically significant ($t[18.92]=7.291$; $p<0.05$), indicating that men felt more controlled by management through their rules and procedures than did women. At the time of the study, all the social workers with the rank of lieutenant colonels in SAPS were female, therefore the male participants in this study would have reported to female social work managers. From a cultural perspective, men are traditionally in leadership positions and may not be used to taking orders from women. In a traditionally patriarchal society like SA (Roberts, 2010), males may find it harder to be subordinate to women and to comply with their rules and procedures, resulting in males feeling more controlled by their managers than did the women.

Participants who worked in urban areas (M=4.81; SE=.137) scored on average lower on physical comfort, than those who worked in peri-urban areas (M=5.49; SE=.273) and this result was statistically significant ($t[51.72]=5.993$; $p<0.05$); indicating that those in the urban areas were less satisfied with the physical work environment in which they worked than those in peri-urban areas.

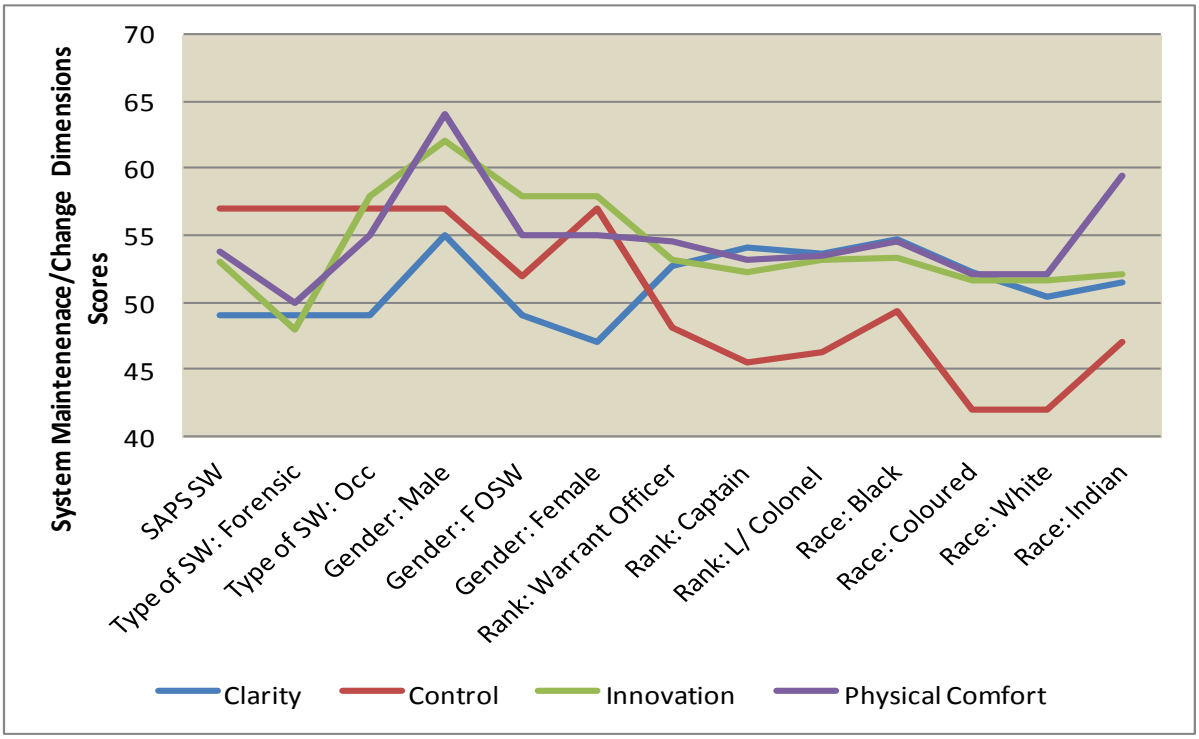


Figure 9.10: WES Sub-scales Depicting the System Maintenance and Change Dimension (N=128)

Peri-urban areas in South Africa are historically not as well resourced as urban areas; therefore social workers employed in peri-urban areas may be more used to living and working with fewer resources than urban areas. Although many studies have shown that a comfortable work environment is likely to result in more productive employees (Moos, 2008), in order to improve the physical comfort of the work environment funding and resources are required, which may not be immediately available due to budgetary constraints. However, these constraints should not deter social workers from requesting improved working conditions and increased resources. If social workers are going to advocate for the well-being of their clients and for the organisation, similarly they need to be able to advocate such improvements for themselves.

Two themes that emerged from the interviews addressing the system maintenance and change dimension of the work environment at SAPS included the corporate culture and the availability of resources.

- ***Theme one: The SAPS culture***

As SAPS is a paramilitary environment, the rules and regulations are clearly defined and employees are required to comply with such regulations. The formalised rank systems within SAPS help to maintain order and control; however bureaucratic and autocratic procedures are often very task-focused, neglecting the human aspect. As Participant 29 explained, *"SAPS still has a long way to go before it*

can accommodate professional people. They need to improve on their humanitarian ways" (P29). The following three participants identified the regimented and bureaucratic SAPS culture as prohibitive for social workers' optimal growth and service delivery,

> *"SAPS is very autocratic and they do not like change - that impacts negatively on the growth of social workers" (P16).*

> *"Nothing except the rules, their rules and regulations that sometimes,, the protocol is very difficult, if you want to help someone you also need to go through the protocol and imagine if someone needs your help now and you have to go through the commander, you have to go through the commander's manager and the person's problem still prevailing by the time you finished with the protocol, will it be too late for, that is another thing that make it difficult" (P30).*

> *"The rank structure, the authority... if someone has a higher rank then, obviously you must keep quiet where otherwise you wouldn't have kept quiet, if there wasn't a rank between the two. So there's a lot of victimisation and if you don't do as the person do, even though they won't do it, things like, say for example, I'm an inspector and another person is a captain, when the captain says something you must keep quite" (P29).*

Helping professionals often struggle to work within bureaucratic systems which tend to be highly depersonalised and emotionally detached. Zastrow (2013) attributes conflicting value orientations of the organisation and the social work profession to be problematic in that aspects such as power, leadership, flexibility, communication and decision-making are perceived differently. He argues that helping professionals often have emotional responses to conflicts involving orientation into bureaucratic systems, as the helping professionals attribute a particularly negative personality to the organisation. The response of Participant 6 to the SAPS organisation could be understood through Zastro's explanatory lens,

> *"No…it kills your soul…it really, it kills a person, because you cannot fight the system, and somewhere along the line after last years breakdown I realised I cannot fight the system, and you get to a point where you say no and you withdraw and your personality is not that type - you can't live like that forever, it's like spiritual suicide to sit there and become like the rest of the police and you become one of them, you sit at your desk reading a newspaper, I cannot believe it. I always said I would die before I leave, I'm committed and loyal and to the policemen, I know what they go through but it gets to a point where - I said the other day to one of the young social workers - you know if there's an opportunity outside I'm going to have to take it. As much as I love the work I do, and I believe in what I do, I cannot carry on" (P6).*

Occupational social workers are tasked with the function of trying to establish a more humane and equitable work environment (Du Plessis, 2001). Fulfilling this mandate may be extremely difficult in an environment such as SAPS, and requires the occupational social worker to be extremely strategic,

creative and realistic. Knopf (1979 as cited in Zastrow, 2013, p. 300) provides invaluable advice as to how a helping professional can survive work in a bureaucracy,

> Be aware that you can't change everything, so stop trying. In a bureaucracy, focus your change efforts on those aspects that most need change and that you have a fair chance of changing.... do not try to change everything in the system at once. Attacking too much will overextend you and lead to burnout. Start small and be selective and specific.

Considering how many work stressors the social worker is confronted by, not discounting the levels of secondary trauma exposure, social workers need to conserve their energy and carefully consider what social work interventions will be successful. It is imperative that adequate supervision is provided to guide the social worker and prevent burnout from occurring. It is worth considering the words of Participant 28 who advised, "*Accept the harshness of the environment and don't let things get personally to you".*

- ***Theme two: The availability of resources within SAPS***

Eleven (36.66%) of the interview participants mentioned that working without adequate resources often made adequate performance of their duties very difficult. In particular the lack of available transport prohibited social workers from being able to get to police stations in emergencies when their services were urgently required. Participant 28 explained why she felt that SAPS was not conducive to social workers, a response which was echoed by Participant 19 who did not feel that SAPS looked after its social workers,

> *"Yeah, it does, like, even lack of resources and, uh, sometimes you, let's say I'm working for 6 stations with no transport with no resources and sometimes they say, we have to come to this station like, right now and this person need to see you but we don't have transport to go there. So, it's frustrating because sometimes we end up not doing what we want to do because of resources. So, no the work environment, really for us, that SAPS is not conducive for social workers" (P28).*

> *"Ja…and then the autocratic bureaucracy comes into play of - I am your senior and you listen to what I say - you are not here to question or negotiate - just do it and make sure the stats look good … don't tell me you don't have transport - there are people that are doing work with um their private vehicles, I mean young chaplains and young social workers that are committed will travel their private vehicles around if there is no vehicle available the system doesn't accommodate the nature of the work we do, the police system doesn't look after us - not even nearly" (P19).*

Two (6.66%) of the participants who were interviewed felt satisfied with the resources available to them. One of the social workers had previously worked for a nongovernmental welfare organisation which had few resources and so in comparison the resources available to her at SAPS were sufficient. These two participants commented on the resources at SAPS,

> *"Also what is satisfying for me, I think we have the resources unlike other people, we don't struggle with cars, we are having offices, where I'm staying, I'm in my own office, I don't share an office, unlike other people, people will complain about sharing offices, some of my colleagues are three in an office but with me, when I was working in Limpopo, I was not sharing an office, here I am not sharing an office. I'm having my own, talking about resources, I'm having my own computer, I'm having my own printer, so you know, I'm satisfied with my salary, I'm satisfied with my resources that I receive at work, I am satisfied with my support system" (P18).*

> *"I come from an NGO so we have much better resources at SAPS than the where I worked" (P22).*

Increasing available resources would be ideal for any organisation; however, this option may not always be feasible due to practical and financial limitations experienced by many government organisations. In a country like South Africa where resources have in the past been allocated disproportionately along racial and geographical lines, it may take decades before the equitable allocation of resources is adequately addressed. The majority of South African citizens live in poverty and many survive on government grants. Moreover, in a country with a recorded population close to 60 million, only six million South Africans pay personal tax to the government. Although ideally the resources allocated to the social worker need to be improved, due to the limited funding available, the situation is not likely to change in the near future.

Given this scenario, perhaps social workers should try to make creative use of the limited resources at their disposal, and for example make their offices a welcoming environment not only for their clients but for themselves as well. While the researcher was conducting face-to-face interviews, she observed that some of the social workers really tried to make their offices attractive and improve the aesthetic appeal, by putting up calming pictures, introducing pot plants and placing cushions on the chairs. The aspect of improving social workers' offices was highlighted as a recommendation by the survey participants and is discussed along with other recommendations to SAPS in the following section.

9.7 RECOMMENDATIONS TO SAPS

9.7.1 The Tenth Qualitative Objective

The first part of the tenth qualitative objective was to obtain recommendations from participants about how SAPS could improve the work environment.

9.7.2 Participants' Recommendations to SAPS

In order to improve the working environment at SAPS, survey participants identified a variety of strategies, which are displayed in Figure 9.11. These suggestions were categorised into four predominant themes, namely: improving available resources; promoting the mental health and professional development of social workers; creating a platform for professional recognition; and improving the communication.

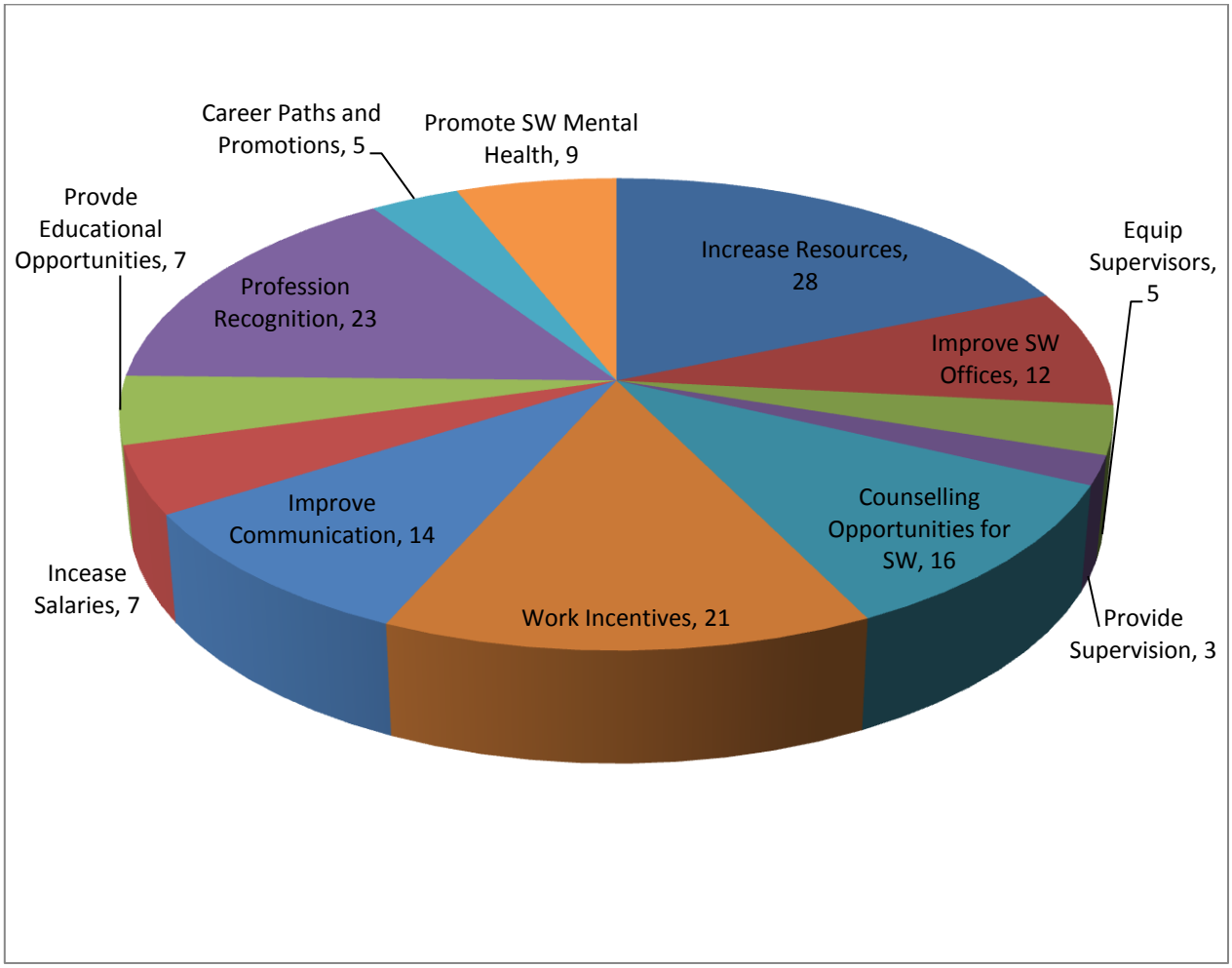


Figure 9.11: Participants' Recommendations to SAPS (N=117[9])

[9] Note 13 participants did not answer this question.

- ***Theme one: Improving available resources***

The most frequently identified recommendation of the participants (28 or 23.93%) was to increase resources such as transport and cellular phones in order to ensure that social workers can adequately fulfil their work tasks. As the following four participants explained:

> *"On appointment, provide office for social worker, a computer, furniture, telephone so that one can work" (P79).*
>
> *"They need to think that Employee Health and Wellness need all the facilities in order to work effectively because without facilities it will be difficult" (P48).*
>
> "*Must take care of their employees in terms of salaries, making neat offices, give us vehicles to do the jobs" (P92).*
>
> *"To provide adequate resources to work can be more easily done if resources are available" (P58).*

Considering that the social workers spend a considerable amount of time in their offices, 12 (10.26%) participants spoke about how they felt that their offices need to be improved. The environment where counselling takes place, needs to foster a certain atmosphere so that traumatised children or police officers will feel comfortable to talk about traumatic situations. As two participants commented,

> *"Better offices with nice furniture and air conditioners and warm feeling/atmosphere" (P73).*
>
> "*Offices should be ventilated to conform to the changing weather conditions"* (P62).

Lindy and Wilson (1994, p. 389) explain that "in the sanctuary of the therapist's office, a relationship can be created that allows for recovery, healing, and the integration of the traumatic life experience". Social workers need to be particularly aware of how important it is to create a safe and comfortable space for their clients. Another aspect that should be considered is the physical location of the social worker's office. Participant 39 explained that police officers may not want to be seen walking in and out of the social worker's office:

> *"Offices apart from the police station we are working at, where people can enter our offices without being exposed" (P39).*

Management needs to take this factor into consideration when they are allocating office space, as police officers may feel stigmatised going for help in the tough macho environment of SAPS. *S*even (5.98%) participants recommended that additional social workers be employed, so that the levels of work pressure could be reduced for the existing social workers and in turn this strategy would improve not only the quantity but also the quality of social work services offered.

- ***Theme two: Promoting social workers' mental health and professional development***

Promoting social workers' mental health was identified as a priority for 9 (7.69%) of the participants. In particular, suggestions included attending care for the care giver workshops, and being educated about secondary trauma. Seven (5.68%) persons suggested that more educational opportunities for social workers (7 or 5.68%) should be created. As Participant 63 said, *"Managers must send people to workshops for self-empowerment".* According to the SACSSP, continuing professional development (CPD) is a statutory requirement for every social worker, and helps to provide opportunities for social workers to enhance their knowledge, develop new skills and gain greater insight into their own practice (Lombard, Pruis, Grobbelaar & Mhanga, 2010). Formalising the available counselling opportunities for social workers was highlighted by three participants (2.91%). Participant 52 described how attending counselling would help clear one's mind,

> *"Have counsellors to counsel social workers when in need as we are working with members who experience trauma and stress, problems at home etc, So that we can be able to work again tomorrow with clear minds and fresh minds".*

The suggestions relating to theme two, promoting the professional development of social work personnel are elaborated upon in greater depth in the following chapter.

- ***Theme three: Creating a platform for professional recognition***

Only seven (5.98%) participants identified improving the salaries as a top priority which SAPS should address. As two participants advocated, *"Pay social workers what they deserve"* (P84) and *"SAPS should offer increased competitive salaries for social workers"* (P114). Although many of the participants may have agreed with these sentiments, increasing salaries was not the top item on the agenda for most SAPS social workers; instead the majority of the suggestions were about improving aspects of the work environment in order to ensure more effective service delivery and/or the professional development of the social worker. This finding underscored SAPS social workers' commitment to the profession and to ensuring that they offered quality services to clients; it is noteworthy that when participants were given a platform to make recommendations to the organisation, most of the participants did not highlight their own needs. Five participants (4.27%) emphasised how SAPS needed to create career paths and promotional opportunities for social workers.

- ***Theme four: Improving communication within SAPS***

Improving communication structures and policies within SAPS were identified by 14 (12.17%) of the participants. More consultation opportunities were requested, *"We should have more meetings with*

our managers so that we can all discuss our problems" (P58). As Participant 76 explained, *"Consultation with employees, stop favouritisms, be professional, let the right hand know what the left hand is doing" (P76).* Participant 88 specifically requested improved communication when there were changes in the organisation or when new policies were introduced, *"There should be consultations with all social workers if there are new policies to be implemented" (P88).* Increasing opportunities where changes, policies and procedures could be discussed, were perceived to have numerous benefits, such as establishing *"clear expectations, open communication. There is not enough time to communicate what you think and feel" (P81).*

9.8 CONCLUSION

The challenging and difficult work circumstances in which SAPS employees are required to function is not something that many would dispute. As a result of the long term exposure to trauma, social workers may experience vicarious trauma resulting in changes in their beliefs and perceptions of the world. It is particularly important that social workers understand the impact and influence that these factors may have on the counselling relationship. Understanding transference and counter-transference reactions can help social workers to become more self aware and know how to intervene appropriately in a therapeutic relationship. The findings showed that social workers did not appear to be aware of concepts such as vicarious trauma, transference and counter-transference.

Education about these constructs could potentially assist and help social workers to facilitate posttraumatic growth. Social workers in SAPS experienced high levels of compassion satisfaction, indicating high levels of fulfilment and rewards experienced through the work they do. However, burnout levels within SAPS social workers were a concern, requiring the implementation of more professional and personal strategies. Moreover, the inconsistency in supervision provided for the social workers in the different departments and geographical locations needs to be addressed as supervision can be a powerful mechanism in which the negative effects of trauma can be ameliorated and growth opportunities created. The next chapter explores how these social workers coped with the constant exposure to secondary trauma and examines what specific attributes participants identified as contributing to their development of resilience.

CHAPTER TEN

FINDINGS AND DISCUSSION 3

COPING WITH TRAUMA AND RESILIENCE

"The Noble Path, that transcends the two extremes and leads to enlightenment and wisdom and peace of mind, may be called the Middle Way. What is the Middle way: It consists of the eightfold Noble Path: right view, right thought, right speech, right behaviour, right livelihood, right effort, right mindfulness and right concentration"

(From the Teaching of Buddha as quoted by Bloom, 1997, p. 226).

10.1 INTRODUCTION

Given the complexity of trauma related disturbances and the inherent differences in the ways that individuals respond to and cope with secondary trauma (Allen, 2005), it is important to enhance understanding in this area. This third chapter of the findings and discussion section explores how participants coped with exposure to secondary trauma. The findings in respect of the last four objectives of this research are presented and discussed through the use of descriptive and inferential statistical analysis of the quantitative data, supplemented by the qualitative data that were collected through the interviews.

Maintaining a holistic perspective, coping is explored through various aspects, namely: the physical, emotional, cognitive, social and spiritual dimensions. A more recent discourse in traumatology has explored the role of resilience and what characteristics determine or influence why some people cope with a traumatic situation while others do not cope (Pack, 2014). The chapter then discusses the participants' levels of resilience, and the characteristics constituting resilience and which were explored through the interviews.

10.2 COPING WITH SECONDARY TRAUMA

10.2.1 The Seventh Objective

The seventh quantitative objective was to explore levels of coping resources as determined by Marting and Hammer's (2004) Coping Resources Inventory (CRI) and the seventh qualitative objective was to identify practitioners' trauma coping mechanisms (formal and informal).

10.2.2 Marting and Hammer's (2004) Coping Resources Inventory

Standard scores were calculated according to the guide provided in the Coping Resources Manual, as results could then be used for clinical interpretation. The overall result of the CRI indicated that participants perceived themselves to have an average level of coping resources at their disposal.

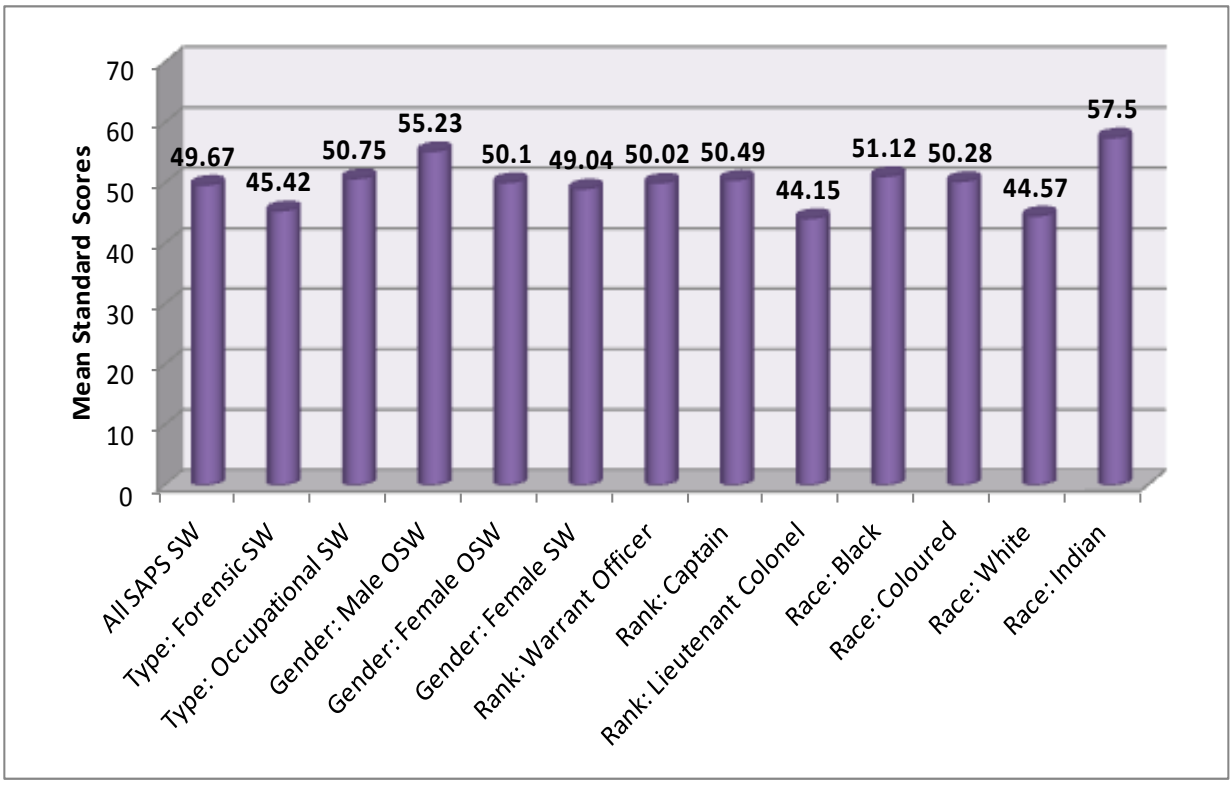


Figure 10.1: Mean Total Standard Coping Scores (N=128)

This conclusion can be drawn based on the fact that participants obtained a total mean score of 49.57 (SD=9.39) where Marting and Hammer (2004), the developers of the scale, obtained a mean of 50. The following categories of participants scored below average showing that they had less than average coping resources: forensic (M=45.42; SD=9.64); female (49.04; SD=9.36); Lieutenant Colonel (M=44.15; SD=9.16) and White (M=44.57; SD=8.35) participants. These findings suggest that staff training within SAPS should have a specific focus on improving coping resources for the groups that scored below average total scores, namely, forensic social workers, lieutenant colonels, and White social workers. In contrast, the male (M=55.23; SD=8.054) and Indian group (M=57.50; SD=2.12) showed the highest level of coping resources. However, it is acknowledged that there were only two Indian participants, which factor may have skewed the results.

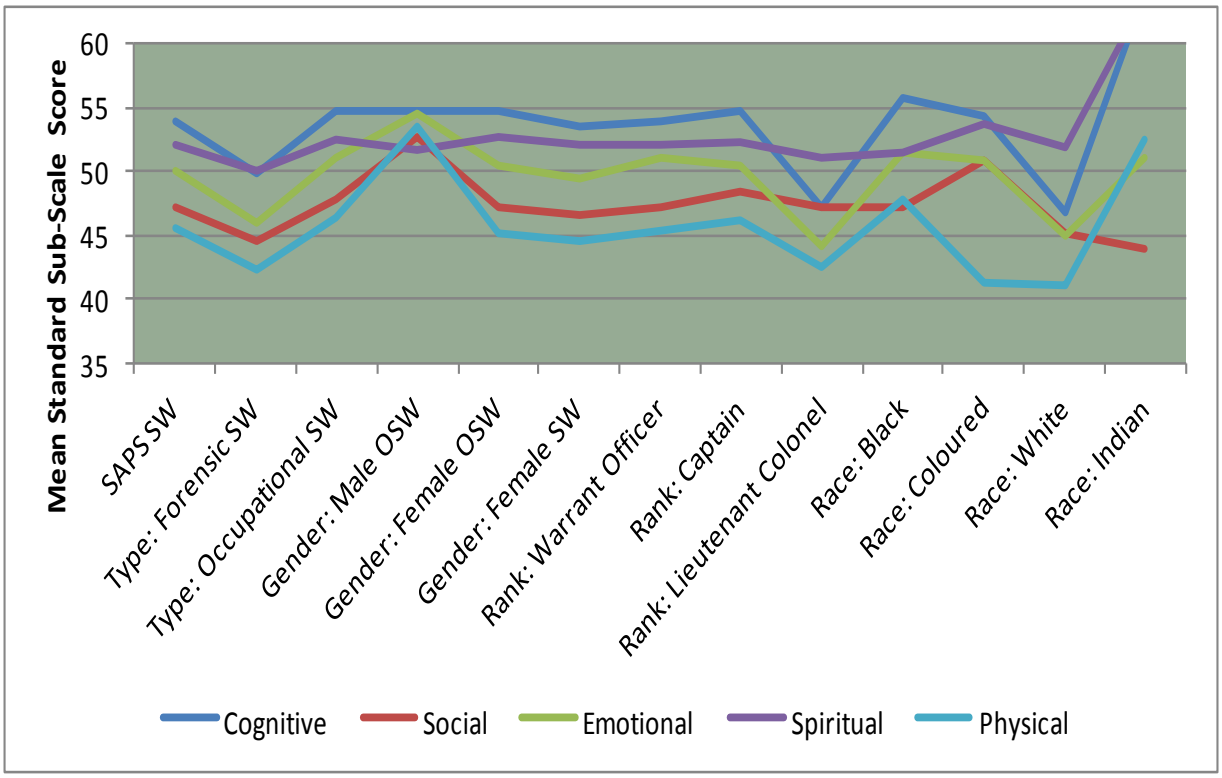


Figure 10.2: Mean Standard Sub-Scale Coping Scores (N=128)

Figure 10.2 shows the mean standard results for the coping sub-scales. The graph line shows that men tended to score slightly higher (have more coping resources) than the other groups on all the sub-scales, apart from the spiritual sub-scale where women scored M=52.16 (SD=7.61) and men M=51.77 (SD=9.78). Forensic SWs had the lowest scores for every sub-scale indicating that they had lower coping resources than occupational social workers, with their highest scores occurring in the spiritual (M=50.20; SD=4.202) and cognitive (M=49.90; SD=4.252) dimensions. The highest mean score for all groups (apart from the forensic group) was obtained on the cognitive resources sub-scale. Marting and Hammer (2004) explain that the cognitive sub-scale measures the extent to which an individual maintains a positive sense of self-worth, feels motivated and develops a positive outlook on life. All groups, apart from the male grouping (M=53.46; SD=7.76), scored the lowest on the physical resources dimension. Although it is noted that all the results for this sub-scale were still above the standard mean of 28 as suggested by Marting and Hammer (2004), enhancing physical coping resources should still be a specific focal point in order to enhance overall coping. The physical scale measures the degree to which individuals promote their physical health through engaging in health-promoting behaviours, such as eating balanced nutritious meals, having adequate rest and sleep and engaging in physical exercise. The most frequently utilised coping resource was the cognitive resource as all but one group (Forensic SW), had the highest result on this sub-scale. Forensic social workers' highest score was on the spiritual coping resource (M=50.15; SD=7.27), followed by the cognitive

coping resource (M=49.85; SD=10.55). Spiritual coping resources were the second highest resource identified by most of the participants (M=52.12; SD=7.08), indicating that spiritual and religious beliefs were an important coping resource. This finding is not surprising as many religious people are drawn to working in the helping professions and it is therefore possible that some social workers may have entered the profession due to what they would have perceived as 'a religious calling'. Evans, Bibeau, Conley (2001) found that nursing staff working at a residential hospice predominantly used positive reappraisal coping strategies which they attributed to their religious beliefs in order to cope with the constant exposure to death. Jung (1970) understood the importance of religion in the human quest for meaning, and emphasised the centrality of understanding this quest to be central for the individual to achieve personal integration or wholeness.

Coping results were further explored through inferential statistics, where the raw scores were used, in order to determine statistically significant relationships and to test hypothesis 5. There was almost no difference in scores between single (M=175.84; SD=18.59) and married (M=175.37; SD=21.04) participants and despite the average scores of the lieutenant colonels (M=163.62; SE=5.417) being lower than the captains (M=177.34; SE=2.5) and warrant officers (M=176.25; SE=2.68), these differences were not statistically significant (t[78]=.675; $p>0.05$) and (t[59]=.958; $p>0.05$). Forensic social workers had much lower average levels of coping resources (M=162.12; SE=4.10) than occupational social workers (M=177.69; SE=1.902); however this difference was not statistically significant (t[126]=-2.460; $p<0.05$). The linear regression model displayed in Table 10.1, explained 12.7% of the changes in coping scores when incorporating the type of social work, gender, rank and race of participants, and coping was the dependent variable. When controlling for other variables, coping results showed that forensic social workers scored on average 12.097 lower than occupational social workers and that White social workers scored 9.223 on average lower than Black social workers. Considering South Africa's traumatic past, Black communities were exposed to constant trauma in the townships, particularly at the hands of the apartheid state (Abdullah, 2015). Consequently, many Black South Africans developed ways of coping, particularly through community and social support networks in order to survive. Most Whites have lived in more secure areas, where exposure to violence and trauma in the traditionally White suburbs was monitored through adequate policing or private security companies (Steinberg, 2008). As a result White social workers, who may not have been exposed to such high levels of trauma, and may experience more secondary trauma symptoms, may have less coping resources to draw upon than Black social workers.

Table 10.1: Linear Regression Model with Coping as Dependent Variable

Model		Unstandardised Coefficients		Standardised Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	175.709	3.808		46.143	.000
	Forensic	-12.097	4.667	-.245	-2.592	.011
	Male	3.181	5.685	.048	.560	.577
	In relationship /married	.110	3.582	.003	.031	.975
	Captain	5.644	3.864	.141	1.461	.147
	Lieutenant Colonel	-10.538	6.726	-.160	-1.567	.120
	Peri/Urban	.706	3.931	.016	.180	.858
	Rural	7.990	5.403	.129	1.479	.142
	Coloured	3.291	5.080	.058	.648	.518
	Indian	27.718	14.806	.173	1.872	.064
	White	-9.223	4.546	-.189	-2.029	.045

$p<0.05$

Forensic social workers are predominantly engaged in case work and have higher caseloads than the occupational social workers as the latter also engage in other methods of social work practice, for example group work and training. This factor may have contributed to their lower levels of coping resources as they may have had less time available to utilise different coping resources. The implication of these findings is that specific measures need to be adopted by SAPS in order to try to improve the levels of coping among the forensic social workers.

10.2.3 Hypothesis Testing

The null hypothesis for hypothesis 5 stipulated that there would be no significant differences between the levels of coping of male and female social workers. Male SWs had higher coping scores (M=181.54; SE=4.81) than females (M=174.86; SE=1.88); however the difference was not significant ($t[126]=1.145$; $p>0.05$). The null hypothesis was therefore accepted as there were no significant differences in coping scores between men and women. Nevertheless, this finding needs to be interpreted with caution as the sample sizes for males and females were unequal. Previous research has found that there are differences in coping levels between men and women. Various discourses have been presented to explain gender differences in coping. These differences have been largely attributed to gender socialisation, as men are encouraged to be more self-reliant, inhibit emotional expressiveness and self-disclosure, while woman are encouraged to be more emotional and to value close relationships (Monat & Lazarus, 1991). Differences in men's and women's perceptions of stressors have also been understood to influence their coping levels (Santacana, Kirchner, Abad & Amador, 2012). Gender

differences have manifested in the types of coping strategies that men and women employ. Figure 10.2 shows that in the current study men and women had different mean scores for the various sub-scales, suggesting that the types of coping strategies that they used were not the same. In a study with medical students Madhyastha, Latha and Kamath (2012) found that women were more likely to engage in emotion focused and social support strategies, including help-seeking behaviour whereas men used humour, a positive emotion-focused strategy and self-blame, which could be construed as a maladaptive strategy. Furthermore, women are more likely to utilise more coping strategies than men (Santacana et al., 2012). In a study exploring how holocaust survivors coped with trauma, gender differences manifested in survivors' appraisals of their own experiences and in the types of coping skills they employed (Sway, 2015). However, the present study has shown that there were no significant differences in coping levels between men and women. This finding could be explained by the nature of the population studied. While the feminisation of social work as a caring and helping profession is well documented (Sithole, 2010), it is possible that the type of male who chooses to study social work has particular characteristics and values, and so traditional gender stereotypes and different ways of coping are not as pronounced in this population. Further research into the personality profiles of male versus female social workers would throw light on this issue.

10.2.4 Understanding How Participants Coped with Secondary Trauma Exposure

In an environment that reinforces the mantra 'tigers don't cry', it would be expected that there would be additional pressure for social workers to present the image that they were able to cope with the traumatic nature of their work. A few participants explained how the organisational culture advocated that one should just cope, as Participant 7 explained, *"others would say they, they have a saying in Afrikaans um, jy's maar net sterk wees, um,* ***you must just be strong****" (P8).* What emerged from the interviews is that participants had a range of coping strategies. While most participants felt that these strategies enabled them to cope, some felt that they were not coping.

10.2.4.1 Not coping with the trauma

Some participants (4 or 13.33%) felt that they were not coping with the nature and extent of secondary trauma exposure and three (10%) of these participants admitted that they wanted to leave SAPS's employ.

- ***Theme one: Acknowledgment of not being able to cope with the trauma***

Admitting that one is negatively affected by the trauma exposure, might have been difficult for some participants. The researcher was particularly aware that participants may have felt that talking about not coping may have been considered an admission of failure or viewed as a form of weakness and

hence they may have been reluctant to share this aspect openly with the researcher. Although confidentiality had been assured, participants may still have felt unsafe to speak about not coping. Four participants (13.33%) felt that they were not coping with the constant trauma exposure and work pressures. As one participant explained,

> *"… and I've become this negative person, I have to concentrate on the words that come out of my mouth because I can so easily say the negative I see and I'm supposed to be there for support and give them hope and I'm battling to do that at this stage, I'm battling.." (P8).*

During the interviews three participants cried as they shared with the researcher how they felt that they were not coping. As these interviews were conducted telephonically, the level of anonymity may have allowed participants to feel less inhibited and respond emotionally. The researcher tried to respond empathically and offered to arrange counselling for these participants but none of them felt that this option was necessary. As a counsellor herself it was difficult for the researcher, as she had to maintain the role of researcher and not that of counsellor in this situation.

Despite acknowledging that they were not coping, these four participants could still identify specific coping strategies that they consciously implemented to help enhance their functioning. Some of the participants, who felt that they were coping, spoke about times when they felt they were not coping and how they had chosen or learnt to implement various techniques to reduce the negative effects of the trauma. What could be deduced is that for participants working in the trauma environment, the acknowledgment of not being able to cope could be an important stage or phase they are likely to experience. Trauma often leaves an individual feeling overwhelmed as current realities and beliefs are shattered (Matsakis, 2005; Pearlman & Saakvitne, 1995b). In order to re-establish emotional equilibrium, one needs to either draw upon or implement coping strategies. Alternatively limiting the trauma exposure can facilitate faster recovery and allow a person to integrate the traumatic experience as part of their narrative. An environment where they are not encouraged to talk about struggling to cope, may exacerbate feelings of incompetence and lower self-esteem. Therefore, creating a work culture where social workers can admit to difficulties and feelings of exhaustion is imperative in order to provide opportunities to develop resilient practitioners.

- ***Theme two: Wanting to leave SAPS***

Prior to the data collection phase, SAPS Head Office was unable to accurately indicate to the researcher how many social workers were employed at a specific time within SAPS. A Lieutenant Colonel at SAPS Head Office attributed the uncertainty in respect of the accurate employment figures to the high attrition rates of social workers in the police. When social workers resigned, these

positions were not automatically refilled, which often resulted in the social workers who remained at SAPS having to assume more work responsibilities. Inadequate staff levels often exacerbated social workers' feelings of exhaustion and work dissatisfaction thereby contributing to social workers wanting to resign from SAPS. One participant spoke about how, despite loving her work, leaving SAPS was essential to her survival.

> *"I'm feeling angry because um, out of the, um because of, if I look in the social work environment, we are the little people and we just keep on working, working, working because we are only two now, here in my area where we were five previously. Now, and it's going on now for the third year that we only two people...Um, so if I want to, actually want to survive, I must get out of the police, because, because, because they don't change the things. They don't appoint more people, they don't promote people. Um, so, so ja... I'm here for the work itself, I love the work itself "(P9).*

Acknowledging that this type of work negatively affected their mental health, three participants spoke about wanting to leave SAPS and find alternative employment. Removing oneself from a stressful environment is a strategy that is sometimes necessary. However, leaving a permanent position is not always an option for some, when such a decision could jeopardise their livelihoods and consequently create additional stressors. One participant who was a single mother wanted to leave SAPS; however she realised that she could not leave as there was limited chance of her obtaining another job with the medical aid benefits that she received from SAPS, which she needed for her children. Another participant mentioned that as she lived in a rural area, the availability of social work jobs was limited and so she could not leave SAPS's employ. Although, leaving SAPS was an option that these participants felt they wanted to take, the likelihood of this option occurring was not always realistically or financially possible. Considering that practitioners may want to leave SAPS but are not in a position to do so, they need to make the most of their employment situation. The responsibility to ensure that the necessary support structures are in place to facilitate a healthy reciprocal interaction between the social workers and the work organisation lies both with the organisation and with social workers themselves.

10.2.4.2 Exploring participants' coping strategies and resources

Commenting on how his coping changed over time, Participant 3, explained that developing appropriate coping strategies occurred as he matured as a person, *"I think it's my coping mechanism ... I also grew up, I think I, as you get older, you start to cope, to learn to how to cope with certain things"*. Coping strategies and techniques employed by people are individualised; they are not static and can also change over time. The constant exposure to trauma requires one to adjust and employ specific coping strategies that are effective in reducing the negative effects of traumatisation.

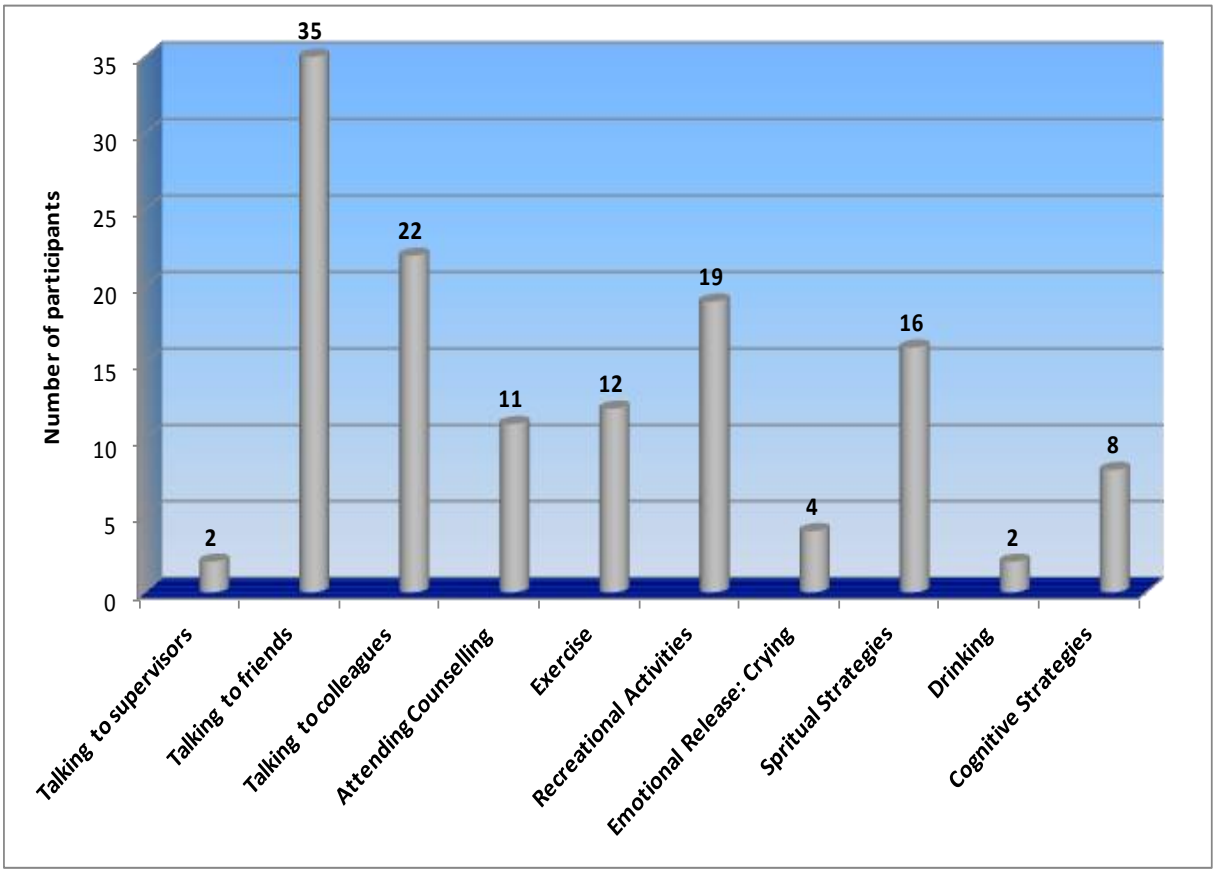


Figure 10.3: Coping Strategies Identified by Interview Participants (N=115[10])

Survey participants identified an array of coping strategies they utilised to help them deal with the traumatic nature of their work as depicted in Figure 10.3. Only 26 (22.61%) identified more than one coping strategy. The most commonly identified coping strategy was talking about a traumatic event to someone who could be trusted. As Participant 79 explained, "*I talk about the incident to people I trust and who can attentively listen to my concerns".* Participants indicated they would talk to family or friends (35 or 30.44%); talk to colleagues (22 or 19.13%); or their supervisors (2 or 1.74%). It is of concern that only two participants acknowledged their supervisors as a supportive social coping resource. Talking through an event not only creates an opportunity for emotional expression but also for cognitive mastery (Eagle, 2000). Participants highlighted the importance of collegial support, "*I talk to colleagues about it (the trauma) and it gradually disappears" (P53),* "*I share the experience, whether negative or positive, with a colleague" (P84).* Less than ten percent (11 or 9.56%) of the participants identified attending their own counselling as a coping strategy.

[10] 13 participants did not answer this question. Responses total more than more 115 because participants mentioned more than one strategy.

Table 10.2: Coping Resources and Strategies Identified by Interview Participants (N=30)

	Category	Themes	Sub-themes
Coping Resources	Physical	Physical Activity	Sporting activities Recreational Activities
		Rest Periods	Holidays Breakaways
		Increased indulgence	Increased alcohol usage Increased eating
		Medication	Anti-Depressants Chronic Medication
	Emotional	Emotional Regulation	Developing appropriate emotional responses Journal writing
		Attending counselling	Not necessary to attend counselling Willing to attend counselling Have attended counselling
	Cognitive	Establishing boundaries	Balanced work life Separate home from work
		Psychological Defences	Repression Depersonalisation Dissociation Avoidance Splitting
		Desensitisation	
	Social	Spouses/Partners	Supportive spouses Unsupportive spouses
		Friends and Family	Supportive friends and family Unsupportive friends and family
		Colleagues	Supportive Colleagues Unsupportive Colleagues
		Community	Supportive Community Unsupportive Community
	Spiritual	Drawing on Religious Or Spiritual beliefs and practices	Prayer Beliefs
		Deriving a Sense of Meaning	

Other strategies identified included: participating in recreational activities (19 or 16.2%); drawing upon spiritual strategies (16 or 13.91%); engaging in physical exercise (12 or 10.43%); emotional release through crying (4 or 3.48%); adopting cognitive strategies (8 or 6.96%) and increased consumption of alcohol (2 or 1.74%). These coping strategies that were identified were explored in more detail with the interview participants. Two participants (1.74%) indicated that they did not have any coping strategies. The coping strategies identified by interview participants in order to cope with the trauma of their work were analysed through the five coping dimensions of the CRI, namely;

physical, emotional, social, cognitive and spiritual and a summary of these themes is displayed in Table 10.2. While participants did not differentiate between adaptive and maladaptive coping, some of the coping strategies that were identified could be considered maladaptive coping strategies. The researcher is also aware that participants may have been reluctant to admit or share with her any possible maladaptive strategies for fear of being judged or being labelled and may therefore have furnished socially desirable responses. Some coping strategies may be initially helpful and necessary when utilised in moderation, however some coping strategies may become maladaptive when they are used excessively or are maintained indefinitely. For example, defences such as denial or repression may be initially necessary after a traumatic event but if these defences are maintained for extended periods, they could negatively impact upon an individual's functioning.

What was apparent was that many of these coping strategies were interconnected and certain coping strategies could be incorporated in more than one dimension. This factor was particularly evident for themes that were identified on the cognitive or emotional dimensions.

CATEGORY ONE: THE PHYSICAL DIMENSION

Despite the effectiveness of physical coping strategies being sufficiently acknowledged and researched, this dimension was the least identified coping resource by the interview participants. The physical coping strategies identified by interview participants included: engaging in sporting and recreational activities; having breakaways and rest periods; and taking medication for depression and anxiety.

- ***Theme one: Physical and recreational activities***

Only five participants reported engaging in physical activity as a coping strategy. The activities mentioned included a variety of sports such as jogging, attending a gym, mountain climbing or water sports. Besides the physical benefits of engaging in sporting activities, two participants spoke about how engaging in recreational activities helped them forget about the traumatic nature of their work and allowed them to have a 'normal life' for a while. As these participants explained,

> *"I enjoy things in nature and doing fun stuff, going jet skiing and scuba diving and that takes my mind off a lot..." (P9).*
> *"Like I play with my child in the swimming pool, just to, just a normal life for things a bit" (P23).*

Three participants acknowledged how important it was to have a break away from work and recharge through taking physical breaks or holidays. Participant 4 spoke about *"going to a farm about twice a*

month to get away". Participant 2 explained that her husband made sure that she got away regularly in order to rest and recharge, *"We will go away for weekends or do something nice, take, go and do, make, uh have a picnic or drive with the bicycles around town".* Acknowledging the need for a break and how important it is for carers to look after themselves, some of the social workers made informal plans amongst themselves and would go away to re-invigorate themselves. As Participant 19 explained,

> *"Sometimes we (social workers) go somewhere also to recharge and talk about our frustrations and for the camping or something for an outing once a month and talk about, we say it's care for the caregivers. We think there is nobody who is taking care of us, but we are caring for other people" (P19).*

Initiatives such as the one previously mentioned, incorporate numerous coping dimensions as the opportunity for emotional and physical rest are provided in a social environment, thereby enhancing social support and collegial relationships. Sharma (2011) emphasises the important role that relaxation plays in facilitating coping reactions. If such opportunities were scheduled on a regular basis, the benefits could be far-reaching and help to enhance positive coping strategies. The informal nature of such events would also possibly make these opportunities appear more desirable to attend. However, such initiatives could also be encouraged by the management of SAPS.

- ***Theme two: Taking medication***

Five participants spoke about taking anti-depressant medication and how it helped them to cope and have a more positive outlook. As Participant 2 explained, *"but I must say, using the medication that I'm using, I'm a bit more positive, you know, more motivated to get going"*. Clinical depression and substance abuse problems can occur as a result of trauma-induced biological changes (Friedman, 2006; Matsakis, 2005). The physiological and psychological changes occurring as a consequence of traumatisation have been explored extensively by researchers such as Bessel van der Kolk. His work titled 'The body keeps the score' emphasised the connection between the brain, the mind and the body in the trauma healing process (Van der Kolk, 2014). However, mental health issues are often stigmatised by society and issues of mental health are often perceived as character weaknesses and subject to ridicule.

> *"There's a lot of them (social workers) that's quite open about using, using anti-depressants and making jokes about it...it's also one of the things that, that, Black humour they call it in the police. But we do, we make jokes of things that are not really funny" (P9).*

Physiologically trauma can give rise to a range of bodily changes which include: increased heart rate,

blood sugar, muscle tension and breathing difficulties (Friedman, 2006; Matsakis, 1994). Participant 25 felt that the stress of the job was affecting the health of the Employee Health and Wellness (EHW) personnel in her area,

> *"My colleague and I were talking the other day of the 33 EHW personnel in our province. At least 30 are on medication whether its heart medication, blood sugar medication or anti-depressants. We think the stress is getting to us".*

Herman (1997) advocates that medication should be considered as an option when a trauma survivor is highly symptomatic as medication can assist in the reduction of hyperarousal and intrusive symptoms and help to restore biological rhythms of eating and sleeping. Briere and Scott (2006) note that paradoxically although hypervigilance can be debilitating, trauma survivors are often reluctant to take certain psychotropic medications due to their sedating effects, often resulting in the trauma survivor feeling as though they are losing control. In order to address these concerns, these authors recommend that in the early phases of treatment, patients are closely monitored and that psychotropic medications should be administered as a useful adjunct to trauma focused psychotherapy. Despite social workers being mental health practitioners, education and awareness of mental health issues have not always been sufficiently addressed during undergraduate social work training.

Cultural understandings of mental health issues also may influence a practitioner's understanding of conditions such as depression. Social workers may feel embarrassed to admit that they themselves need medication, such as anti-depressants or tranquilizers, in order to cope and may be reluctant to let others be aware of this factor. The researcher was cognizant of the fact that some participants might consider the use of anti-depressants as a sign of weakness or might be concerned about the judgement associated with taking anti-depressants and might not want to admit to a stranger (the researcher) that they were on anti-depressant medication. Hence, social workers employed in a trauma setting may require additional training on mental health issues associated with trauma.

- ***Theme three: Indulgence in food or alcohol***

A few participants mentioned the fact that they indulged in certain behavioural coping strategies, which included increased alcohol and food intake. Two male participants admitted that they sometimes increased their alcohol intake in order to feel better after having to deal with particularly traumatic cases at work. Another participant spoke about how she would overeat when she felt that she could not cope, which resulted in her gaining weight and she mentioned how this weight gain

adversely affected her self-esteem. According to Gilman (1999), substance abuse, self-mutilation, binge eating or starvation and promiscuity are often common responses of the trauma survivor in an attempt to reduce anxiety levels evoked by the trauma. While these coping mechanisms have obvious physical consequences, on an emotional level they serve a distractive function and allow the trauma survivor to self-regulate feelings and avoid pain that is too overwhelming for the ego to cope with. Some addictions are more or less stigmatised than others, for example caffeine addiction can also be harmful to one but is viewed as a more acceptable addiction than alcohol. Developing healthy habits requires conscious effort and determination and should be encouraged.

CATEGORY TWO: THE EMOTIONAL DIMENSION

Trauma exposure is often associated with destructive, harmful and sometimes unbearable emotional states. Unlike the initial physiological fight or flight response to trauma, sufficient emotional control mechanism, can create opportunities where emotions are cultivated, expressed and regulated (Allen, 2005). Participant 2 explained that *"My biggest coping mechanism.... that I have...is talking about my emotions".* In order to allow the correct opportunity for emotional expression, *t*he appropriate environment or opportunity needs to be created. Themes identified in the emotional dimension included engaging in creative activities which, in turn, promoted emotional expression and attending counselling.

- ***Theme one: Developing appropriate emotional regulation***

Two participants explained how they had grown emotionally and learnt about appropriate emotional regulation,

> *"So, I think I also grow. I see it also as a positive sometimes because whereas before I would easily cry previously when the client walk out, um, you know, now I will handle it.. professionally, much more professionally" (P11).*

> *"Separate my personal life from that of a social worker. Anticipating the type of trauma and developing mechanisms" (P26).*

Learning appropriate emotion regulation strategies is important for social workers regardless of the setting in which they work. However in a trauma environment, social workers through learning self-regulation activities can reduce their emotional responses to trauma (Collins & Laughlin, 2005; Sweifach, Linzer & Heft LaPorte, 2012). Being able to express emotion in a safe space through journaling or through creative activities was identified by three interview participants. Participant 13 reflected on how journaling helped her,

> *"I also write down my feelings... Ya, that is positive and negative and... sometimes I forget to write, but when I do write, it's like maybe over, two to three days I don't write and then I write everything, summarising everything that has happened".*

According to Berceli and Napoli (2006), conscious attempts at suppressing traumatic thoughts actually increase the occurrence of those thoughts. Acknowledgement and regulation of emotions can be developed through the use of appropriate mechanisms and strategies. Journal writing creates the opportunity for self-exploration and allows for the release of thoughts, feelings and perceptions. Seaward (2002) explains that journal writing has meditative aspects in that old thoughts are permitted to leave, creating space for expanded awareness, new depth of thought and increased understanding. Participants identified activities such as cake decorating, decoupage, music and gardening as coping strategies which helped them to forget about the trauma. Toyoshima, Fukui and Kuda (2011) found that participation in creative activities reduced stress levels as cortisol levels were markedly decreased through activities such as playing the piano, clay modelling and calligraphy. Other expressive art activities include drawing, painting, collage making, movement and dance and mask making (Capacchione, 2001). Social workers should therefore be encouraged to find a creative activity that they enjoy and which can assist with purposeful emotional expression.

- ***Theme two: Attending personal counselling sessions***

Most (87 or 68.1%) survey participants indicated that they had not attended any counselling sessions in order to address aspects of work trauma. Almost two-thirds (26 or 63.4%) of those who had attended counselling indicated that they had attended six or less counselling sessions. Only 15 (11.7%) participants indicated they attended counselling sessions when they felt the need for such sessions. When this theme was explored with interview participants, three sub-themes became apparent, which are displayed in Table 10.3.

Yalom (2001) understands the development of professional mental health practitioners to extend far beyond the tertiary training that is required for professional registration. He maintains that professional growth needs to be mirrored by personal growth in order to develop a competent and effective therapist. Currently social work training in South Africa, does not require students to attend their own counselling, which would provide opportunities for personal growth. Unlike professional South African psychology training, sufficient emphasis is not placed upon the personal growth of a student and how imperative the integration is, regarding personal and professional selves in the development of an effective mental health practitioner.

Table 10.3: Interview Participants' Views on Attending Counselling as a Coping Resource (N=30)

Theme	Sub-theme	No of participants	Quotes to illustrate this theme
Attending Counselling as a Coping Resource	Don't see the need to attend counselling	16	• *"No, I don't need that" (P3).* • *"No, it's not necessary" (P26).*
	Would like to attend counselling	6	• *"Because, it, it is not easy, sometimes you do have personal problems, and then you have to take your personal problems and put them on a gate when you enter the workplace. Then after work, then again, you have to deal with them. So you can imagine they're your personal problems, and the work problems and know the client's problems, everything. So it is very difficult, so I would say, I, we really need that. Some kind of an emotional support" (P2).* • *"Ya, it's very important but previously I thought it was like, I'll be okay, it was for other people or whatever...But now I've learned that I, I also need, I also need" (P10).* • *"You know I was also saying now I really need to really go because the work that we are doing here, really traumatic indirectly, but it also is affecting us, so I would prefer to really have it every month" (P6).*
	Have attended counselling	8	• "*Just to ventilate my feelings and I have contact, um and an open door policy with a psychologist just to, just to get some advice or just to vent" (P8).* • *"Because there's no support system in the police for us, um, so I'm seeing a psychiatrist every few months" (P15).* • *"So, I talk about the incidents, it gets, you know... when you go for counselling there is a lot of things inside of you but when you go to somebody who's able to listen to you, everything get out of you, out of your mind, out of your emotion, maybe you are exhausted but after talking to somebody, I feel relieved, no longer exhausted and my mind is also relieved of the pain and patient, you know, I get a little bit better and relieved and I feel like somebody's there to listen to me and to give me more insight on how to address the problem" (P19).*

Skynner (1989) maintains that many people enter the counselling professions due to their own personal traumas and unmet needs. Although these motives may often be unconscious, unresolved personal trauma increases practitioners' vulnerability to secondary and vicarious trauma (Bride, 2007a; Figley, 1995; Killian, 2008; Pack, 2014). It is therefore a matter of concern that most of the participants had never attended their own counselling which would have provided opportunities for increased awareness and personal growth. Considering South Africa's traumatic past and the current socio-economic conditions, one can assume that most social workers have had to endure hardships and possible traumatic situations.

Unresolved personal issues have the potential to adversely affect the helping relationship (Pearlman & Saakvitne, 1995a). The argument that it is a trauma practitioner's ethical responsibility to attend their own counselling has increasing merit in a country like South Africa. What is surprising is that despite counselling opportunities being available to SAPS social workers through the police medical aid scheme, most of the social workers in the study did not take advantage of this opportunity.

CATEGORY THREE: THE COGNITIVE DIMENSION

The main premise underlying cognitive-emotional therapy emphasises that the way we think, reason and perceive events will result in our behavioural and emotional responses (Payne, 2005). It is therefore not surprising that those coping strategies occurring on the emotional and cognitive dimensions may overlap and could be considered coping strategies relevant to both cognitive and emotional dimensions. Cognitive coping strategies that interview participants spoke about included: establishing professional boundaries, utilising psychological defences, and desensitisation of the trauma.

- **Theme one: Establishing professional boundaries**

Participant 28 emphasised that in order to cope with work trauma she establishes emotional boundaries, *"...Ya (Yes), Not getting that, not getting so involved, personally involved"*. Participant 2, who only had a few years of social work experience, explained how she was learning to establish professional boundaries in order to protect her personal time.

> *"I'm starting to cut out things that is social work related, after hours especially and weekends. So um, if someone phones me on the weekend or someone sees me in town and asks me oh, I want to ask your advice on this and this, um, I immediately start to get irritated where in the past I would have said yes let me help you".*

Establishing appropriate professional boundaries is essential for any mental health professional. Practitioners may find it difficult, especially in the early years of practice, to put up emotional boundaries with their clients. Trauma counsellors need to be able to engage in aspects of their life where they are not required to deal with traumatic or negative aspects. The social work supervisor's role could be of critical importance, especially during the initial years of practice at SAPS, in helping the practitioner establish and reinforce appropriate professional boundaries. Shulman (1991) maintains how important the supervisor's role is in helping the supervisee to establish clear expectations and contracts with clients.

- ***Theme two: Psychological defences***

Participant 18 explained that "*nothing can shock me, um, and I think it's my way of, of also defending myself otherwise I won't be able to cope"*. One could possibly attribute this response to the use of defence mechanisms, such as repression, where the individual subconsciously suppresses the trauma, or depersonalisation where one separates oneself from feelings and from others (Brown & Pedder, 1991). Just as the development of psychological defence mechanisms plays a crucial role in assisting not only the primary trauma survivor to cope and work through the traumatic effects, so defences can assist secondary trauma survivors. Courtois (2010) identifies predominant defence mechanisms of repression, amnesia, dissociation and splitting, as common defences an individual uses to suppress traumatic material. Two participants spoke about how they had learnt to dissociate in order to cope with their work, as one participant explained, "*I have learned to dissociate myself from my work"* (P17). In the following quotation from a forensic social worker, one can see how she utilises the defence of splitting and how she splits off and suppresses the reality of the sexual abuse,

> *"As soon, I don't know why but I'm working with these sex abused but as soon as another element comes in, like financial difficulties, or um, something else, then I become upset but not with the sexual abused that much anymore. So, it's as if I'm so used to the sexual abused, hearing that every day, so as soon as something else like the child is disabled or the child is in financial need or his clothes are torn that upsets me" (P2).*

In the following two quotations, participants mentioned how they sometimes tried to avoid dealing with trauma cases,

> *"At some stage, you know, if you under a lot of stress, you just feel like tired, like at times feel like you don't want to deal with the cases of trauma, you'd rather present the workshops...you not liking, you no longer want to, to deal with it" (P10).*

> *"Ya, some of it still stays with me. And now, to the extent, that now, if I have a case like that, I would want to refer it, you know" (P14).*

Avoidance of events, clients or contexts that remind the therapist of the traumatic experiences are symptoms of secondary traumatic stress (Figley, 1995). Avoidance behaviour can also be understood as defensive behaviour. Due to constantly hearing about painful and distressing trauma stories of clients, the counsellor can reach a stage of emotional saturation and psychic overload. At this stage Wilson (1989) suggests that the therapist may experience some degree of psychic numbing and emotional anaesthesia and he cautions that the therapists' deliberate avoidance of trauma or psychic numbing can have an adverse effect on the counselling relationships and the counsellor's ability to create a positive and sensitive counselling environment.

- ***Theme three: Desensitisation to trauma***

Participant 11 reflected how over time she had changed and that she was no longer affected by trauma as it had just become just part of her job,

> *"I think I'm used to it now, like, it's like there's something that is, if somebody was involved in a shooting, I don't have a problem with it, I'll, I'll go and do the debriefing with the group or individual, the family or whatever but I, I don't have a problem, like it's different, like when I come here, for me it's like, it was too much, every month, it's this then that but for now, it's like it's a job" (P11).*

Through the repeated exposure to trauma, individuals can become desensitised in that they are not as affected as they might initially have been. One can ask whether this subconscious process occurs as a result of psychic numbing and whether it may be necessary for a trauma counsellor to become desensitised. Systematic desensitisation and flooding have proven to be useful techniques in trauma therapy (Figley, 1995). Briere and Scott (2006) explain that as desensitisation occurs, exposure to environmental and internal triggers no longer results in the same level of negative emotions. However, this process may have other long term negative effects for the counsellor, such as the inability to experience appropriate emotional responses with clients or even in their personal lives. It is imperative that social workers have adequate supervision and attend their own counselling to learn to utilise their defences in a healthy and adaptive manner.

CATEGORY FOUR: THE SOCIAL DIMENSION

Most of the participants (25 or 83.33%) identified family, friends or spouses as vital support systems. Participant 6 explained the importance of having someone to offer or provide support, explaining that everyone needs a pillar, *"Ya, that's one (referring to her family) very important because if I didn't have*

any support, and I didn't have anyone... I wouldn't have, be able to... to how do I go on...So it's very important for a person to have a support so that you can at least have something, ***a pillar*** *to say but I can, I can continue, no matter what".*

- ***Theme one: Support from family and friends***

Support received from family and friends was the most commonly mentioned form of social support as family provided guidance and showed acceptance to participants; the following participants explained:

> *"I think I have a good support system that helps me to cope with, well-balanced. I can rely on it totally and I know that I'll be fine. It's my husband, my sisters, my friends, my colleagues" (P13).*

> *"I think that in my social environment, my friends and family, my brothers and sisters are also educated so they usually come with their problems and I would give them advice so they would say you are doing your social work on us. So then you talk with them and find out that they also experience problems then you calm it down, and you can learn from them" (P1).*

However, for some (two or 6.7%), family were not a safe haven as they felt family was one of the last places that they would want to show their vulnerabilities as reflected in the quotation by Participant 12,

> *"I don't share with my family. Oh, just lack of trust because if you share something with, they'll throw it back to you, so it's not good to share".*

Having friends outside of the profession is also important as they can provide opportunities to see life from different perspectives. One of the professional principles of the social work profession is the confidential nature of social work. Ethically one is prohibited from speaking about cases to others if they are not members of a professional team. Although at times this constraint may feel limiting for the social worker who may be struggling with a difficult case, having friends not associated with the profession and with whom one cannot talk about cases is also important. Friends outside the profession can help the professional to maintain a balanced perspective about life. As one forensic social worker commented,

> *"Oh...and friends, friends that, that also, ya, if I have a difficult court case, without them, they understand that I can't discuss these things with them. I would just say that I'm having a bad week and they take me out" (P2).*

Figley (1999) identified four skills that families can implement when supporting a traumatised family

member. These include providing social support, clarifying insights, correcting distortions and helping the family member to reframe the traumatic event. Often it is difficult for helping professionals who are used to assuming the 'giving role' in relationships, to acquiesce to being on the receiving end from others. Hence social workers need to be educated about the importance of establishing supportive relationships in their own lives.

- ***Theme two: Support from spouses or partners***

Despite 18 of the participants being married or cohabiting, only six participants identified their partners as important supports in dealing with the trauma. In particular, three of these six participants attributed the support that they received from their spouses to the latter being helping professionals themselves (teachers or social workers). Two participants specifically mentioned how their husbands helped to reduce their anxiety levels,

> *"I'm in a wonderful marriage. So you know, I can't wait for four o'clock in the afternoon just to get to my husband because he calms me down, you know, at home. It has a positive effect on me" (P2).*

> *"He does understand because I do talk to him about some of these cases and tell him how I feel about them and how I feel about people who and he understands but he, he's, luckily he's not just hyper as I am. He's free with people, not as I am though. He is a support because he, he's a teacher himself" (P15).*

While 12 of the other married participants did not mention their spouses as a part of their support system, one participant specifically drew attention to the fact that her husband did not understand her responses to her work stress,

> *"He says just go on with it, it's part of life, you understand? So he, he's not really, he's not able to sympathise in that way" (P9).*

Family members may also be affected by the practitioner's responses to secondary traumatisation. They could become fearful of their loved one who may exhibit responses involving anger and aggression (Jeenah & Moosa, 2012). Constant mood changes, irritability and social withdrawal can be disruptive for the partner, who often bears the brunt of these negative emotions. This experience can result in emotional distancing and negative long-term effects on family relationships. Matsakis (2005) refers to anyone who works for the military, police force or emergency services as living under the sword of Damocles. She explains that these spouses also live under the sword, as not only is there the constant fear of death occurring at work, but the emotional exhaustion and trauma defences that people in these professions develop, can have a long-term negative impact on intimate relationships.

Spouses can be left feeling rejected, disappointed and lonely. Social workers should therefore not only focus on educating police members about the effects of trauma, but intervention strategies should include education for family members. In turn, the same intervention should be in place for social workers, so that their spouses are also informed about the effects of secondary trauma.

- ***Theme three: Support from colleagues***

Just over a third (11 or 36.66%) of the participants identified their colleagues as a significant support in coping with work trauma. Some participants (7 or 23.33%) acknowledged their colleagues as their most important support system. The following three quotations emphasise this aspect:

> *"I think for me my support system **is** my colleagues" (P1).*
>
> *"It's not that I don't believe tigers don't cry but at times you feel like emotional drained and I've got colleagues with me, I'll share with them, I will talk to them and say listen guys, this is the story and we will just share and talk about it and I'll be okay "(P3).*
>
> *"I think sometimes you know if you can accept there are new ways of doing things and if you have a problem you just ask a colleague, that way it's easier for you to cope with problems because you can ask a question and a colleague can also advise you or tell you some of the incidents that have happened" (P29).*

Working with people who experience the same stressors could create a natural support group, as colleagues are likely to understand the nature and extent of traumatic stressors experienced in the job. Others (6 or 20%) did not feel that they could trust or obtain any support from their social work colleagues but felt that they obtained this support from other colleagues at SAPS, namely; the station commander (1) or other employee wellness practitioners including: the psychologist (1) or the chaplains (4). Two participants spoke about professional jealousy existing between the social workers which resulted in these participants keeping to themselves and not sharing with colleagues. Some participants felt that speaking to other professional colleagues outside of SAPS was 'safer' and that these colleagues provided the support they needed.

> *"I speak to, you know, colleagues outside of SAPS doing the same work that I'm doing or (who are) referring cases to me, I feel it's therapeutic itself, talking about things" (P2).*
>
> *"I will always refer back to my ex-colleague who worked here previously. Because um... I knew if I phoned that colleague and say, listen I have to see you and I need the support, they wouldn't think twice to help me with it" (P29).*

Catherall (1999) refers to the synergistic quality that collegial group support offers which is not

generated through individual collegial support. He advocates that although collegial support may occur informally through casual interactions, it should have a degree of formal organisation that is amenable to the particular dynamics of the group.

- ***Theme four: Community support***

The importance of community support was emphasised in the following quotations,

> *"The understanding of the community, the way we work and the way they accept us as people who are there to help and then to help the kids and then the way they support us because when you go out to them and ask for information or you want them to help the kids with something because they have just experienced trauma and you try and explain what's going on, they, they understand and they, they try and help you to do whatever you need to do" (P13).*

> *"Ya, ya, we do have support with the community because we don't experience much problems when we need their assistance and they are very, very reliable to help" (P11).*

In the above two quotations the social workers were referring to how the community assists them in the functioning of their work. The above two quotations were from forensic social workers, who are often required to work alongside community members in the daily execution of their duties. In African culture, the importance of the community has traditionally been woven into the fabric of African society. Numerous culturally mandated practices promote activities of volunteerism, mutual support and communal gain which build community solidarity and promote co-operation (Patel, Kaseke & Midgley, 2012). Other participants spoke about how community systems help support them as individuals, as reflected in the following quotations,

> *"In the community, where I am staying now, I have friends, like, um, I'm seeing the children but I do have friends within the community, I do visit my friends sometimes, we go out. You know, it's only that" (P18).*

> *"Ag, nothing other than sitting with my friend, my friends. Living, uh, we usually, I usually, like this sitting, we call it a society, women will just sit, women that's working, let me just say women that's working. Ya, also helped me "(P7).*

Community burial societies and stokvels are mutual aid arrangements that have many benefits for a member, in addition to those of only financial or capital gain. Matuku and Kaseke (2014) found that stokvels also promote opportunities for women empowerment and mutual support or assistance. Surprisingly, only four participants spoke about how they viewed community support as an important factor that helped them to cope. In African culture the principle of 'ubuntu' speaks to an African philosophy where community values are acknowledged above individual values. The Zulu adage

'umumti ngomuntu ngabantu' meaning that a person is a person because of other persons, has been used to explain ubuntu. Western critics, especially those who have followed Charles Darwin's theory of evolution, have viewed ubuntu as human primitivity and a "recipe for retarding modernisation" (Murove, 2014). Despairingly Msafiri (2008) observes that advocating community values in an individualistic world is a formula for continuing defeat and he asks a rather controversial question, "Is ubuntu a sufficiently well worked out and strong principle...or is it just a romantic admission of defeat?" This view was supported by a male participant who laughed when the researcher asked him about the concept of community support and said *"There is not support in the community...it's every man for himself" (P3)*.

Increased community cohesion and solidarity in times of war have highlighted the importance of social processes and support. Bracken (2002) places tremendous importance on the nature of the social context and how it can profoundly affect the individual's experiences and reactions to trauma. Steinberg (2008, p. 181) explains the complex relationship of the police and South African communities to be that of "scorned lovers...their relationship brittle, moody, untrusting and ultimately very needy". Although community support is desirable and could play a fundamental role in assisting the SAPS social workers, this notion is possibly a naive ideal and far from the reality of what traumatised South African societies can offer at this point in time.

- ***Theme five: Social isolation***

Eight participants (26.66%) spoke about how they socially isolated themselves from people. This isolation included withdrawal from friends, colleagues and family members.

> *"I just realised that um, if I go home after work it's as if I'm starting to cut myself off from the world outside" (P17).*

> "*Ya, thinking of that, previously, I didn't want to be alone at all, I was always around people. Um, over weekends, I always visit someone lately, on Saturdays, um, I don't want to go to the shops any more, I would rather stay at home, um, lying in front of the TV, watching a movie, or just you know, walking around in the garden and .. you know avoiding people" (P2).*

Social isolation is a common response to trauma often resulting in individuals not sufficiently utilising existing social coping resources. Although 'time out' is often appropriate and allows the individual space and the opportunity to work through feelings and emotion, increased social isolation can become problematic and develop into a maladaptive coping strategy. As individuals are increasing exposed to trauma so the need to create a physically and psychological safe space becomes essential.

Distress or impairment in social functioning is identified in criterion F of PTSD classification (American Psychiatric Association, 2013), indicating how trauma can diminish an individual's capacity to love and interact with others. Trauma exposure influences people's ability and willingness to trust others (Matsakis, 1998) often resulting in victims increasing their withdrawal from others.

Through detaching from the outside world for a period of time, participants felt that this strategy helped them to have more control and freedom in their own lives. Sandra Bloom's (1997) seminal work in the field of trauma highlights the need to create safe environments in a toxic world and she emphasises the need for creating sanctuary in order to heal and recover. Participant 6 spoke about how she needed a place to feel safe where she could acknowledge and experience the range of emotions that she felt after being exposed to traumatic situations at work:

> "S*ometimes you'll get isolated, you will not want to speak to anyone, you know, you'll want to be alone and want to withdraw from other people and you will want to, you'll feel sorry or sometimes you'll feel guilty, worried, you know those kinds of emotions" (P6).*

Feelings of anger, guilt, fear and anxiety are common emotional reactions after an individual has been exposed to trauma (Matsakis, 2005). In order to facilitate recovery, these feelings should be acknowledged (and not suppressed) in an appropriate environment. Participant 13 spoke about the need to isolate herself and remove herself from the workplace where there was conflict with colleagues. Another participant felt that she wanted to isolate herself from people outside of the police environment as they did not understand her world. Within the police she felt understood and so only wanted to integrate with people who could relate to her challenges and experiences.

> *"So I avoid people because I'll rather be alone now the days… I would just say, I would rather do it myself and go on my own than to sit with an office full of people where there's conflict" (P13).*

> *"It's almost as if you feel, you feel safe here in the police … here I can interact and what, what, what but out of the police, it's, ya, I'm um, isolating myself" (P9).*

Skovholt (2001) believes that friendships outside the organisation are important in order to help a trauma worker pursue a different perspective of life. Trauma related problems can undermine attachments and the traumatised individual can feel increasingly alienated from sources of support. Jeenah and Moosa (2012, p.555) refer to this process of trauma isolation as a 'vicious cycle of spiralling distress' which can result in further traumatisation. Bloom (1997) acknowledges how important connections with other human beings are, in order to address the disrupted attachments and the changes in regulation and moderation of affect occurring as a result of traumatic experiences.

For this reason, sufficient social support needs to be incorporated into the culture of SAPS, and formal and informal social opportunities need to be created in order to reduce social isolation.

CATEGORY FIVE: THE SPIRITUAL DIMENSION

The culminating stage for many trauma intervention models is about assisting the individual to derive a sense of meaning or mastery through the traumatic experience (Eagle, 2000; Ringel & Brandell, 2012). Trauma practitioners also need to reflect on how the incorporation of traumatic material becomes part of their own narrative. For many of the practitioners, deriving a sense of purpose through their work as well as drawing on existing spiritual beliefs helped to guide and sustain them in the wake of repeated trauma exposure.

- ***Theme one: Spiritual or religious beliefs and practices***

Almost half of the interview participants (13 or 43.33%) spoke about how their spiritual beliefs helped sustain them through the traumatic nature of their work. The following quotations illustrate this theme:

> *"As a Christian I pray and ask the Lord to make me strong in my work" (P22).*
>
> *"I am a born again Christian. Prayer is my life style. I draw my strength from God and I tell Him about everything!" (P18).*

Most religions address the issue of suffering and purpose, providing understandings and purpose for the follower. Confrontation with issues of humanity and mortality, may ignite or initiate a journey of spiritual searching for the trauma counsellor. For one practitioner "*Spending most of my time at church, reading the bible and singing" (P21)* were aspects of her religious practices that helped to sustain her. Prayer was also an important spiritual coping resource identified by many of the participants. Two participants felt that working as a social worker in SAPS was a specific vocation or 'calling from God'. Participant 2 explained how she could continue to be a forensic social worker: "*He (God) will give me the strength to go through and do this job...because he needs me here" (P18).* Participant 15 drew on her understandings of life, *"I always tell myself that it's part of life. Other traumatic incidents cannot be avoided but they pass with time" (P15).*

From a phenomenological perspective approaches to trauma and meaning require individuals to engage with and reflect on their philosophical assumptions of life and death. Bracken (2002, p. 110) offers Heideggar's understanding of the world which does not place emphasis on the 'now' as things are actually experienced; instead, "The primary meaning of existentiality is the future".

- ***Theme two: Deriving a sense of meaning***

Two participants explained how assisting others promoted their own sense of purpose,

> *"It's just to see result of who...you've been counselling, debriefing members and to see that they are okay, or if members went through a bad patch after they'd been traumatised, you see that they are recovering and they are coping....but that is things that help me, that make it worth my while" (P9).*

> *"I do work that I am supposed to do in order to assist the client and lessen their trauma exposure. I then feel better because of helping them" (P26).*

Marxist philosophy maintains that one of the concerning outcomes of capitalism is the alienation of the worker, depriving the worker of a sense of accomplishment and reducing opportunities for creativity and expression. This idea is consistent with Franz Fanon's (1952) notion of alienation as a form of psychopathology. If one can derive a sense of meaning and purpose from one's work, the inner satisfaction obtained can help a worker to endure and overlook many other difficult aspects of the job. As Friedrich Nietzsche explained 'he who has a why to live can bear almost any how', deriving a sense of meaning from their work also helped to motivate and enrich the lives of some of the practitioners. McTighe and Tosone (2015) studied how many Manhatten social workers found significant meaning in being of support and benefit to clients in the aftermath of the 11 September 2001 terrorist attacks. When training social workers to intervene in traumatic situations, greater emphasis should be placed upon the positive contribution social workers can make in the aftermath of traumatic situations and how social workers need to learn to develop their own sense of meaning from their work.

10.3 RESILIENCE

10.3.1 The Eighth Objective

The eighth quantitative objective was to ascertain levels of resilience as measured by Wagnild (2009)'s Resilience Scale, while the eighth qualitative objective was to explore the phenomenon of resilience with the interview participants.

10.3.2 Wagnild's (2009) Resilience Scale

Wagnild's Resilience Scale provides cut scores which determine whether an individual has high (moderately high to high), medium (moderately low to moderate) or low levels of resilience. These results are displayed in Figure 10.4.

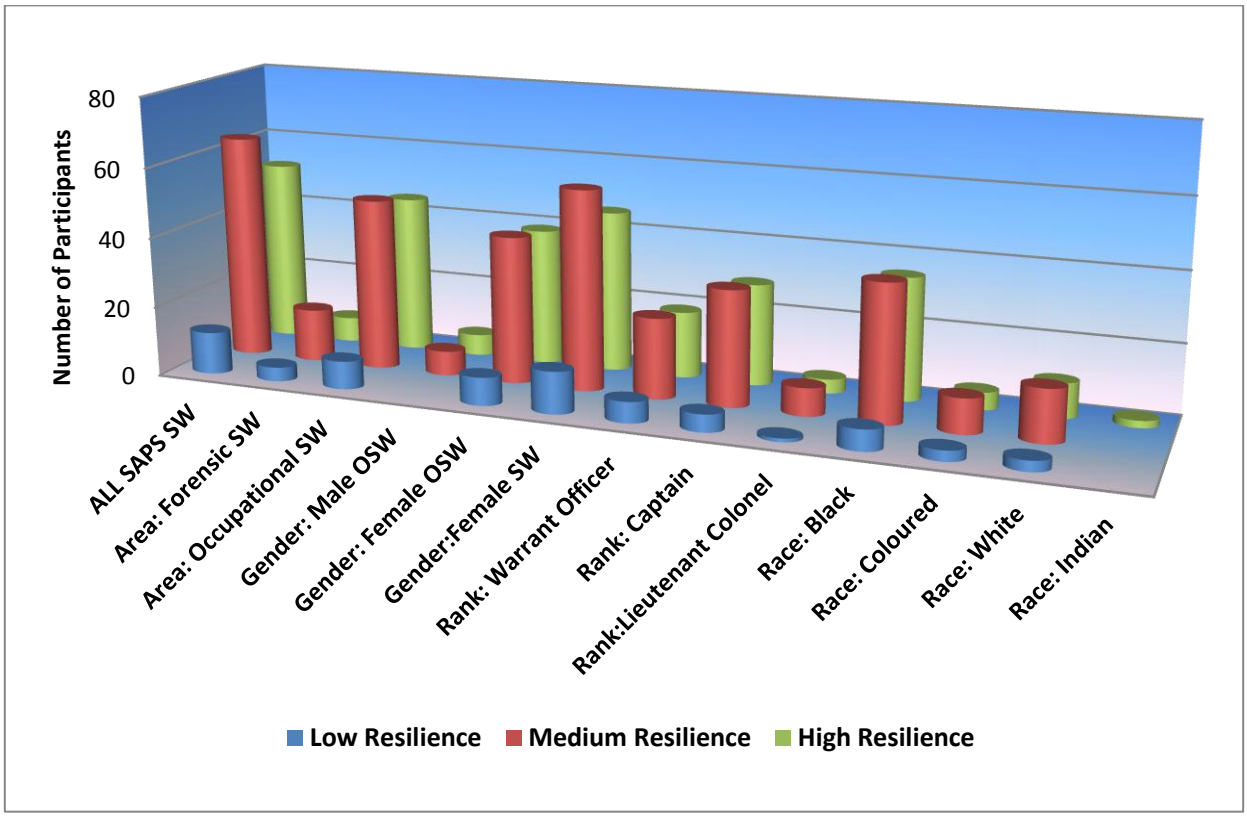


Figure 10.4: Resilience Scores of the Participants (N=128)

Most participants scored either a medium (64 or 50%) or high (52 or 40.63%) level of resilience and only a few (12 or 9.38%) had low levels of resilience. None of the male participants had low levels of resilience and most females had medium levels of resilience (57 or 44.53%). Males had higher mean scores (M=146.71; SE=3.02) than females (M=140.62; SE=1.3) but the difference was not statistically significant (t[16.797]=1.853; p>0.05). Recent resilience studies have found that there are gender differences. For example, the study by Stratta, Capanna, Patriarca, De Cataldo, Bonanni, Riccardi & Rossi (2013), found that male students who experienced an earthquake had higher resilience levels than female students. Stratta et al.'s (2013) study suggests that there is a need for one to adopt a gender sensitive approach when enhancing resilience in practitioners.

A surprising finding was that single social workers scored higher (M=143.69; SE=1.99) on average than married social workers (M=139.53; SE=1.527), suggesting that single social workers may have learnt to be more resilient within themselves, as perhaps they did not have a partner to rely on although the difference was not statistically significant (t[125]=1.685; p>0.05). The mean resilience score for superintendents (M=138.31; SD =13.2) was lower than for warrant officers (M=139.92; SD=14.1) and captains (M=142.72; SD=13.23). Lieutenant colonels have greater responsibility and may be more frequently exposed to more of the severely traumatic cases which may increase their vulnerability and

account for lower resilience scores. Looking at whether there were racial differences, the resilience mean score for Coloureds (M=135.78; SD=16.54) was lower than for Whites (M=137.54; SD=13.22) and Blacks (M=143.36; SD=12.78), although this result was not significant, so consequently racial differences were explored through a regression model.

Table 10.4: Regression Model with Resilience as the Dependent Variable

Model		Unstandardised Coefficients		Standardised Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	143.396	2.668		53.743	.000
	Forensic	-7.929	3.270	-.233	-2.425	.017
	Male	4.921	3.983	.109	1.236	.219
	In relationship/ married	-4.600	2.510	-.164	-1.833	.069
	Captain	5.563	2.708	.202	2.054	.042
	Lieutenant Colonel	-.392	4.713	-.009	-.083	.934
	Peri-Urban	-1.289	2.755	-.042	-.468	.641
	Rural	1.774	3.786	.042	.469	.640
	Coloured	-4.601	3.559	-.117	-1.293	.199
	Indian	17.595	10.374	.159	1.696	.093
	White	-3.092	3.186	-.092	-.971	.334

$p<0.05$

The regression model displayed in Table 10.4 explains 9.8% of the changes in the resilience scores. When controlling for other variables, forensic social workers scored an average of 7.93 points lower than occupational social workers, indicating that they were less resilient than occupational social workers. One could possibly attribute this finding to the nature of forensic social work in that these social workers may find it harder to build defences or become desensitised when investigating children who may have been abused since children represent one of the most vulnerable groups in society. It is therefore recommended that particular strategies are established within SAPS to assist forensic social workers to enhance their levels of resilience. Captains were also found to be more resilient than warrant officers and had an average score of 5.56 higher on the resilience scale. As the entry level rank for a social worker is a warrant officer, one can assume that the captains had been employed for longer at SAPS than the warrant officers and therefore had developed more resilience over time.

The resilience scale comprised five sub-scales, namely, self-reliance, meaning, equanimity, perseverance and existential aloneness. These mean sub-scale results are displayed in Table 10.5 and visually depicted in Figure 10.5.

Table 10.5: Mean Resilience Sub-Scale Scores (N=128)

		Self Reliance		Meaning		Equanimity		Perseverance		Existential Aloneness	
		Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
All SAPS SW		28.85	3.26	28.47	3.02	27.3	4.06	28.06	3.4	29.1	3.4
Type of SW	Forensic SW	27.65	3.32	28.12	2.73	25.5	4.65	26.77	4.19	27.5	3.6
	Occupational SW	28.4	3.27	28.56	3.09	27.76	3.79	28.39	3.2	29.5	3.3
Gender	Male OSW	28.31	4.19	30	2.31	28	4.23	30.23	2.38	30.2	3.43
	Female OSW	28.42	3.14	28.35	3.15	27.73	3.75	28.12	3.22	29.4	3.41
	Female SW	28.24	3.16	28.3	3.05	27.23	4.06	27.82	3.49	29	3.43
Rank	Warrant Officer	27.92	3.4	28.08	3.24	27.42	3.57	27.42	3.58	29.1	3.15
	Captain	28.46	3.39	28.81	2.91	26	4.17	28.64	3.33	28.3	3.45
	Lieutenant Colonel	28.38	3.16	28.15	2.64	27.7	4.71	27.46	3.47	28.3	3.5
Race	Black	28.04	3.62	28.93	2.64	28.35	2.99	28.46	3.27	29.5	3.38
	Coloured	28.44	2.97	27.61	3.01	25.28	1.41	26.56	2.12	27.89	3.61
	White	28.57	2.32	27.46	3.02	25.5	4.88	27.57	3.29	28.43	3.32
	Indian	30.5	0.7	32.00	1.41	29.00	1.41	32.5	2.12	32	2.82

On every sub-scale, forensic social workers had lower mean scores than the occupational social workers. Males obtained slightly higher mean scores for each sub-scale than the females did, apart from the self-reliance sub-scale where males scored (M=28.31; SD=4.19) and females scored (M=28.24; SD=3.16). Existential aloneness was the resilient characteristic that was most pronounced for all the different groups apart from the forensic group. Existential aloneness emphasises an individual's uniqueness and the individual's need to share experiences with others or to be alone (Wagnild, 2009). Meaning refers to an individual's understanding that life has a purpose and that the individual can make a significant contribution (Wagnild, 2009) and was the highest resilient characteristic for forensic social workers. As forensic social workers are continually exposed to a harsh side of life, seeing brutality and cruelty inflicted upon children (Truter & Fouche, 2015), it is important for them to be able to see life holistically and from other perspectives and not only the negative side of human behaviour.

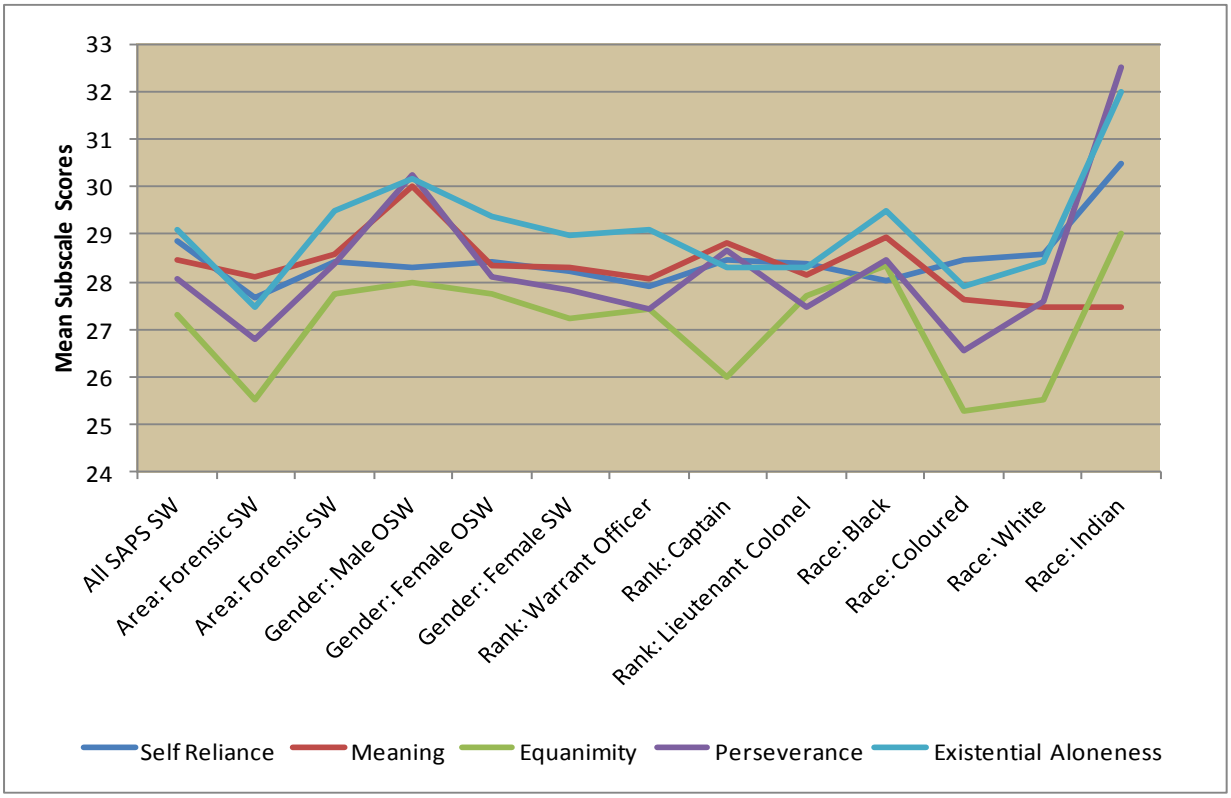


Figure 10.5: Mean Resilience Sub-Scale Results (N=128)

Acknowledging that they have a purposeful role to play and contribution to make in protecting the lives of children, can help to sustain them in what could be experienced as 'soul destroying' work. Black social workers' mean scores did not differ substantially between sub-scales (Range=28.04-29.5), and were higher than other racial groups. Coloured and White social workers had the lowest mean scores for equanimity (M=25.5; SD=5.35) and (M=25.28; SD=4.88), while self-reliance was the highest mean score for Coloureds (M=28.44; SD=2.975) and Whites (M=28.57; SD=2.31). This finding suggests that these racial groups may have a less balanced perspective on life and place emphasis on being self-reliant. Indian social workers obtained high results for all the sub-scales, with perseverance being the highest (M=32.5; SD=2.12) and equanimity (M=29.00; SD=1.44) the lowest. However, as there were only two Indians in the sample, results in respect of this sub-group need to be interpreted with caution.

In order to increase resilience levels within social workers in SAPS, education about resilience is important and could particularly emphasise aspects of equanimity, while assisting and equipping the social workers to have a balanced perspective on life. This approach needs to be reflected in the organisational policies as well, where limits on the amount of overtime social workers can work should be monitored.

10.3.3 Understanding Resilience

As resilience can be culturally and context specific (Truter, Theron & Fouche, 2014), one needs to determine what factors contribute to resilience in individuals in a particular context. When exploring the construct of resilience, participants were asked what (if anything) they could identify within themselves, their community or their work environment which contributed to their resilience in coping with the traumatic aspects of their work. Some participants were not familiar with the term resilience and so the researcher provided the explanation that 'resilience is the ability to bounce back from adverse (difficult) circumstances and enhance well-being' (Turner, 2001, p. 441). All participants were able to identify specific aspects contributing to their resilience. Some participants could identify these aspects more easily than others, who were rather pensive and could not easily identify the factors contributing to their resilience. While the term resilience has been around since the 1800s, it is only since the 1970s that resilience research gained momentum as physiological and psychological domains collaborated in understanding resilience as a construct (Tusaie & Dyer, 2004).

Acknowledging that developing resilience was a process, one participant felt she was resilient but to get to this point had been quite a journey for her "*Yes...but it's been a hard road to travel (to become resilient)"* (P22). Another participant elaborated on this discourse when she explained*, "I think, also, for me, like now I can, I can stand some of the things that I couldn't before. I can face some of the challenges that I was, that I couldn't face before" (P11).* The debate as to whether resilience is a process or occurs as a result of being a character trait has dominated resilience literature, as researchers have tried to create a universal understanding of the construct (Folke, 2006; Wagnild, 2009). Themes that emerged when exploring resilience in participants included: personality characteristics or attributes, spiritual beliefs, empowerment, acceptance of self and others, as well as support from work, religious and cultural communities. These themes are displayed in Table 10.6.

Table 10.6: Factors Identified As Contributing To Personal Resilience (N=30)

Identified theme contributing to resilience	Sub-themes	Number of participants mentioning theme	Selected Quotations Illustrating themes
Personality Attributes	***Easy going disposition***	***2***	• *"I am very, I'm very easy going person and I relate well to people" (P19).*
	Patience	***3***	• *"Patience and being a good listener" (P12).* • *"I think that I am patient... and so my creativity as well helps" (P13).*
	Perseverance/ Determination	***3***	• *"I'm more patient, to, to be patient, um, to persevere and try again, and again, and again, and again, so I've learned that for myself, is to, try, I keep on trying, make plans, if plan A doesn't work, go on and even if you get to plan Z then you can give up, and I've never gotten to plan Z" (P9).*
	Resourcefulness	***2***	• *"I will find solutions. I'm a determined person too you know I won't start something and just drop it at the end. I will finish it" (P17).*
	Assertiveness	***3***	• *"My personality...being outspoken...And not feeling shy to ...say what you feel... Ya, even to a stranger, (P11).* • *"Ya I'm one, someone who's an extrovert, and besides being an extrovert, I call a spade a spade" (P23).*
	Locus of Control	***1***	• *I think my internal locus of control (P20).*
	Strong and secure sense of self	***2***	• *"I'll say my strong personality …So I didn't allow anyone to destroy me or to belittle me because I know I am strong and I can do it" (P23).* • *"I think personally I had a very safe and trauma free childhood" (P29).*
	Ability to express emotions	***2***	• "Talking about my emotions" (P8). • "So I don't hold things that are bothering...I talk them out" (P3).
Spirituality	***Existential Purpose***	***5***	• *"I have things within me that I think I can identify. It's...I think it's my spiritual relationship with God. I, I think that helps me to be resilient and, and cope with the work that I do" (P13).* • *'Firstly my religion, I'm very religious" (P2).* *"I must say I'm a person I pray a lot. So prayers have helped me to cope with whatever come in my way" (P22).*

Empowerment	***Professional Knowledge and Skills***	***4***	• *"The courses, ne, they do have courses here that we usually attend...the in-service training" (P6).* • *"I think the trainings that is provided for us helps a lot, especially lately we have another training and I think it really helped just to build up on whatever we had and, and it does help" (P13)*
	Organisational Knowledge	***1***	• *"You know I would say the fact that I got to know the organisation better to feel uncertain about the knowledge that I have. So that also helps in terms of I and I just trust myself more in this environment as a social worker" (P21).*
	Establishing boundaries	***7***	• *"Um... the fact that I create emotional distance between myself and the client....the fact that I set boundaries, that I could set boundaries" (P23).* • *"I don't know. I think it's also a positive decision to make. You know this is your work, this work stays at work" (P29).* • *"I'm trying to leave things here at the office, not taking It home" (P31).* • *"Try not to take things personally will help you not to be too much involved" (P30).*
Acceptance	***Acceptance of self***	***1***	• *"Not to deny but to be realistic in terms of I'm also a human person and I cannot be perfect" (P26).*
	Acceptance of others	***1***	• *"Accepting people for who they are... and remember their own beliefs is their beliefs. My situation is not to change them but to maybe give some few pointers on how best to go on with certain things, but not necessarily change them" (P26).*
Support from various communities	*Work community: colleagues*	*4*	• *"The support I get from my colleagues that is the most one" (P6).* • *"With the support system that we are giving each other at work, the support that I'm having ... as a person, the support system that I'm having, I think they help me to be resilient" (P19).*
	Religious community	***1***	*"I like church very much, I'm a Christian and I am the kind of person who likes to talk, when I have a problem, I do talk to someone... and pray" (P8).*
	Socio-Cultural Community	***3***	• *"They (the community) provide a lot of support for the child which then gives you hope to go back and help the child at the same time" (P13).*

			• *".. you know, it was a social club that I was a member of, and we are all women and we would also recharge. During the holidays we would go to Durban, we go to recharge, we were professional ladies, we teach us lessons, you know, around the location then we move, we talk, we meet at the restaurant, we eat once a month and then at the end of the year, we go for an outing. So we really happy because we talk and we recharge as well" (P19).*

Only three participants recognised the role that their culture or community played in their resilience and only one identified her religious community as a source of her resilience. According to Wagnild (2003) resilience, however fluid, is not a process but an enduring personality characteristic. He understands resilience to be an inherent personality trait, which, depending on life's circumstances, can either be developed or diminished. A nurturing family, education, social involvement and personal relationships are factors contributing to the process of moving from vulnerability to one of resilience. One participant spoke about how her healthy and secure childhood made her resilient. For others this resilience came through empowerment or personality attributes they identified. Using Wagnild's resilience framework, themes that were identified by participants were grouped into the five resilience characteristics and are presented in Figure 10.6.

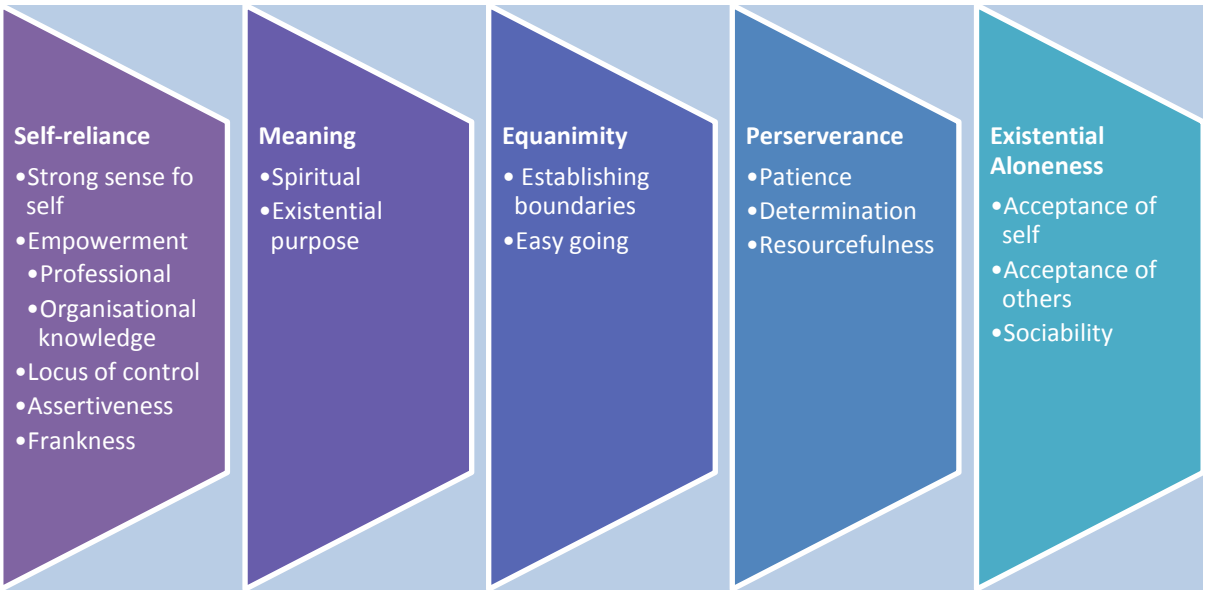


Figure 10.6: Resilience Themes Analysed Through Wagnild's Resilience Characteristics

A limitation of Wagnild's resilience framework (and use of Wagnild's scale in this research) is that the reciprocal nature of resilience is not incorporated, and the theme which incorporated community

support, could not be appropriately included in Figure 10.6. Taking this factor into account the researcher tried to explore the construct in the interviews utilising a systems framework and explored what personality, cultural and community factors participants identified as contributing to their resilience. However, most participants (25 or 83.33%) only identified aspects within themselves that they felt made them resilient. Only eight (16.66%) participants mentioned aspects in their social circles or community (work, religious or cultural) as factors contributing to their resilience, while the majority of participants could not identify any aspects in the community that enhanced and promoted their resilience.

As the construct 'resilience' has predominantly been understood to be an intra-psychic or individual characteristic (Tusaie & Dyer, 2004), participants may have answered from this viewpoint. This finding could also be attributed to the erosion of societal and cultural support in South African society, due to the increasing adoption of western values of individualisation and self-determination. African culture has always promoted a strong sense of community support, through practical and emotional assistance. Social cohesion and belonging are also established through rituals and traditions where family and community members show support (Patel, Kaseke & Midgley, 2012).

Polk's (1997) perception of resilience acknowledges that resilience is a multidimensional phenomenon that incorporates four aspects: physical and psychosocial characteristics, relational patterns (social roles and relationships), situational patterns (how one views the world) and philosophical patterns (one's beliefs and values). In order to enhance resilience, all aspects need to be considered and explored. The relevance of ecological theory and the salience of ecological considerations need to be acknowledged (Harvey, 2007). The role of resilience in coping with secondary trauma is further explored in the following section.

10.3.4 Hypothesis Testing

Hypothesis 7 investigated whether there was a significant relationship between vicarious trauma and resilience. The null hypothesis proposed that there was not a significant relationship between these two variables. Results showed that there was a negative and highly significant relationship between vicarious trauma and resilience ($r=-.443$; $p<0.01$). This finding indicated that higher levels of resilience were associated with fewer vicarious trauma symptoms. Both vicarious traumatisation and resilience develop over time and occur as a result of exposure to, or experiences of, adversity. Moreover, vicarious trauma and resilience are both constructs that are reflective of, or built upon the belief structure of the individual. The process of enhancing the characteristics of resilience, is likely to decrease vulnerability and subsequent negative changes in beliefs and thoughts, which are

characteristics of vicarious traumatisation. Analysis of the data revealed a negative and highly significant relationship between resilience and burnout (r=-947; p<0.01). Resilience was also found to have a negative and significant relationship with secondary trauma symptoms (r=-.443; p<0.01), indicating that the more resilient practitioners are, the less likely they are to exhibit secondary trauma symptoms. Connor, Davidson and Lee (2003) and Campbell-Sills, Cohan and Stein (2006) found that resilience moderated the relationship between risk factors and Posttraumatic Stress Disorder (PTSD). In contrast, Fincham, Altes, Stein and Seedat's (2009) study found that resilience did not moderate stress levels and that positive adaptation by South African adolescents who were abused shielded them from developing PTSD symptoms.

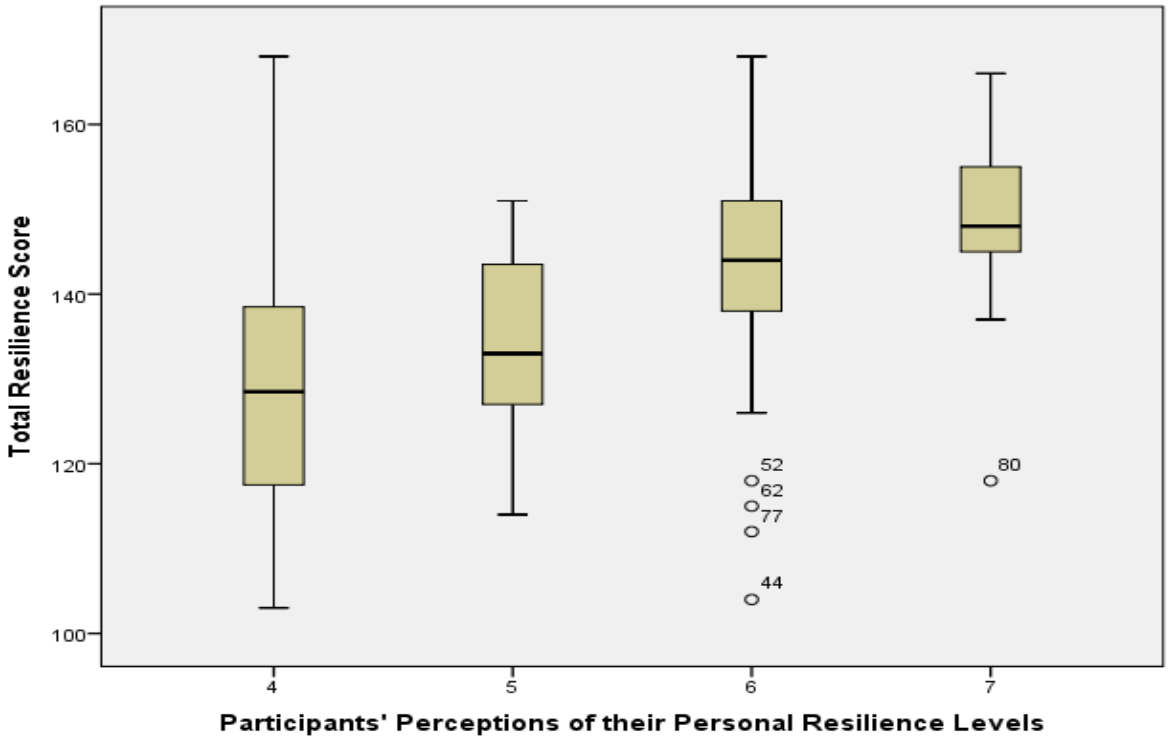
Null hypothesis 8 stated that there would be no significant relationship between resilience and compassion satisfaction. This null hypothesis was not supported by the data (r=0.450; p< 0.01), indicating that a positive and highly significant relationship existed between resilience and compassion satisfaction. Developing resilience can help trauma practitioners to experience the positive aspects of their work and promote both personal and professional empowerment (Sansbury et al*.,* 2015; Skovholt, 2001). Alongside vicarious traumatisation, trauma work offers practitioners the unique opportunity to develop vicarious resilience, as they can also learn to overcome adversity and experience positive transformation through witnessing their clients' healing processes (Hernandez-Wolfe, Killian, Engstrom & Gangsei, 2015). Although the construct of vicarious resilience was not specifically explored in this research, (which is a potential limitation of this study), two participants spoke about how they learnt from, and were encouraged by, the ways in which their clients overcame traumatic situations. This process was reflected in the following quotations,

> *"..Yeah, so I think, that, that thing that I want that person to get out of the situation, I want this person... to find a way to get out of this situation, I think it's what pushed me, what motivates me every day in doing my work and even me"(P12).*

> *"You find that other clients are having more problems than you can think of, so when you get all those kinds of problems with different people and all that and how they cope I think you can learn that way" (P22).*

Vicarious resilience is a relatively new construct in the field of traumatology, but it is a construct that warrants further exploration and research, particularly in South Africa. If practitioners become more aware of the opportunities trauma counselling and engagement with secondary trauma provides, they may be more open to learning from the experience. The education of social workers in this regard is therefore imperative.

Most survey participants (102 or 79.69%) indicated that they considered themselves to be resilient. Only (9 or 70.31%) felt that they were not resilient, while 17 (13.28%) did not answer this question. Pearson's product moment correlation coefficient was used to determine if participants' perceptions of their resilience was correlated with their total resilience levels and the results showed that there was a positive and highly significant relationship ($r=0.485$; $p<0.01$). These results are displayed in Figure 10.7. The figure also indicates the outlier scores, showing that a few social workers' perceptions of their resilience levels were greater than the resilience score that they obtained.



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Figure 10.7: Box Chart Showing Participants' Resilience Score and their Perceptions of their Resilience (N=128)

In order to be effective practitioners, social workers need to have appropriate levels of self-awareness, and in particular they need to be aware of their strengths and weaknesses. Resilience and age of participants were also positively correlated and significant ($r=0.206$; $p<0.01$), indicating that resilience does appear to develop over time and through life experience. Consequently, particular emphasis needs to be placed on assisting younger social workers within SAPS to develop resilience by creating appropriate spaces where the more mature social workers, who are potentially more resilient, can share their experiences and mentor younger social workers.

Contemporary social work practice incorporates a strengths paradigm that does not focus on the weaknesses of clients but instead explores their strengths and opportunities. As Saleeby (2002, p.4) explains, social workers need to "mobilise client's strengths (talents, knowledge, capacities, resources) in the service of achieving their goals and visions and the client will have a better quality of life on their own terms". Strength based principles compliment the understanding of resilience. The SAPS social work service adopted the strengths based approach as the basis of the occupational social work practice within SAPS (Stutterheim & Weyers, 2004). Considering that this professional approach is adopted with clients, practitioners themselves need to be aware not only of their weaknesses but of their strengths consequently adopting strategies to enhance their own resilience.

Van Breda (2011) refers to the 'pile up' of events which can increase the vulnerability of an individual. The occurrence of multiple life stressors or traumatic situations that are not dealt with and instead 'pile up' can diminish resilience. For social workers who are over-worked, with high caseloads and numerous traumatic cases, this 'pile up' can easily occur resulting in them being more susceptible to secondary traumatisation. Reflexive practice and increased self-awareness would not only enhance the quality of counselling services offered to clients but could potentially assist practitioners to regulate the negative effects of secondary trauma exposure and enhance their compassion satisfaction.

Resilience was significantly and positively correlated with work environment scores ($r=0.249$; $p<0.01$), indicating that the healthier the work environment, the more opportunity there is for resilience levels to increase or alternatively that the more resilient people are, the more likely they are to perceive the work environment in a positive manner.

A significant and negative relationship existed between resilience and burnout ($r=-0.313$ $p<0.01$). Furthermore, there was a significantly positive relationship between resilience and work cohesion ($r=0.237$; $p<0.01$); resilience and managerial control ($r=0.179$; $p<0.01$); and resilience and innovation ($r=0.203$ $p<0.05$). The importance of collegial support and having a sense of belonging at work as well as a clear understanding of a supervisor's expectations are all factors that resonate with resilience (Truter & Fouche, 2015), as these aspects are incorporated in equanimity and existential aloneness characteristics. Therefore from a systemic conceptualisation of resilience, promoting a healthy work environment would help to facilitate opportunities for practitioners to be become more resilient. Specific emphasis should be placed on promoting work cohesion, ensuring adequate managerial control and allowing opportunities for innovation. In addition, supervision, individual counselling and

educational workshops would be important mechanisms to facilitate this growth and help practitioners to become more resilient.

10.4 PARTICIPANTS' RECOMMENDATIONS TO REDUCE THE EFFECTS OF SECONDARY TRAUMA

10.4.1 The Tenth Qualitative Objective

The second part of the tenth qualitative objective was to obtain recommendations from the participants about how to reduce the negative effects of the traumatic material encountered in their work.

10.4.2 Participants' Recommendations to Reduce the Effects of Secondary Trauma

Survey participants identified various strategies to reduce the effects of secondary traumatisation. These strategies are displayed in Figure 10.8. Exposure to trauma is endemic within the SAPS environment and therefore intervention strategies need to be incorporated which include both preventative and responsive measures. Suggested pro-active strategies requiring implementation by the SAPS organisation included the following:

- Employing more social work staff in order to reduce the individual's trauma exposure (3 or 25.21%);
- Appointing appropriate social workers (1 or 0.84%) - One participant with five years' SAPS experience emphasised that *"a prospective employee's personal attributes should be considered i.e. unstable people should not be employed" (P110);*
- Monitoring trauma exposure (2 or 16.81%) - One participant spoke about how SAPS should review the extent of trauma to which SAPS social workers are exposed: "*EHW members (social workers) must not to be forced to go to the scenes but rather to do trauma debriefing to employees after they were exposed to the trauma" (P68);*
- Providing educational trauma workshops for staff (14 or 11.67%) - As Participant 82 emphasised, *"social workers need to be empowered with regard to what is trauma and its causes" (P82);*
- Organising retreats (5 or 4.20%) to provide social workers with time to recharge and reflect; and
- Implementing care for the care-giver programmes (16 or 13.45%) - Formalised support structures and education should assume a fundamental component of pro-active strategies. As Participant 38 explained, *"If members can be given or educated on their coping mechanisms so that they can be able to survive the trauma".*

Most of the proactive strategies suggested by the participants incorporated strategies that SAPS needed to implement in order to reduce secondary traumatisation. Only five participants (4.20%) highlighted the practitioners' responsibility to incorporate proactive strategies. These included, trying to limit trauma, drawing upon personal social supports and engaging in physical exercise. As Participant 73 stated, *"Try not to expose yourself - like visiting scenes; establish and care for the caregiver support group whereby different themes can be discussed and also for support; talk to friends and family about your own feelings; exercise regularly"*. Participant 91 emphasised how important it was to implement effective self-care strategies and to ''look after yourself" and "know the warning signs''.

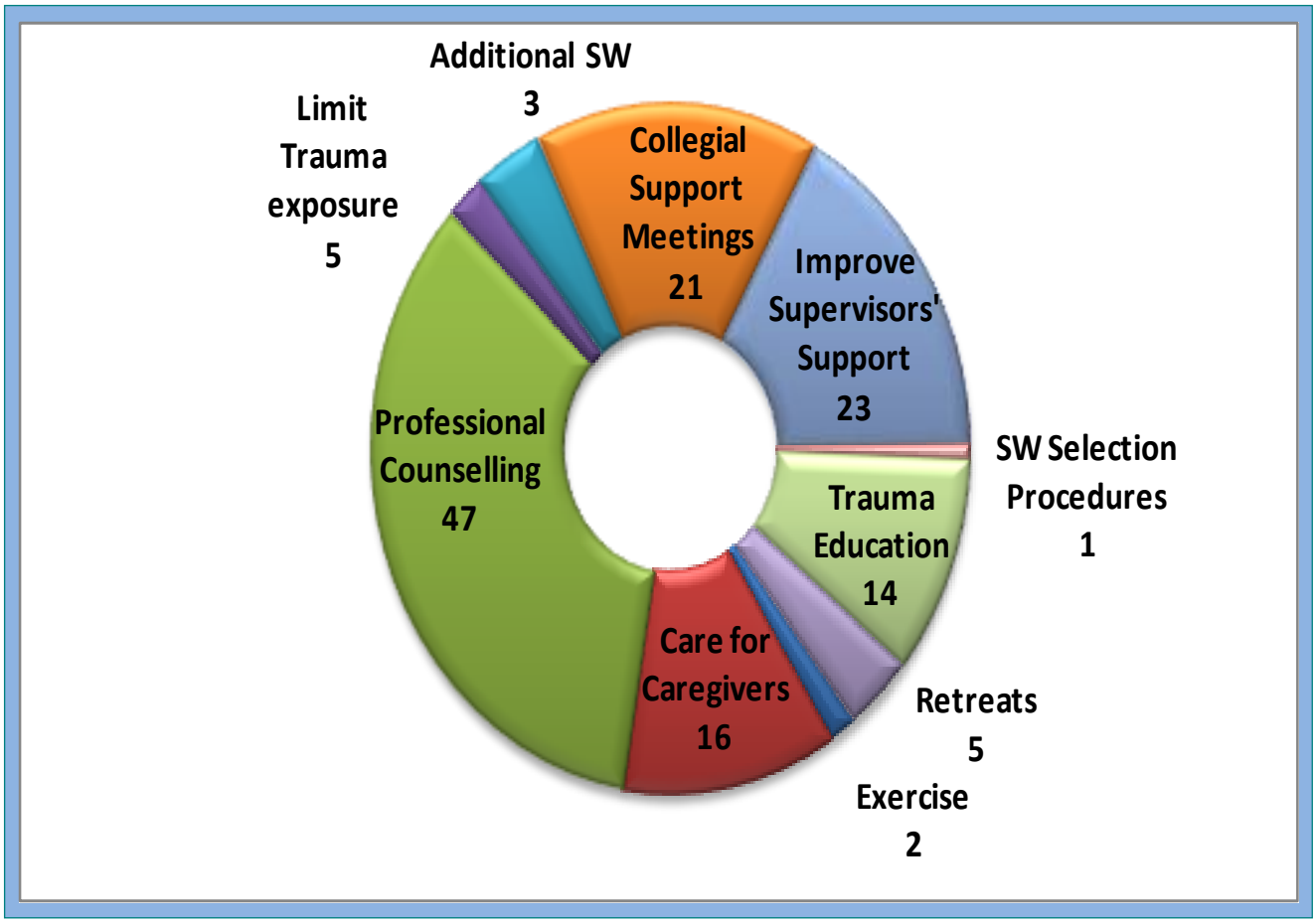


Figure 10.8: Survey Participants' Suggested Strategies to Reduce Secondary Traumatisation (N=119)

The need for professional counselling services offered by psychologists and/or social workers was the most frequently identified strategy (47 or 39.5%) as articulated by Participant 92, *"Social workers should have special therapists for ventilation".* Furthermore, almost half of these participants (22 or

18.80%) indicated that they would prefer to attend counselling with an independent or external professional who was knowledgeable about the effects of secondary trauma as they did not want to attend counselling with a professional who was internal to SAPS. The request for an external counsellor, suggests that participants experienced discomfort in sharing personal and professional information with another professional they were required to work alongside in their capacity as a mental health professional. A possible suggestion included, *"The SAPS must put in place a panel of psychiatrists and psychologists which we can phone anytime after any traumatic event to debrief us" (P126).*

Ensuring adequate levels of social support within the workplace was another important strategy that participants identified. In particular, workplace support could be fostered through enhancing supervisor support (23 or 19.38%) and holding regular collegial support meetings (21 or 17.65%). There appeared to be a strong sense that supervisors needed to be more supportive of junior staff, as two participants explained, *"Supervisors should be more interested in junior employees" (P16); "Social workers need more support from management regarding the stress they are exposed to" (P121).* Supervisors also need to be sufficiently trained in trauma theory so that they know how to deal appropriately with subordinates who experience secondary traumatisation.

In addition, many participants (21 or 17.65%) recommended that social workers attend colleague group trauma debriefing sessions in order to talk and share their experiences with each other. A few participants acknowledged that they might not feel comfortable talking to colleagues and suggested that support groups should comprise colleagues who could be trusted. Participant 32 felt that "*SAPS social work should engage in activities building trust amongst colleagues in order for them to share openly during a group supervision session".* As the philosophy of the SAPS employee wellness programme is to assist and support members of SAPS, this premise of promoting a supportive collegial system, needs to start with the social workers themselves, as Participant 107 boldly stated, *"EAS members should take care of each other before preaching to SAPS".*

10.5 CONCLUSION

What is apparent is that the social workers in this study drew upon an array of different coping resources; most of the supports mentioned were individual strategies that practitioners' utilise and develop. While not negating the fact that all practitioners have a significant responsibility for their own mental health, there is also a responsibility for the organisation to be more proactive in reducing the negative effects of secondary trauma through increasing and formalising necessary support systems, thereby helping to develop not only resilient practitioners but also a resilient organisation.

Lindy and Wilson (1994) emphasised the importance of creating a 'trauma membrane' around those who experience a traumatic event. This trauma membrane helps to reduce additional demands on an already overwhelmed ego and helps to protect and cushion the person against additional stressors. The trauma recovery process is likely to be enhanced if sufficient emotional and social support systems are in place.

CHAPTER ELEVEN

FINDINGS AND DISCUSSION 4

MODELS FOR UNDERSTANDING SECONDARY TRAUMATIC STRESS AND VICARIOUS TRAUMATISATION

"Wisdom is not a product of schooling but of the lifelong attempt to acquire it" **(Albert Einstein).**

11.1 INTRODUCTION

Bride (2007b) contends that as secondary traumatic stress has increasingly become understood to be an occupational hazard of the social work profession, so researchers need to explore and research the effects of indirect trauma, in order to ameliorate these effects and guide the organisations that employ social workers in terms of policy and practice procedures. In order to further understand the impact of secondary traumatic stress experienced by the social workers employed at SAPS, it is important to explore how the different variables interact with each other. The preceding chapters have explored the levels of trauma exposure, secondary traumatic stress, vicarious traumatisation, compassion satisfaction, burnout, the work environment, coping and resilience. This chapter endeavours to draw all the strands together by assessing how these variables simultaneously interact with each other. Through the use of multivariate analysis, namely tests of factor structure, multiple regression, structural equation modelling and moderation models, efforts are made to understand the complex nature of secondary traumatic stress.

11.2 MULTIVARIATE ANALYSIS

11.2.1 The Ninth Quantitative Objective

The ninth quantitative objective was to determine the nature and extent (if any) of the relationships between secondary trauma exposure, secondary traumatic stress, vicarious traumatisation, compassion satisfaction, burnout, the work environment, coping resources and resilience as experienced by social workers in the employ of the South African Police Service.

11.2.2 Results of the Analysis

The results of the advanced statistical analysis are presented as follows: firstly, the tests of factor structure; secondly, hierarchical multiple regression using vicarious traumatisation and burnout respectively as dependent variables tests and multivariate relationships with the more direct inference

of specific directionality; thirdly, the structural equation modelling which tests a more complex, endogenous path model with latent variable; and lastly, the final section tests of moderation effects. (This section is based on a report by Professor Gregory Lee, Research Director of the Wits Business School who assisted with the statistical analysis).

11.2.2.1 Tests of Factor Structure

As a first analysis, the dimensions of each construct were subjected to internal reliability testing, as seen in Table 11.1. All reliability analyses indicated acceptable or good internal consistency of construct dimensions with the exception of the original vicarious trauma dimensions, which were separated into safety, intimacy, esteem, control, and trust dimensions, each of these, in turn, has additional self-orientation and other-orientation items.

Therefore, exploratory factor analysis (specifically, principal axis factoring on item covariances with a promax rotation) was conducted on the items of vicarious trauma. Instead of the five-factor split of safety, intimacy, esteem, control, and trust, a two-factor solution was found to fit best with Kaiser-Meyer-Olin sampling adequacy of .78 and proportion of variation explained by the two factors was equal to 103% (bearing in mind that the oblique nature of principal axis factoring allows overlap of explanation and therefore greater than 1.00 proportions of variation). Analysis of the rotated factor structure suggested that the two factors split neatly along the 'self- and 'other' vicarious trauma items, and therefore this overall construct of vicarious trauma, could be separated into these two sub-dimensions. As seen in Table 11.1, the internal reliability scores of these two factors could be regarded as good.

As vicarious trauma was a key outcome variable, and the factor analysis suggested the split along the self and other lines, these two sub-dimensions were entered separately into two different SEM path analyses to assess whether the overall structure of the main model differed depending on whether self-trauma or other-trauma were analysed. Therefore vicarious traumatisation was analysed as 'vicarious trauma self' and 'vicarious trauma other' in the multivariate analysis. As discussed in the methodology section (Chapter 7), the final multi-dimension constructs of the study were formed in confirmatory factor analysis (CFA) through a combination of traditional reflective factors and formative factors formed through the methodology of Treiblmaier et al. (2011).

Table 11.1: Internal Reliability of Construct Dimensions

Factor	Construct	α
Avoidance	Secondary traumatic stress	.87
Intrusion	Secondary traumatic stress	.80
Arousal	Secondary traumatic stress	.87
Compassion	Compassion Satisfaction	.87
Burnout	Burnout	.70
Cognitive resources	Coping	.83
Social resources	Coping	.76
Emotional resources	Coping	.86
Physical resources	Coping	.76
Spiritual resources	Coping	.75
Self reliance & aloneness[a]	Resilience	.74
Meaning	Resilience	.67
Equanimity	Resilience	.70
Perseverance	Resilience	.68
Work environment	Work environment	.77
Vicarious trauma (self)	Vicarious trauma	.86
Vicarious trauma (other)	Vicarious trauma	.86

Notes. [a] Initial analysis suggested a combination of the self-reliance and aloneness sub-dimensions of resilience.

Only those factors with multiple sub-dimensions were included in the initial CFA (i.e. coping, resilience, secondary-trauma, vicarious trauma [self] and vicarious trauma [other]), since singular constructs (like traumatic stress which is a single-score summation of yes responses in the scale) were already in final factor form. This final CFA had acceptable fit, with Chi-square = 202.67(104), $p < .01$, SRMSR = .06, RMSEA = .08 (90% CI = .06-.10), CFI = .92, and NNFI = .90 (Lee, 2015).

The aggregation strategy to form final constructs involved the use of factor scores arising from the confirmatory factor analysis (using SAS's PROC SCORE for the non-SEM analyses and the internal factor score estimation in PROC CALIS within the path analyses), sums of yes/no constructs, and averages for single-dimension constructs (burnout and compassion satisfaction). As univariate results do not reflect

multivariate realities and also do not model specific dependent variable relationships, multiple regression analysis was conducted.

11.2.2.2 Regression Models

This section utilised multiple linear regression to model the impact of the variables on two focal dependent variables of the study, namely vicarious trauma and burnout. Since there were a large number of demographic control variables, as well as various categories of independent predictors, the analysis employed hierarchical regression to test the effect of various variables or variable sets over prior variables. Multiple linear regressions were used to model the impact of the variables on two focal dependent variables, namely burnout and vicarious trauma. In light of the fact there were a large number of demographic control variables, as well as various categories of independent predictors, the analysis employed hierarchical regression to test the effect of various variables or variable sets over prior variables. For the vicarious trauma regression, the analysis proceeded through the following steps:

- Model 1 incorporated all *demographic control variables*;
- Model 2 added the *work environment*, which was assumed to be a fairly stable control construct;
- Model 3 added variables considered to be given in the short term, in other words aspects of the individual disposition (captured through *resilience and coping*);
- Model 4 added *exposure to traumatic events*, which was considered an externally-controlled input to the trauma process;
- Model 5 added *secondary traumatic stress*, which was considered an intermediate outcome of traumatic stress exposure;
- Model 6 added *compassion satisfaction* as a possible secondary outcome of trauma, although also considered a predictor of vicarious traumatisation.

For the hierarchical regression process for burnout the same procedure was used as described above for vicarious trauma, except that the vicarious trauma variable was added as an additional step (Lee, 2015).

(i) Hierarchical Regression on Vicarious Trauma (Self)

Table 11.2 shows the results of the model for vicarious trauma (self) as the dependent variable. The initial demographic model indicated moderate fit, with R^2 = .23. The addition of work environment in Model 2 improved the model in all respects, with a small to moderate β = .21 ($p < .05$) and R^2 = .26. The addition of coping and resilience in Model 3 improved the model tremendously, raising adjusted R^2 from .18 to .77 as the higher R^2 is, the better the model explains variation in the dependent variable (Adams *et al,,* 2006).

The slopes of coping and resilience were moderate and large respectively (β = -.35 and -.60 respectively, p<.01) indicating that these issues were associated with a decrease in vicarious trauma (self) as the beta coefficient shows the comparison of the strength of association between the different independent variables and the dependent variable (Adams et al*.,* 2006). In addition, the effect of work environment in this model fell to near zero.

The addition of traumatic exposure in the next model added little explanatory power, and the variable had a negligible slope, with other variable slopes remaining as per the prior model. This regression analysis highlighted the importance of establishing and developing coping resources and resilience within the practitioner, in order to reduce the negative effects of vicarious trauma on the practitioner's belief structure and schema which relate to the self. Furthermore, if the practitioner has sufficient supports in place, the different range of trauma exposure and the work environment have negligible effects on the practitioner's vicarious trauma levels (self).

Resilience had the greatest predictor effect on vicarious trauma self, highlighting the role that an individual's personal characteristics have in terms of how much the trauma is likely to affect the individual's beliefs or views of the world. Model 5 indicated that secondary traumatisation does have explanatory power in terms of the level of vicarious trauma and therefore it is important that SAPS social workers are educated about the effects of secondary trauma so that they can incorporate preventative strategies which can help to ameliorate both secondary and vicarious traumatisation.

(ii) Hierarchical Regression on Vicarious Trauma (Other)

Table 11.3 shows the hierarchical results for vicarious trauma (other). These results were in some respects roughly analogous in size and effect as in the previous model (R^2s of roughly similar size, little impact from traumatic exposure and compassion satisfaction) with the following important differences: Coping had now emerged as the most powerful predictor (β =-.52, p<.01) of vicarious trauma (other); Resilience had declined dramatically as a predictor compared to vicarious trauma (other) with $\beta = .15, p<.10,$ indicating that coping resources had a stronger association with the measure of vicarious trauma relating to beliefs about others than did resilience. Furthermore, this finding highlights the role that resilience plays in vicarious trauma relating to beliefs about the self. In particular, coping resources need to be increased in order to reduce the vicarious traumatisation relating to beliefs about others. The role of secondary traumatisation was far more important here ($\beta = .38, p < .01$), showing that there was a stronger association with secondary traumatisation and beliefs relating to others as opposed to beliefs relating to self.

Table 11.2: Hierarchical Regression Model with Vicarious Trauma (Self) as Dependent Variable

Parameter	Hierarchical Regression Models – Vicarious Trauma (Self) as Dependent Variable											
	Model 1		Model 2		Model 3		Model 4		Model 5		Model 6	
	B	β	B	β	B	β	B	β	B	β	B	β
Intercept	1.16		1.64*		-.40		-.40		-.40		-.64	
Age	-.03**	-.18	-.04**	-.20	.02*	.11	.02*	.11	.02*	.11	.02*	.11
SAPS tenure	.02	.02	-.01	-.01	-.05	-.04	-.05	-.04	-.06	-.05	-.06	-.05
Trauma experience	.00	.02	.00	.01	.00	-.05	.00	-.05	.00	-.03	.00	-.03
Warrant Officer	-.38	-.20	-.48	-.25	.04	.02	.04	.02	.11	.06	.11	.06
Captain	-.68**	-.36	-.76**	-.41	-.01	.00	.00	.00	.04	.02	.04	.02
Forensic	.33	.14	.29	.13	-.06	-.03	-.06	-.02	-.08	-.04	-.08	-.04
Female	.25	.08	.21	.07	-.04	-.01	-.05	-.01	-.01	.00	.01	.00
Other race	-.21	-.08	-.27	-.11	-.23*	-.09	-.23*	-.09	-.25**	-.10	-.24*	-.09
White	.66***	.29	.54**	.24	.14	.06	.14	.06	.09	.04	.11	.05
Urban	.09	.04	.16	.08	-.02	-.01	-.02	-.01	-.04	-.02	-.04	-.02
Periurban	-.42	-.14	-.52**	-.18	-.06	-.02	-.06	-.02	-.08	-.03	-.06	-.02
Single	-.12	-.06	-.12	-.06	.08	.04	.08	.04	.06	.03	.04	.02
WES			-.19**	-.21	.02	.02	.02	.02	.04	.04	.04	.04
Coping					-.34***	-.35	-.34***	-.35	-.34***	-.35	-.35***	-.36
Resilience					-.60***	-.60	-.60***	-.60	-.57***	-.57	-.58***	-.58
TSS							.04	.01	.00	-.01	-.01	-.01
STSS									.11**	.12	.11*	.12
Compassion satisfaction											.06*	.05
F	2.79***		3.10***		29.91***		27.8***		27.27***		25.72***	
R^2	.23		.26		.80		.80		.81		.81	
Adj R^2	.14		.18		.77		.77		.78		.78	
AIC	-24.87		-28.96		-192.34		-190.37		-193.57†		-192.37	
BIC	-19.96		-23.55		-185.81†		-183.21		-185.73		-183.81	
SBC	12.20		10.97		-146.7†		-141.88		-142.23		-138.18	
PC	.95		.92		.26		.26		0.25†		.26	

Notes: *** = $p < .01$ ** = $p < .05$ * = $p < .1$

Table 11.3: Hierarchical Regression with Vicarious Trauma (Other) as Dependent Variable

Parameter	Hierarchical Regression Models – Vicarious Trauma (Other) as Dependent Variable											
	Model 1		Model 2		Model 3		Model 4		Model 5		Model 6	
	B	β	B	β	B	β	B	β	B	B	B	β
Intercept	1.18		1.48		-.14		-.21		-.19		-.23	
Age	-.02	-.11	-.02	-.13	.02	.12	.02	.12	.02*	.12	.02*	.12
SAPS tenure	.06	.05	.03	.03	-.04	-.03	-.05	-.04	-.09	-.07	-.09	-.07
Trauma experience	.00	-.10	.00	-.10	.00**	-.16	.00**	-.16	.00	-.09	.00	-.09
Warrant Officer	-.58*	-.30	-.65*	-.34	-.16	-.08	-.12	-.06	.10	.05	.10	.05
Captain	-.80***	-.43	-.85***	-.46	-.18	-.10	-.16	-.08	-.01	-.01	-.01	-.01
Forensic	.20	.09	.18	.08	-.16	-.07	-.12	-.05	-.21	-.09	-.21	-.09
Female	-.05	-.02	-.08	-.02	-.18	-.06	-.22	-.07	-.12	-.04	-.12	-.04
Other race	-.34	-.13	-.37	-.15	-.22	-.08	-.23	-.09	-.30**	-.11	-.29**	-.11
White	.61***	.27	.53**	.24	.23	.10	.23	.10	.07	.03	.07	.03
Urban	.08	.04	.13	.06	.00	.00	-.01	-.01	-.07	-.03	-.07	-.03
Peri urban	-.51**	-.18	-.58**	-.20	-.20	-.07	-.18	-.06	-.24	-.08	-.23	-.08
Single	-.07	-.04	-.07	-.03	.06	.03	.05	.02	-.02	-.01	-.02	-.01
WES			-.12	-.13	.04	.04	.05	.05	.12**	.13	.12**	.13
Coping					-.53***	-.54	-.51***	-.52	-.50***	-.52	-.51***	-.52
Resilience					-.24**	-.24	-.25***	-.25	-.15*	-.15	-.15*	-.15
TSS							.05	.10	.02	.04	.02	.04
STSS									.37***	.38	.37***	.38
Compassion satisfaction											.01	.01
F	3.43***		3.36***		13.79***		13.29***		18.47***		17.28***	
R^2	.26		.28		.65		.66		.74		.74	
Adj R^2	.19		.19		.60		.61		.70		.70	
AIC	-30.39		-30.74		-119.16		-120.23		-153.96		-151.97	
BIC	-25.47		-25.34		-112.63		-113.07		-146.12†		-143.41	
SBC	6.69		9.18		-73.53		-71.75		-102.62†		-97.78	
PC	.90		.90		.45		.45		0.34†		.35	

Notes: *** = $p < .01$ ** = $p < .05$ * = $p < .1$

(iii) Hierarchical Regression for Burnout

Table 11.4 shows the hierarchical regression effects for burnout. In this model, the same progression was followed as previously, except that the vicarious trauma variables were added in an extra step. As can be seen, the following occurred: The addition of work environment to the demographics in Model 2 was significant (β=-.36, p<.01) with substantive improvement to adjusted R^2 and information criteria. However, as previously, the effect of work environment declined through the remainder of the models, although not to zero. In this instance, coping and resilience added little value as predictors to the burnout models. Traumatic stress exposure initially added some value but this value also declined through the remainder of the models. Secondary traumatic stress added significant value to the models with an initial increase in the adjusted R^2 from .25 to .40 and lowering of all information criteria. This finding highlights the association between burnout and secondary traumatic stress, suggesting that practitioners experiencing secondary traumatic stress are more vulnerable to experiencing burnout. For the practitioner the consequences of experiencing burnout include not only symptoms of emotional exhaustion and depersonalisation but also decreased work performance. This finding suggests that SAPS needs to ensure that they have adequate procedures in place to reduce the effects of secondary trauma.

Compassion satisfaction was associated with lower burnout and added significantly to the models which emphasised the importance of employee satisfaction and fulfilment from their work, in order to mitigate burnout. Vicarious trauma (self) was associated weakly and negatively with burnout (β = -.18, p<.05), which result was unexpected. Furthermore, vicarious trauma (other) had a negligible association with burnout. These findings suggest that burnout was not strongly associated with vicarious traumatisation (self) or vicarious trauma (other).

Since these regressions did not account for the more complex endogeneity involved in vicarious trauma being a major outcome of other variables, this result was not seen as informative until the SEM models were subsequently formulated. Model 6 had good overall fit (adjusted R^2 = .41) with leading predictors being secondary trauma (β =.49, p<.01) and weaker effects from compassion satisfaction and vicarious trauma self (β= -.18 for both, p <.05).

Table 11.4: Hierarchical Regression with Burnout as the Dependent Variable

Parameter	Hierarchical Regression Models – Burnout as Dependent Variable													
	Model 1		Model 2		Model 3		Model 4		Model 5		Model 6		Model 7	
	B	β	B	β	B	β	B	β	B	β	B	β	B	B
Intercept	1.85*		2.77**		2.14**		2.00*		2.02**		3.14***		3.02***	
Age	-.01	-.03	-.01	-.07	.03	.01	.01	.05	.02	.01	.03	.01	.01	.03
SAPS tenure	.28*	.20	.21	.15	.20	.14	.17	.12	.12	.09	.10	.07	.09	.07
Trauma experience	.03	.10	.02	.10	.02	.08	.02	.07	.04*	.16	.04**	.17	.00*	.17
Warrant Officer	-.17	-.08	-.37	-.17	-.21	-.10	-.13	-.06	.19	.09	.18	.09	.20	.09
Captain	-.27	-.13	-.43	-.21	-.20	-.10	-.15	-.07	.05	.02	.03	.02	.04	.02
Forensic	-.23	-.09	-.30	-.12	-.40	-.16	-.32	-.13	-.45**	-.18	-.46**	-.18	-.47**	-.18
Female	.46	.13	.38	.11	.29	.09	.21	.06	.35	.10	.29	.08	.29	.09
Other race	.05	.02	-.07	-.03	-.07	-.02	-.10	-.03	-.19	-.07	-.26	-.09	-.29	-.10
White	.54**	.22	.30	.12	.17	.07	.16	.07	-.06	-.02	-.13	-.05	-.11	-.05
Urban	-.05	-.02	.09	.04	.03	.01	.02	.01	-.07	-.03	-.07	-.03	-.07	-.03
Peri urban	.18	.06	-.03	-.01	.11	.04	.15	.05	.07	.02	-.04	-.01	-.04	-.01
Single	-.10	-.05	-.09	-.04	-.03	-.01	-.05	-.02	-.14	-.07	-.08	-.04	-.07	-.03
WES			-.37***	-.36	-.31***	-.30	-.28***	-.28	-.17**	-.17	-.16*	-.15	-.16*	-.15
Coping					-.09	-.09	-.07	-.06	-.06	-.05	-.01	-.01	-.05	-.05
Resilience					-.20	-.18	-.22	-.20	-.07	-.07	-.02	-.02	-.13	-.12
TSS							.10**	.18	.06	.11	.06	.11	.06	.11
STSS									.52	.49***	.51***	.48	.51***	.49
Compassion satisfaction											-.26**	-.19	-.25***	-.18
Vicarious trauma (self)													-.20**	-.18
Vicarious trauma (other)													.05	.05
F	1.86**		3.27***		3.41***		3.6***		5.96***		6.06***		5.44***	
R^2	.16		.27		.31		.34		.48		.50		.50	
Adj R^2	.07		.19		.22		.25		.40		.42		.41	
AIC	11.33		-4.55		-8.11		-11.46		-39.55		-42.77†		-39.82	
BIC	16.25		.86		-1.58		-4.30		-31.71		-34.21†		-29.65	
SBC	48.41		35.38		37.52		37.03		11.79		11.42†		20.08	
PC	1.03		.91		.88		.86		.69		0.67†		.69	

Notes: *** = $p < .01$ ** = $p < .05$ * = $p < .1$

According to Lee (2015), although multiple regressions are capable of revealing much about the focal relationships, they revealed some flaws in the context of this study. These included the following:

- They did not allow for endogeneity, in other words they could not model relationships between multiple dependent variables simultaneously or between independent variables. Such endogenous relationships seem plausible however. (For instance, the methodology here suggests that resilience may affect coping, and that vicarious trauma may mediate between other variables and burnout);
- Regression could not model feedback loops;
- To date the analysis had not dealt with measurement error in the multi-item scales of the main variables, other than to report sufficiently high coefficient alphas. However, this procedure retained any measurement error within these variables. Latent variable analysis allows for explicit modelling of measurement error and the formation of latent variables that better reflect the true, underlying construct; and
- The moderately high correlations between the main variables may suggest same-method bias, as discussed in the methodology chapter. A feasible solution for this problem was to again use latent variable modelling, where a single latent variable underlies all manifest (i.e. directly observed) variables (Lee, 2015).

The above concerns with regression can be addressed in structural equation modelling (Kline, 2010). Accordingly, the following section employed this technique to account for the issues mentioned here.

11.2.2.3 A Model of Secondary Trauma and Vicarious Trauma

As previously mentioned, structural equation modelling is considered to be more of a confirmatory than an exploratory procedure; the theoretical model/s that are constructed by the researcher are then tested with measures of the degree to which the data fit the models. A theoretical model of secondary and vicarious trauma is displayed in Figure 11.1. This model, which is based on literature and the findings from the preceding chapters, shows how the variables that have been explored in this study relate to each other.

The model depicts the variables (highlighted in green) namely: the amount of secondary trauma exposure social workers have experienced; the length of time in an organisation (SAPS); and factors in the work environment (clarity, control, innovation, physical comfort, autonomy, task orientation, work pressure, involvement, cohesion and supervisor support), and how they are likely to influence the levels of secondary traumatic stress experienced by social workers. However, the social workers' view of the world, social support and levels of coping resources on physical, emotional and spiritual levels influence how affected they become, the subsequent levels of secondary traumatic stress and

whether they are able to derive a deeper level of fulfillment and satisfaction from their work (compassion satisfaction – indicated in red).

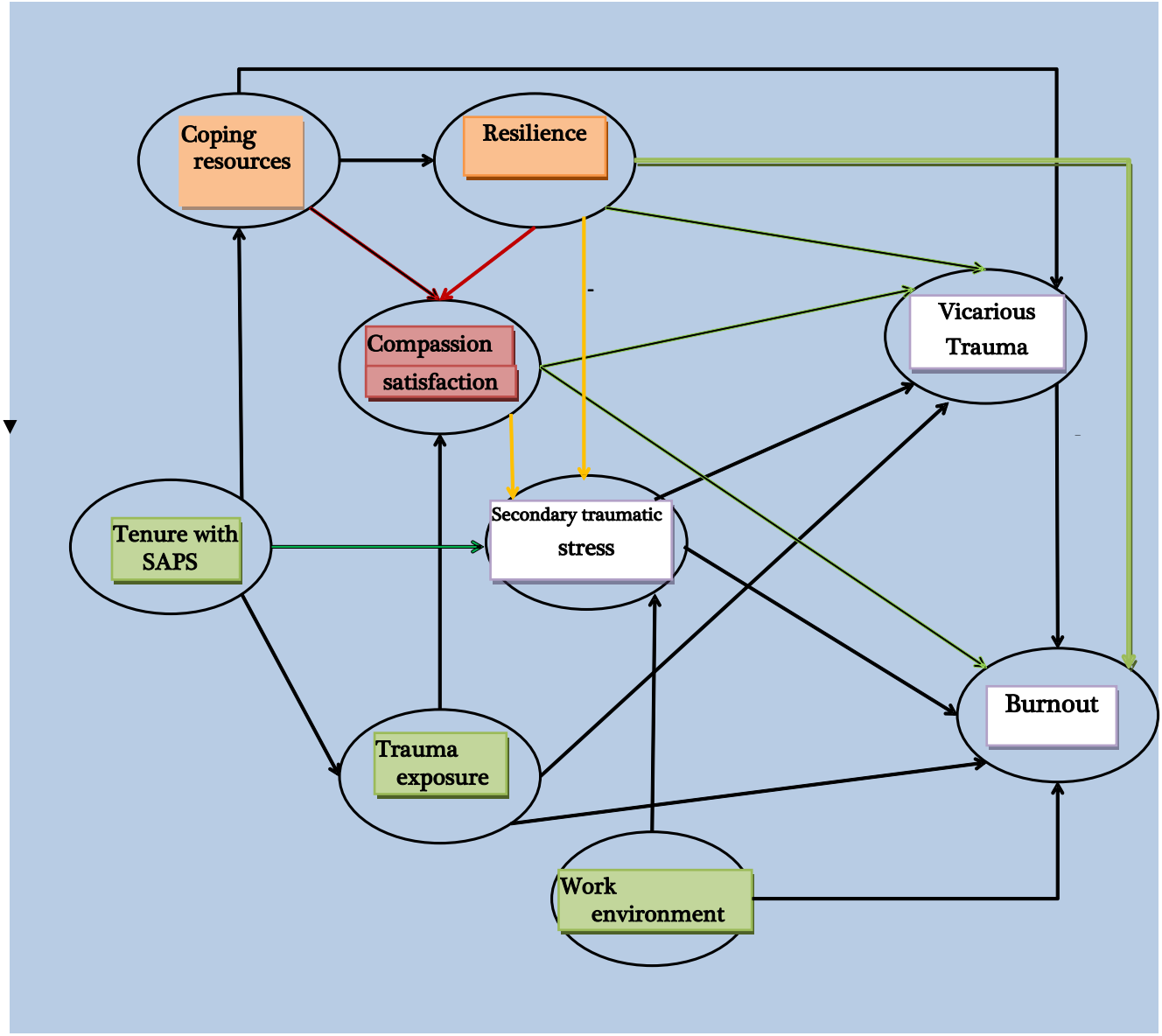


Figure 11.1: A Model of Secondary Trauma and Vicarious Trauma

The response to secondary trauma exposure is not necessarily a polarised one as individuals may derive certain aspects of fulfilment from their work while still experiencing negative symptoms resulting from the trauma (intrusion, arousal and avoidance symptoms). The extent of secondary traumatic stress can be mediated by an individual's compassion satisfaction and how resilient the individual is (as indicated by the orange arrows). Individuals' coping resources are likely to influence the level of resilience that they may develop, which can have a direct effect on how they can

assimilate exposure to traumatic experiences into their own narratives and affect the level of compassion satisfaction they may derive.

Vicarious trauma, similar to secondary traumatic stress, can be mediated indirectly by compassion satisfaction. The final negative outcomes of exposure to secondary trauma are secondary traumatic stress, vicarious trauma and/or burnout. Resilience and compassion satisfaction directly moderate vicarious trauma and burnout (see green arrows), in a similar manner to the way that they moderate secondary traumatic stress.

In conclusion, the work environment, secondary traumatic stress and vicarious trauma are likely to contribute to burnout. The model highlighlights the need to increase the coping resources and levels of resilience of social workers so that they can experience more compassion satisfaction from their work, which in turn will help to mediate levels of secondary traumatic stress, vicarious trauma and burnout. Increasing support within the work environment can also help to reduce levels of secondary traumatic stress and burnout. This model is then explored further through structural equation modelling.

11.2.2.4 Structural Equation Models

The analysis of structural equation modelling proceeded through the application of normal theory maximum likelihood estimation, using the SAS CALIS programme. The research followed the standard two-stage process of first doing a confirmatory factor analysis (CFA) to assess whether the hypothesised constructs were adequately represented through latent variables which were indicated by the observed manifest variables. This step has already been discussed in the first results section of this chapter. Second, the analysis proceeded to a structural path analysis between the latent variables, which was the ultimate end-point of the analysis. The following sections report these findings, separated for vicarious trauma (self) and vicarious trauma (other) since these two outcomes yielded different outcomes in the initial regressions and separation allowed for greater clarity in effect analysis and mapping whereas with such a small sample the extremely large number of paths involved in including both together would have been problematic. Both models explored the direct and indirect effects of the variables SAPS tenure; work environment, trauma exposure, coping resources and resilience on the variables, secondary traumatic stress, vicarious trauma (self or other) and burnout.

(i) Structural Path Analysis on Vicarious Trauma (Self)

The first SEM analysis had acceptable fit, with Chi-Square (101) = 149.06, p = .0013, SRMSR =.08, RMSEA =.06 (90% CI = .03-.08), CFI = .96, NNFI = .94. Figure 11.1 shows the path diagram for this first SEM analysis, noting that a few very small paths have been omitted to facilitate clarity (no paths on final outcomes are omitted, and all path effects were presented in the effect decomposition, Table 11.5).

Table 11.5 displays the complete effects decomposition, including direct, indirect and total standardised effects. This approach proved helpful because of the great amount of endogeneity in this model: many variables were found to affect each other through complex and multiple mediator paths.

Figure 11.1 and Table 11.5 show the following regarding the important endpoint variables: Vicarious trauma (self) had a good R^2 of .69, and burnout had a good R^2 of .41. Of all total effects in the model, the biggest predictors associated with vicarious trauma (self) were a very large effect from coping (β = -.71, p< .01), a large effect from resilience (β = -.54, p< .01) and a small association with tenure with SAPS (β = .14, p<.01). Other total effects were negligible; Burnout had moderate total effects from almost all predictors except vicarious trauma (self). The largest effect was secondary traumatic stress (β = .42, p<.01), with smaller negative moderate effects from work environment, resilience, coping, and compassion satisfaction. Burnout also had weak positive associations with tenure with SAPS and traumatic exposure (β = .18 and .16 respectively, p<.05). While the associations between tenure, exposure to trauma and burnout were significant, they were weak. It would seem that variables such as secondary traumatic stress and the work environment were better predictors of burnout.

There were several instances where significant mediation effects occurred. These included the following:

- In the case of coping, roughly half of the total effect on secondary stress and vicarious trauma was an indirect, mediation effect, and in fact almost two thirds of the effect on compassion satisfaction was mediated (primarily through resilience);

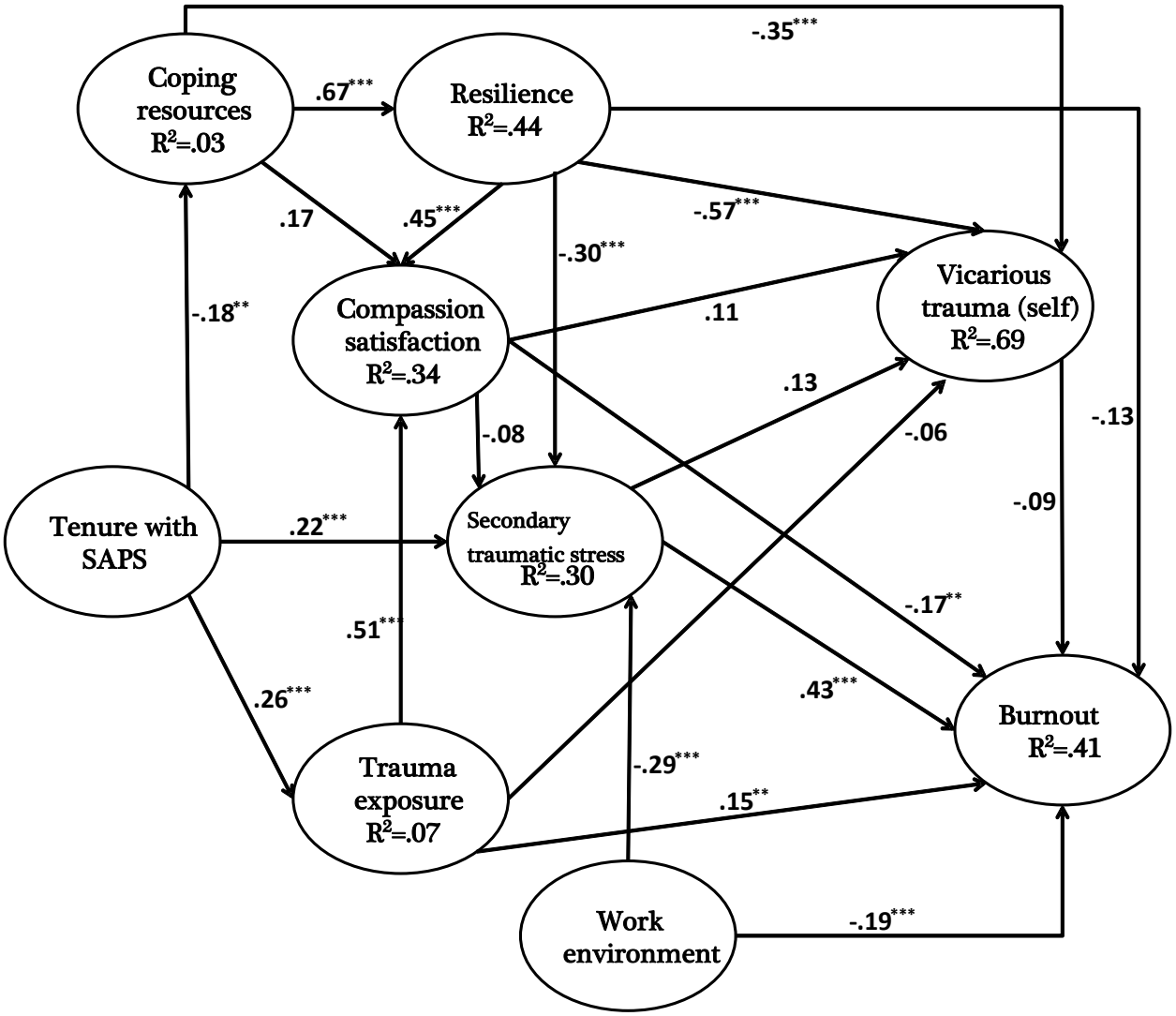


Figure 11.2: Final Path Analysis (Standardised Paths) for Vicarious Trauma (Self)

- Half the effect of resilience on burnout was indirect as seen in the path diagram and effects table; and was mediated through vicarious trauma (self), secondary trauma and compassion satisfaction.
- A substantial amount – almost one-third – of the effect of work environment on burnout was mediated through secondary trauma, highlighting how important it is that the practitioner and organisation have sufficient strategies in place to address secondary traumatisation and which may simultaneously help to ameliorate burnout levels.

Table 11.5: Effects Decomposition of Vicarious Trauma (Self) Structural Equation Model

Causal variables	Endogenous Variables in Vicarious Trauma (Self) Model						
	Coping resources	Resilience	Trauma exposure	Secondary stress	Compassion satisfaction	Vicarious trauma (self)	Burnout
Tenure							
Direct effect	-.18**	-	.26***	.22***	-	-	-
Indirect effect	-	-.12**	-	.05*	-.09**	.14**	.18***
Total effect	-.18**	-.12**	.26***	.27***	-.09**	.14**	.18***
Coping							
Direct effect	-	.66***	-	-.13	.17	-.35***	
Indirect effect	-	-	-	-.16*	.30***	-.36***	-.23***
Total effect	-	.66***	-	-.28***	.47***	-.71***	-.23***
Resilience							
Direct effect	-	-	-	-.18	.45***	-.57***	-.13
Indirect effect	-	-	-	-.04	-	.02	-.12
Total effect	-	-	-	-.21**	.46***	-.54***	-.25**
Trauma exposure							
Direct effect	-	-	-	-	-	-.06	.15**
Indirect effect	-	-	-	-	-	-	.01
Total effect	-	-	-	-	-	-.06	.16**
Work environment							
Direct effect	-	-	-	-.29***	-	-	-.19**
Indirect effect	-	-	-	-	-	-.04	-.12***
Total effect	-	-	-	-.29***	-	-.04	-.31***
Secondary stress							
Direct effect	-	-	-	-	-	.13	.43***
Indirect effect	-	-	-	-	-	-	-.01
Total effect	-	-	-	-	-	.13	.42***
Compassion satisfaction							
Direct effect	-	-	-	-.08	-	.11	-.17**
Indirect effect	-	-	-	-	-	-.01	-.04
Total effect	-	-	-	-.08	-	.10	-.22***
Vicarious trauma (self)							
Direct effect	-	-	-	-	-	-	-.09
Indirect effect	-	-	-	-	-	-	-
Total effect	-	-	-	-	-	-	-.09

Notes. β = standardised effect sizes. *** *= p < .01* ** *= p < .05* * *= p < .1*

These results show that there were complex and powerful explanatory effects for the key outcomes of vicarious trauma (self) and burnout. These findings suggest that in order to reduce the effects of vicarious trauma, emphasis should be placed on increasing coping resources and developing resilience among practitioners. Consistent with this recommendation, previous research by Gil and Weinberg (2015), found that therapists' ability to cope with the traumatic effects of their work was highly dependent on their coping strategies and internal resources. The next section utilised the same techniques to assess vicarious trauma (other).

(ii) SEM path analysis for Vicarious Trauma (Other)

The second SEM path analysis utilising vicarious trauma (other) also had acceptable fit, with Chi-Square (101) = 165.88, p<.01, SRMSR =.08, RMSEA =.07 (90% CI = .05-.09), CFI = .94, NNFI = .93. Figure

11.2 shows the path diagram for this second SEM analysis, again noting that a few very small paths were omitted to facilitate clarity. (No paths on final outcomes were omitted, and all path effects were included in the effect decomposition in Table 11.6).

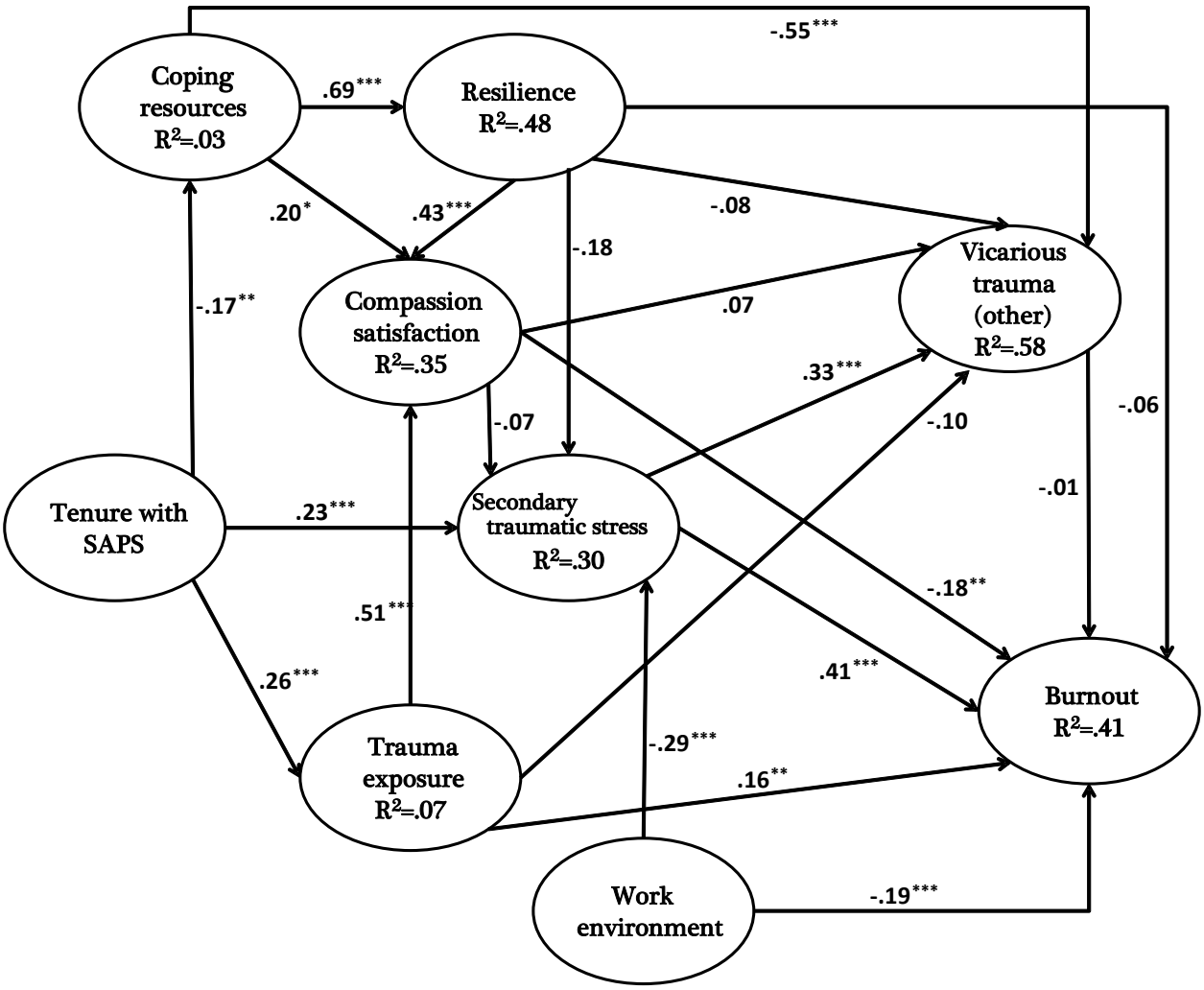


Figure 11.3: Final Path Analysis (Standardised Paths) for Vicarious Trauma (Other)

Table 11.6 shows the complete effects decomposition, including direct, indirect and total standardised effects and is followed by an explanation of the most important findings in the SEM model.

Table 11.6: Effects Decomposition of Vicarious Trauma (Other) Structural Equation Model

Causal variables	Endogenous Variables in Vicarious Trauma (Other) Model						
	Coping resources	Resilience	Trauma exposure	Secondary stress	Compassion satisfaction	Vicarious trauma (self)	Burnout
Tenure							
Direct effect	-.17**	-	.26***	.23***	-	-	-
Indirect effect	-	-.12*	-	.05*	-.08*	.21***	.17***
Total effect	-.17**	-.12*	.26***	.28***	-.08*	.21***	.17***
Coping							
Direct effect	-	.69***	-	-.13	.20*	-.55***	-
Indirect effect	-		-	-.16*	.30***	-.11	-.25***
Total effect	-	.69***	-	-.29***	.50***	-.66***	-.25***
Resilience							
Direct effect	-	-	-	-.18	.43***	-.08	-.06
Indirect effect	-	-	-	-.03	-	-.04	-.17**
Total effect	-	-	-	-.21**	.43***	-.12	-.22**
Trauma exposure							
Direct effect	-	-	-	-	-	.10	.16**
Indirect effect	-	-	-	-	-	-	-.00
Total effect	-	-	-	-	-	.10	.16**
Work environment							
Direct effect	-	-	-	-.29***	-	-	-.19**
Indirect effect	-	-	-	-	-	-.09***	-.12***
Total effect	-	-	-	-.29***	-	-.09***	-.31***
Secondary stress							
Direct effect	-	-	-	-	-	.33***	.41***
Indirect effect	-	-	-	-	-	-	-.00
Total effect	-	-	-	-	-	.33***	.41***
Compassion satisfaction							
Direct effect	-	-	-	-.07	-	.07	-.18**
Indirect effect	-	-	-	-	-	-.02	-.03
Total effect	-	-	-	-.07	-	.05	-.21**
Vicarious trauma (self)							
Direct effect	-	-	-	-	-	-	-.01
Indirect effect	-	-	-	-	-	-	-
Total effect	-	-	-	-	-	-	-.01

Notes: β = standardised effect sizes. *** *= p < .01* ** *= p < .05* * *= p < .10*

Table 11.6 shows the following regarding the important endpoint variables: Vicarious trauma (other) had a large R^2 of .58 and burnout had an R^2 of .41, with both being analogous in size to those in the earlier model; Many of the effects were similar in size or at least provided effective interpretation to the vicarious trauma (self) model. As with the regression model, possibly the most striking effects were those relating to resilience.

Unlike the vicarious trauma (self) model, resilience had almost no direct association with either secondary stress or vicarious trauma (other). This finding severely reduced the effectiveness of resilience as a predictor of vicarious trauma (other), although it had not reduced its total effect on burnout to any great extent. In addition, as with the regression models, secondary trauma was far

stronger as a predictor of the other-dimension of secondary trauma as opposed to the self-dimension of vicarious trauma (β =.33, p<.01 versus β = .13, p>.10). Therefore, practitioners who experience secondary trauma are more likely to experience an increase in changes in their belief and need areas that relate to others, than to experience an increase in changes in their beliefs about themselves.

As was apparent in the previous SEM model, compassion satisfaction had a small and positive direct effect on vicarious trauma other and vicarious trauma self. However, the total effect of compassion satisfaction is in both cases slightly reduced by the indirect effects of secondary traumatic stress. Compassion satisfaction had a negative but weak direct effect upon secondary traumatic stress. One would have thought that the direct effects of compassion satisfaction would have exerted a greater negative direct effect on vicarious trauma (self and other) and secondary trauma. However, in a study with professionals who counsel torture victims, Birck (2001) found that compassion satisfaction had limited influence in preventing secondary traumatisation among the practitioners. Although these findings might appear contradictory and warrant further clarification, one can understand that because practitioners experience satisfaction in their work, they do not necessarily focus on the negative impact of their work and the secondary traumatic stress symptoms that they experience.

The final analysis investigated possible moderation effects. This analysis reverted to regression to test the classic interaction model of moderation.

11.2.2.5 Moderation Models

The final step involved investigation of moderation effects, specifically to do with coping. As discussed in the literature chapter on coping (chapter three), coping may possibly be seen as an interaction variable that determines the strength of other relationships. Specifically, the analysis tested coping as a moderator of the effects of exposure to vicarious trauma and burnout. The analysis followed the classic Baron and Kenny (1986) approach to testing interaction, in terms of which all predictors were centred, and an interaction term composed of the product of the independent variable and moderator was created and added to the other predictors.

Table 11.7 summarises the results for all tested models, in which only a few moderation effects were found for coping, namely, vicarious self and trauma exposure as well as the resilience and burnout relationship.

Table 11.7: Summary of Moderation Model Findings

Dependent variable	Independent variable	Change in adjusted R^2	Information criteria	*β* of interaction term	Overall decision
Vicarious trauma (self)	SAPS experience	.00	1 out of 4 information criteria improved	.07^{ns}	No moderation
Vicarious trauma (self)	Resilience	.00	No information criteria better for interaction model	.06^{ns}	Moderation
Vicarious trauma (self)	TSS	.01	See Table 11.8	.11	Some moderation
Vicarious trauma (self)	STSS	.00	All higher for interaction model	-.00	No interaction
Vicarious trauma (self)	WES	.00	All higher for interaction model	.05ns	No moderation
Vicarious trauma (self)	Compassion satisfaction	.00	All higher for interaction model	-.02ns	No moderation
Vicarious trauma (others)	SAPS experience	.00	No information criteria better for interaction model	.07^{ns}	No moderation
Vicarious trauma (others)	Resilience	.00	No information criteria better for interaction model	-.02	No moderation
Vicarious trauma (others)	TSS	.00	3 of 4 worse for interaction model	.08ns	No moderation
Vicarious trauma (others)	STSS	-.01	All worse for interaction model	-.01ns	No interaction
Vicarious trauma (others)	WES	-.01	All worse for interaction model	.01ns	No moderation
Vicarious trauma (others)	Compassion satisfaction	.00	3 out of four worse for interaction model	-.07ns	No moderation
Burnout	SAPS experience	.00	No information criteria better for interaction model	.03^{ns}	No moderation
Burnout	Resilience	.01	See Table 11.9	.12	Some moderation
Burnout	TSS	.00	All worse for interaction model	-.01ns	No moderation
Burnout	STSS	-.01	All worse for interaction model	-.02ns	No interaction
Burnout	WES	-.01	All worse for interaction model	-.05ns	No moderation
Burnout	Compassion satisfaction	.00	All worse for interaction model	-.05ns	No moderation

(i) Coping Moderating the Traumatic Stress and Vicarious Trauma (Self) Relationship

Table 11.8 shows the hierarchical regression set for this moderation.

Table 11.8: Moderation of Coping on the Traumatic Stress Exposure and Vicarious Trauma (Self) Relationship

	Model 1		Model 2		Model 3	
	B	**β**	**B**	**β**	**B**	**β**
Intercept	.25	.00	-.05	.00	-.05	.00
Tenure with SAPS	.01	.01	-.02	-.02	.00	.00
Time in trauma field	.00	.00	.00	-.01	.00	.00
Warrant officer	-.11	-.06	-.02	-.01	-.02	-.01
Captain	-.18	-.10	-.07	-.04	-.09	-.05
Forensic	.01	.01	-.08	-.04	-.07	-.03
Female	-.11	-.04	.01	.00	.00	.00
Other Race	-.43***	-.17	-.27**	-.10	-.25**	-.10
White	.09	.04	.10	.04	.11	.05
Urban	-.03	-.01	-.01	-.01	.00	.00
Peri-urban	-.16	-.05	-.09	-.03	-.11	-.04
Single	.05	.03	.01	.01	.01	.01
Resilience	-.79***	-.79	-.56***	-.56	-.56***	-.56
Work environment	.03	.03	.02	.02	.03	.03
Secondary stress	.12*	.12	0.11**	.12	.10*	.10
Compassion satisfaction	-.01	.00	.06	.05	.04	.03
Traumatic stress	.01	.01	.00	-.01	-.01	-.02
Coping			-0.34***	-.35	-0.36***	-.37
Traumatic stress x Coping					0.05**	.11
R^2	.76		.80		.81	
ADJ R^2	.72		.77		.78	
PC	.31		.26		.25	
AIC	-166.65		-189.99		-194.89	
SBC	-118.17		-138.65		-140.70	
BIC	-159.49		-182.15		-186.33	

*Notes. β = standardised effect sizes. *** = $p < .01$ ** = $p < .05$ * = $p < .10$*

Figure 11.3 provides a graphical representation of the moderation effect and shows that coping moderated the relationship between trauma exposure and vicarious trauma (self). As a result of the coping moderation, the higher the exposure to traumatic events, the lower the changes in negative beliefs about the self. This moderation supports the literature around secondary trauma (Figley, 1995) and previous empirical research (Killian, 2008; Ortlepp & Friedman, 2002) which found that when there are greater coping resources available, the practitioner is less adversely affected by traumatic events.

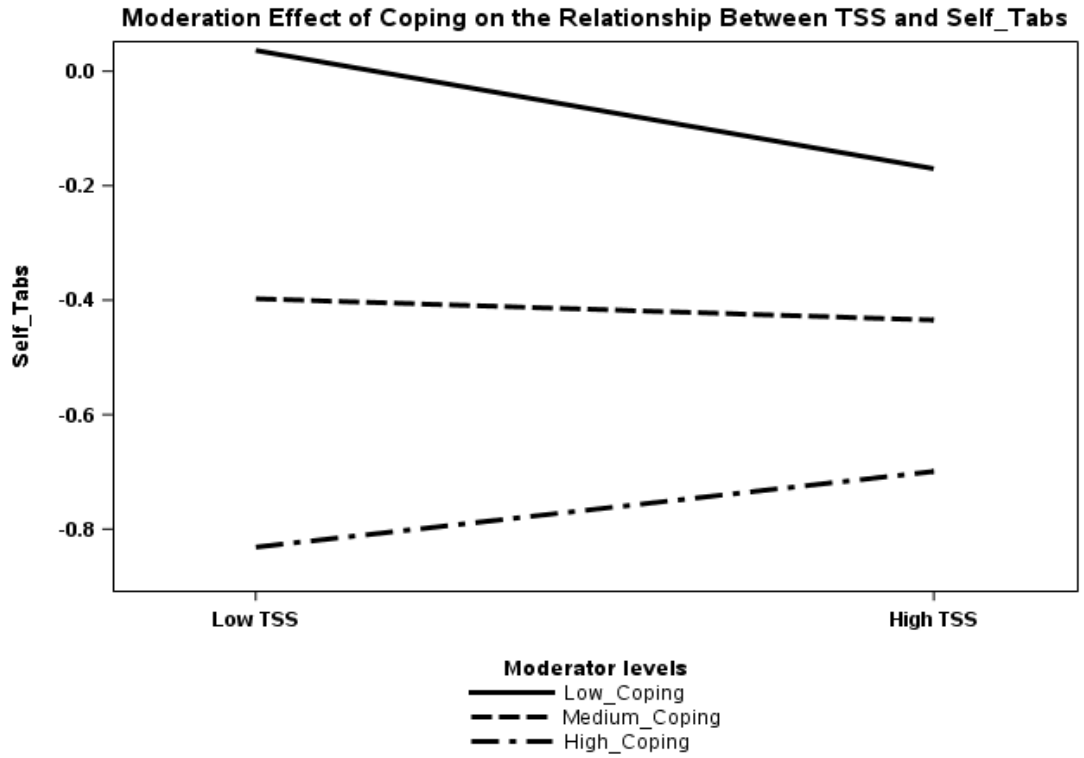


Figure 11.4: Moderation of Coping on the Traumatic Stress and Vicarious Trauma (Self) Relationship

(ii) Coping moderating the resilience and burnout relationship

Table 11.9 shows the hierarchical regression set for coping moderating the relationship between resilience and burnout.

Table 11.9: Moderation of Coping on the Resilience and Burnout Relationship

	Model 1		Model 2		Model 3	
	B	**β**	**B**	**β**	**B**	**β**
Intercept	3.12***	.00	3.04***	.00	3.19***	.00
Age	.00	.02	.01	.03	.00	.02
Warrant officer	.18	.08	.20	.09	.20	.09
Captain	.02	.01	.04	.02	.02	.01
Forensic	-.46**	-.18	-.48**	-.19	-.49**	-.19
Female	.27	.08	.29	.08	.32	.09
Other race	-.31	-.11	-.29	-.10	-.30	-.11
White	-.12	-.05	-.12	-.05	-.08	-.03
Urban	-.07	-.03	-.07	-.03	-.04	-.02
Peri-urban	-.05	-.02	-.05	-.01	-.06	-.02
Single	-.07	-.03	-.07	-.03	-.08	-.04
Trauma field	0**	.17	0*	.17	0*	.17
Tenure with SAPS	.10	.07	.09	.07	.08	.06
Traumatic exposure	.06	.11	.06	.11	.05	.10
Secondary stress	.52***	.50	.53***	.50	.53***	.50
Work environment	-.15*	-.15	-.15*	-.15	-.14*	-.14
Compassion satisfaction	-.27**	-.20	-.25**	-.19	-.28**	-.21
Vicarious trauma (self)	-.12	-.11	-.16	-.14	-.19	-.17
Resilience	-.13	-.11	-.11	-.10	-.05	-.04
Coping			-.06	-.06	-.09	-.08
Resilience x Coping					.10	.12
R^2	.50		.50		.51	
ADJ R^2	.42		.42		.42	
PC	.67		.68		.68	
AIC	-43.50		-41.76		-42.30	
SBC	10.68		15.28		17.59	
BIC	-34.94		-32.42		-32.14	

Notes. β = standardised effect sizes. *** *= $p < .01$* ** *= $p < .05$* * *= $p < .1$*

Figure 11.4 provides a graphical representation of the moderation effect. As seen in this figure, resilience was only a strong negative predictor of burnout when coping resources were low. In fact,

higher resilience seemed somewhat positively associated with burnout when combined with higher burnout. However, these effects cancelled each other, explaining the overall flat effect of resilience on burnout in the regression and path models.

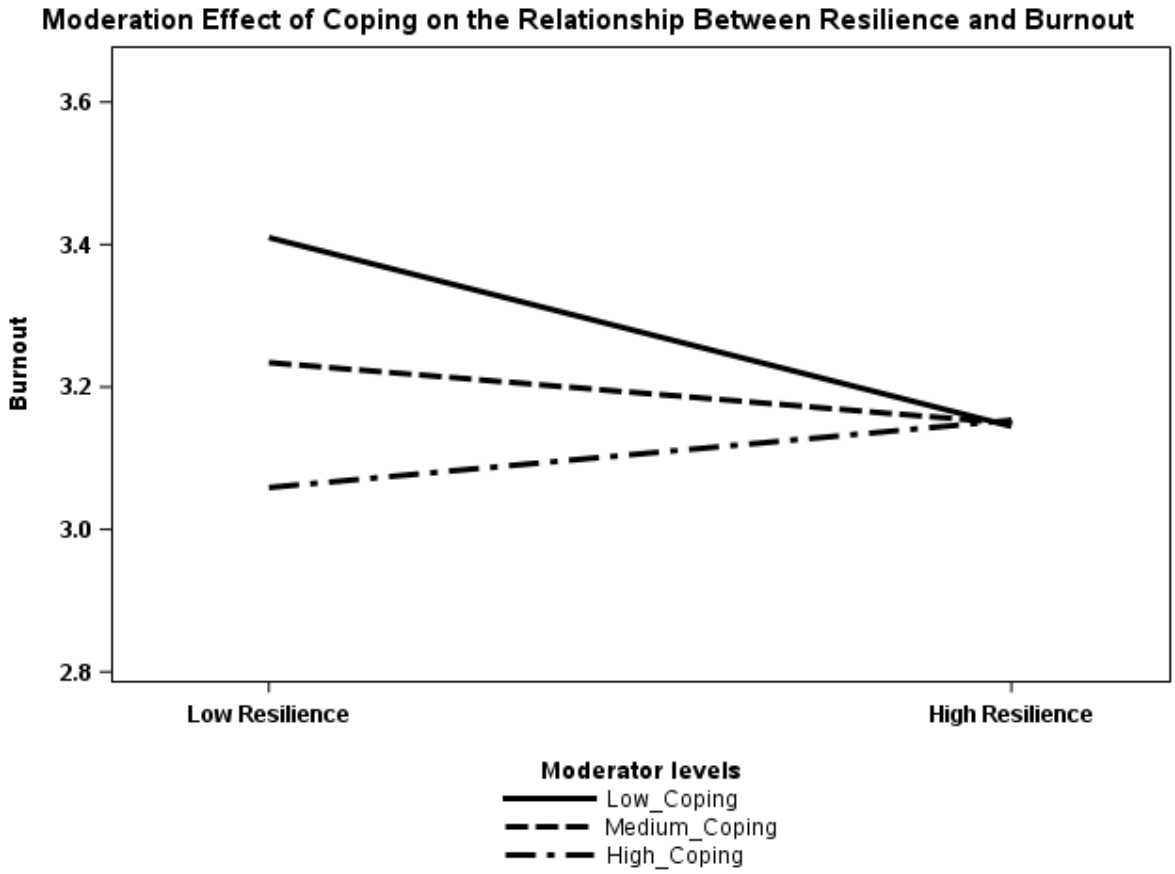


Figure 11.5: Moderation of Coping on the Burnout and Resilience Relationship

11.3 CONCLUSION

The multivariate analysis revealed the complexity of the relationships between the variables and highlights the need to ensure that prevention strategies to ameliorate the effects of secondary and vicarious trauma are multi-pronged, incorporating strategies to improve the work environment as well as to promote coping and resilience among practitioners. What is apparent through all the preceding findings chapters is the need for social work practitioners to prepare themselves for working with trauma within stressful environments such as the SAPS environment. As this study took the form of a cross-sectional design, it was not possible to measure alterations of the stability of STS throughout the tenure of the participants. The recommendation of researchers such as Bourke and Craun (2014); Bride (2007b); and Salston and Figley (2003) for longitudinal studies to be conducted in the areas of secondary traumatic stress is strongly endorsed for future research.

PART SIX

THE EPILOGUE

CHAPTER TWELVE

MAIN FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

> ***"Trauma therapy profoundly changes the therapist. We give up our familiar way of being and beliefs about the world when we embark on this work with survivors of traumatic events. These changes are both inspiring and disturbing, involving gains and losses" (Pearlman & Saakvitne, 1995a, p. 279).***

12.1 INTRODUCTION

According to SAPS Superintendent Molbatsi "South Africans must know that crime is not only a police responsibility; it's everyone's business" (Faull, 2010, p.259). Whether they are working as forensic or occupational social workers at SAPS, these social workers are making their contribution and helping to make South Africa a safer place in which to live. However as Pearlman and Saakvitne (1995, p. 279) maintain, one can never really anticipate the personal effects of assisting those who have experienced traumatic events as "rarely do therapists enter the world of trauma therapy with full understanding of the implications of their choice".

This thesis discussed various theoretical understandings of the effects of secondary traumatisation. Empirical evidence was then presented and discussed in relation to various theoretical frameworks. This final chapter provides a summary of the main findings; the conclusions that emerged from the findings; and the recommendations which are proposed for social work policy, education, supervision, practice and research that emanate from the study.

12.2 SUMMARY OF THE STUDY

At the time this research was undertaken South Africa was struggling to shake off the shackles of discrimination and inequality and was a country notorious not only for its gratuitous violence but also for having one of the highest crime rates in the world. The occupational hazards and stressors of the South African police have received much attention over the past few decades. However, an overlooked group of employees within SAPS, is the social workers who assist the police, either through conducting forensic child abuse investigations or through counselling of police personnel. These social workers, by the nature of their work, are exposed to secondary trauma which in turn has the potential to impact on them both professionally and personally. Therefore, this study aimed to explore the nature and extent of secondary traumatic stress experienced by social workers employed in the South African Police Service. Specifically this research study aimed to answer the following questions:

1. What is the nature and extent of secondary traumatic stress, vicarious traumatisation compassion satisfaction, burnout, coping and resilience in social workers employed by the South African Police Service, as measured by standardised scales?
2. Do marital status, work experience and type of work (occupational or forensic social work) affect the manner in which social workers experience and cope with secondary trauma?
3. What are participants' perceptions of the work environment as measured by Moos's (2008) Work Environment Scale?
4. Is there a relationship between secondary traumatic stress, vicarious traumatisation, compassion satisfaction, burnout, coping resources, resilience and the work environment as measured by standardised scales? If so, what is the nature of this relationship?
5. In what ways, if any, do social workers think they have changed, or their relationships with clients have changed as a result of the constant exposure to traumatic material?
6. How do the participants understand transference and counter-transference reactions in the counselling relationships?
7. What mechanisms do social workers identify in themselves and their environment that enable them cope with the continual exposure to traumatic material?
8. What factors do social workers perceive as contributing to resilience?
9. How does the work environment influence the manner in which social workers cope with secondary trauma?
10. What recommendations would these social workers make (a) to SAPS in order to improve the work environment; and (b) to limit or curtail the effects of secondary trauma?

In order to explore the aim of the study and answer these research questions, a mixed methods research design was employed which incorporated descriptive, exploratory and correlational aspects, and included both qualitative and quantitative components. The data collection occurred in two phases: In the initial phase the researcher administered questionnaires to groups of social workers in different geographical locations across South Africa. Questionnaires were couriered to those social workers who could not attend these meetings so that they could also participate in the study.

The questionnaire booklet that was distributed contained standardised scales measuring the nature of secondary trauma, secondary traumatic stress, vicarious traumatisation, compassion satisfaction, burnout, the work environment, coping resources and resilience levels of practitioners. Open-ended questions were also included in the questionnaire that explored participants' perceptions regarding coping with secondary trauma in the SAPS environment. In addition, participants were asked to indicate whether they would agree to assist in the second phase of the study which would entail an

interview with the researcher about their experiences of secondary trauma. In total 200 questionnaires were distributed and 128 of the 132 that were returned were usable for analysis.

In the second phase of the research process the researcher interviewed 30 participants, either face-to face, telephonically or through Skype. A structured research tool was used to guide the interview in order to explore the participants' perceptions and experiences of secondary trauma while working for SAPS. A criterion for selection in the second phase of the research was that the participants would allow the researcher to tape-record the interviews for purposes of analysis.

The quantitative data were analysed using descriptive and inferential statistics. In particular, advanced statistical techniques were used in the analysis, which included factor analysis, multiple regression, structural equation modelling and moderation models. The interviews were transcribed and the qualitative data was analysed through thematic content analysis. The findings from the qualitative and quantitative data were then compared and a summary of the results is presented in the following section.

12.3 SUMMARY OF THE MAIN FINDINGS

A summary of the participants' profiles is firstly presented; thereafter the main findings of this study are provided.

12.3.1 Profile of Participants

(i) Profile of Survey Participants

In total 128 social workers participated in the study, 102 (79.69%) of whom were occupational social workers and 26 (20.31%) were forensic social workers. There were considerably more female social workers (115 or 89.84%) than male social workers (13 or 10.17%) who participated in the research. The racial distribution of the participants was as follows: the majority (80 or 62.5%) were Black; followed by 28 or 21.88 % Whites; 18 or 14.06% Coloured; and 2 or 1.56% Indians. The age distribution ranged from 25 to 58 years and the average age was 36.6 years.

Most of the participants held the rank of captain (67 or 52.34%), followed by warrant officer (48 or 37.50%), and then lieutenant colonel (13 or 10.16%). The length of employment at SAPS ranged from seven months to 22 years, with the average length of employment at this organisation being 6.2 years (SD=4.51 years). Social work experience ranged from two to 30 years, while the average length of social work experience was 11 years.

Participants were geographically located throughout South Africa and worked in the following provinces: Gauteng (40 or 31.25%); followed by the Western Cape (17 or 13.39%); Limpopo (15 or 11.72%); North West (14 or 10.92%); Mpumalanga (10 or 7.81%); Kwa-Zulu Natal (9 or 7.03%); Free State (8 or 6.25%); Pretoria Head Office (7 or 5.47%); Northern Cape (7 or 5.46%); and Eastern Cape (1 or 0.78%). Most of the participants (78 or 60.93%) were employed in urban areas; more than a quarter (35 or 27.34%) worked in peri-urban areas; and the remainder (15 or 11.72%) were located in rural areas.

While the majority of participants were married or cohabiting (76 or 59.38%), a large proportion (52 or 40.63%) were divorced or single. Most participants (98 or 76.56%) had children, with the mode being two children. All the social workers had obtained either a three or four year social work degree and participants had obtained their undergraduate training at a range of 17 different universities in South Africa. Only 20 (15.62%) participants had completed additional postgraduate qualifications. All the participants had social work experience prior to joining SAPS, with the average number of years of social work experience being 3.8 years (SD=4.53). Participants had previous social work experience in a range of fields namely: child and family sector; generic practice; disability; domestic violence; statutory services; geriatric care; medical social work; occupational social work; substance abuse; and private practice. Participants cited different reasons for joining SAPS including: career development; wanting a change of work environment; the opportunity to work in a specific area of social work; the opportunity to work with adults; and financial incentives.

(ii) Profile of Interview Participants

The demographic profile of the interview participants included the following: 22 (73.33%) occupational social workers and 8 (26.66%) forensic social workers. Most of the interview participants were female (25 or 83.33%) with only 5 (16.66%) being male. The racial composition of interview participants included 20 (66.66%) Black; 3 (10.00%) Coloured; 7 (23.33%) White and no Indian social workers as none of the Indian participants in the first phase had agreed to be interviewed. Nine (30%) of the participants were warrant officers; 19 (63.33%) were Captains and 2 (6.66%) were Lieutenant Colonels. Participants were located in the following provinces: Gauteng (10 or 33.33%); Free State (6 or 20.00%); Limpopo (3 or 10.00%); Mpumulanga (2 or 6.66%); Kwa-Zulu Natal (3 or 10.00%); Western Cape (2 or 6.66%); and North West (2 or 6.66%). None of the participants from the Eastern Cape or Head Office were interviewed as none of these participants agreed to be interviewed or would allow the researcher to record the interviews. The average age of the interview participant was 38 years and the average of employment at SAPS was 7.2 years (SD=4.78).

12.3.2 The Nature of Participants' Secondary Trauma Exposure

The Traumatic Stress Schedule (TSS) was administered to explore the nature of traumatic events to which participants' clients were exposed in the last six months. Participants identified a range of traumatic cases including car accidents (51); shooting incidents (31); police suicide (20); scenes of death and murder (18); child sexual abuse and child murder (19); rape (13); car hijackings (4); hostage situations (4) and domestic violence (3). What the OSW participants did indicate is that more than 50% of their time was spent on individual counselling or facilitating group debriefings, and that FSWs spent more than 50% of their day investigating child abuse cases; which suggests that both groups of social workers were exposed to a significant amount of secondary trauma. There were statistically significant differences in the nature of trauma exposure between the different ranks. Captains experienced significantly higher trauma exposure in comparison to warrant officers and lieutenant colonels obtained significantly higher trauma scores than captains.

According to the results of the TSS, the most frequent types of traumatic incidents to which the OSWs' clients (SAPS members) were exposed included: the loss of a loved one due to an accident, homicide or suicide (78 or 76.47%); clients' motor vehicle accidents (77 or 75.49%); situations where clients were attacked (54 or 52.94%); and clients were physically threatened due to robbery or assault (51 or 50.0%). Traumatic situations that were least experienced by the OSWs' clients included: evacuating their homes (34 or 33.33%); being sexually assaulted or raped (28 or 27.45%) and experiencing damage to their property (26 or 25.49%).

The extent of the exposure to secondary trauma varied substantially between both occupational and forensic social workers and also varied on a daily and weekly basis for participants. OSWs did not spend all of their time at work counselling as they were also required to attend meetings, conduct trainings and attend supervision, whereas forensic social workers spent most of their work day investigating cases. The nature of secondary trauma exposure also differed for forensic social workers as some indicated that they were allocated two new cases a day, while others had only five to six new cases per month. The nature of forensic social workers' exposure to secondary trauma arose from investigating child abuse and neglect cases, whereas for occupational social workers the nature of the secondary trauma exposure emanated from assisting SAPS employees to deal with trauma occurring through either their clients' private or work related events. In the interviews forensic social workers identified particularly traumatic cases as those where the sexual abuse was severe or the child had died as a result of the abuse. In comparison, occupational social workers identified some of the worst cases that they had dealt with as: cases where the police officers became disabled; dealing with police suicides and police family murders or femicide-suicides. The suicide cases were particularly difficult for

the participants as most of them experienced a sense of guilt as they questioned their professional competence. Moreover, social workers felt that they were blamed by the organisation for their client's suicide.

12.3.3 Participants' Levels and Secondary Traumatic Stress Experiences

The prevalence of secondary traumatic stress among SAPS social workers was measured according to Bride, Robinson, Yegidis and Figley's (2004) Secondary Traumatic Stress Scale. Most (108 or 84.38%) participants met at least one diagnostic criterion; at least 74 (or 57.81%) met two diagnostic criteria; and more than a quarter (37 or 28.91%) met all three of the diagnostic criteria. The intrusion criterion was the most frequently experienced criterion (108 or 84.38%), indicating how the traumatic nature of the participants' work was constantly in the thoughts and physiological responses of participants. For only 8 (or 6.25%) participants, none of the criteria B, C, or D was endorsed.

STS scores ranged from 17 to 85 for all participants, the mean score was 40.27 (SD=14.31), indicating mild STS levels within the SAPS social workers. Using the percentiles as interpretative levels, analysis of the different sub-groups revealed that lieutenant colonels and White participants had average scores indicating moderate levels of STS. On average mild levels of STS were indicated for the following groups: Indian, forensic; female; occupational; and female occupational social work. In comparison, male; warrant officers and Black participants' average scores indicated little or no STS.

A positive and significant (although weak) relationship was found to exist between secondary trauma exposure and secondary traumatic stress ($r=.252$; $p<0.01$). Length of time at SAPS was weakly but positively correlated with STS ($r=.179$; $p<0.05$). Furthermore, findings indicated that there were average differences in the levels of secondary traumatisation of participants, depending on their race and rank. Levene's test for equality of variances showed that lieutenant colonels had higher average STS scores than warrant officers and that this result was significant. Furthermore, lieutenant colonels scored an average of 12.65 points higher on STS in comparison with warrant officers in a linear regression model controlled for other variables and where STS was the dependent variable. This regression also showed that Whites scored an average of 12.078 points higher on STS in comparison to Black social workers suggesting that race was a significant factor in STS levels.

Forensic social workers scored on average higher than occupational social workers on every sub-scale indicating that FSWs experienced greater secondary traumatic stress symptoms, although these average differences were not significant. White social workers scored the highest average scores on every sub-scale, whereas Black social workers scored the lowest on every sub-scale. In particular,

there was a significant difference in the mean levels of arousal symptoms between Black and White social workers, indicating that White social workers experienced greater arousal symptoms. White social workers also experienced higher intrusion symptoms than Coloured social workers and this finding was statistically significant.

Acknowledging the effects of secondary traumatic stress appeared to be easier for some participants than others. When exploring the effects of STS, four themes became apparent through the interviews, namely, participants' ability to acknowledge the effects of secondary trauma; experiences of STS symptoms; desensitisation to secondary trauma; and the impact of attending traumatic scenes.

12.3.4 Participants' Levels and Vicarious Traumatisation Experiences

Levels of vicarious trauma were measured by the Trauma and Attachment Belief Scale (TABS). Almost a quarter (29 or 22.66%) of the participants had scores above 60, which suggested relative disruption in schema as these results indicated very high and extremely high levels of vicarious trauma. Most participants (91 or 71.09%) presented with average or high average levels of vicarious trauma and only 8 or 6.25% had low or very low average scores for vicarious trauma. These high levels of disruption were evident in the following groups of participants: lieutenant colonels (6 or 46.15%); Whites (12 or 42.86%); forensic social workers (8 or 30.77%); males (3 or 23.08%) female occupational social workers (18 or 20.22%) and Black social workers (16 or 20%). A linear regression model with vicarious trauma as the dependent variable explained 11.6% of the variance in vicarious trauma scores. When controlling for other variables, social workers working in rural areas scored 21.189 points lower than social workers in urban areas. Furthermore, Coloured social workers scored 20.268 lower than Black social workers on the Traumatic Attachment and Belief Scale.

Females had higher mean scores on the self-trust scale than males and this result was statistically significant. Forensic social workers scored higher on the self-intimacy sub-scale than occupational social workers, and this result was statistically significant. Pearson product-moment correlation coefficient showed that there was a significant positive relationship with STS ($r=.449$; $p<0.01$). Furthermore, the more secondary traumatic stress an individual experienced, the higher their level of vicarious traumatisation was likely to be.

12.3.5 Participants' Understandings of the Concepts of Transference and Counter-Transference

Most of the interview participants (23 or 76.66%) were not aware of the meanings of the terms transference or counter-transference. One could attribute participants' lack of familiarity with these terms as occurring due to memory decay as they may have learnt about these terms in their

undergraduate training. Alternatively the fact that English was not the first language of most of the participants, could explain the lack of awareness of these terms. What also emanated from these discussions in the interviews about transference and counter-transference was that most SAPS social workers had only been trained in one debriefing model and this model was generally applied to every situation and every client.

12.3.6 Participants' Levels and Compassion Satisfaction Experiences

Levels of compassion satisfaction were determined by the Professional Quality of Life Scale (Hudnall Stamm, 2010). The highest proportion of participants experienced average levels of compassion satisfaction (60 or 46.88%), whereas 55 (42.97%) experienced high levels of compassion satisfaction and 13 (10.16%) experienced low levels of compassion satisfaction. These results indicated that most participants only derived an average level of fulfilment through their work as a social worker.

In a linear regression model that accounted for 19.2% of the variance in scores, participants in a relationship scored on average 3.061 points lower on satisfaction that those participants who were not in a relationship. White social workers also scored 5.578 lower than Black social workers, indicating that that White social workers found less satisfaction in their work than Black social workers. A negative and statistically significant relationship ($r=-.310$; $p<0.01$) was found to exist between vicarious trauma and compassion satisfaction; therefore the null hypothesis was rejected and hypothesis 6 accepted. Similarly, compassion satisfaction was negatively but significantly correlated with STS ($r=-.331$; $p<0.01$).

The majority of the interview participants (18 or 60%) did not easily identify many aspects of their work that made them feel satisfied. For the participants who could identify areas of fulfilment from their work, three themes emerged during the interviews, namely: feeling fulfilled through one's work, growth in professional knowledge, and posttraumatic growth. Specific areas of growth identified by participants included learning the importance of establishing boundaries and promoting self-care habits.

12.3.7 Participants' Levels and Burnout Experiences

Levels of burnout were measured by Hudnall Stamm's (2010) Professional Quality of Life Scale (ProQOL). Only four participants (3.13%) scored high levels of burnout, with most participants (78 or 60.94%) obtaining moderate or low (46 or 35.94%) levels of burnout. The mean score for burnout was 54.42 (SD=6.772), which corresponds with the 70th percentile of the reference group. Scores ranged from 35-73, with a mode of 48 and a median of 54.51. The majority of participants (85 or 66.4%)

scored above the group's reference norm for this scale (50), while 56 (43.75%) scored above the 75th percentile, indicating that a substantial portion of the participants had a relatively high risk for burnout.

A linear regression model accounted for 10.7% of the variance in scores. When accounting for other variables, lieutenant colonels scored on average 4.95 points higher than warrant officers, showing that lieutenant colonels had higher burnout levels than warrant officers. In a regression model White social workers scored 3.627 points higher than Black social workers, indicating that there were significant average differences on the burnout scores based on race and that higher burnout levels were evident in the White participants.

Pearson's product-moment correlation coefficient showed that there was a strong positive relationship between STS and burnout ($r=.597$; $p<0.05$). The three dimensions comprising the burnout syndrome as specified by Maslach (1986), namely: emotional exhaustion, depersonalisation, and decreased work performance were identified as themes from the interviews. Four of the interview participants attributed the burnout they had experienced to their work at SAPS. Those participants who spoke about experiencing burnout, did not feel supported by their superiors at SAPS.

12.3.8 Participants' Experiences of the SAPS Work Environment

Moos's (2008) Work Environment Scale was used to measure the work dimensions at SAPS. Overall the average score for participants was 47.97 (SD=1.86), which is below the standard norm (50) indicating that participants experienced below average levels of satisfaction with the work environment at SAPS. A linear regression model indicated that findings were significant and accounted for 8.2% of the variance in scores. When controlling for other variables, Whites scored on average 5.498 points lower than Black social workers. Pearson's correlation coefficient was calculated and showed that there was a weak but statistically significantly correlation ($r=-.289$; $p<0.05$), between the work environment and burnout.

Results showed overall that there were above average scores for managerial control; physical comfort; and innovation. Scores for colleague support and cohesion were below average. Furthermore, the level of autonomy was the lowest score, which was not surprising considering that participants have to adhere strictly to protocol and procedures and they are not encouraged to make their own decisions. While these rules may be necessary in a policing environment, there is also the potential to reduce the personal growth dimension. Significant findings were that captains felt less supported by

their colleagues than warrant officers and Black participants felt more supported than White participants.

The social workers' level of involvement and commitment to their work was a theme apparent from the interviews. The nature of supervision provided was another theme that was explored during the interviews. What was apparent was that the supervision provided differed between the participants, as some of the participants attended group supervision while others attended individual supervision. However, many of the social workers indicated that they did not receive supervision at all and they indicated their willingness to attend such sessions should they be provided.

Considering that SAPS social workers were employed in a secondary setting, it is not surprising that participants would be confronted by numerous professional ethical dilemmas. Interview participants mentioned two ethical dilemmas; namely, having to be trained as a police officer and being required to learn the use of a gun; and having dual loyalties to the SAPS organisation and to social work as a profession. Participants mentioned how important it was to understand the SAPS culture and how the lack of resources in SAPS limited their ability to deliver effective services. Two themes emerging from the interviews and which addressed the system maintenance and change dimension of the work environment at SAPS included: learning to navigate the SAPS culture; and the availability of resources.

12.3.9 Understanding Participants' Coping Mechanisms with regard to Secondary Trauma

Levels of coping resources were determined by Marting and Hammer's (2004) Coping Resources Inventory (CRI) and the overall result indicated that participants perceived themselves to have an average level of coping resources at their disposal. There were no significant differences in coping scores between men and women. Forensic social workers had the lowest average scores for every sub-scale. The highest mean score for all groups (apart from the forensic group which was spiritual) was obtained on the cognitive resources sub-scale. Men tended to score slightly higher (have better coping resources) than the other groups on all the sub-scales, apart from the spiritual sub-scale where women scored higher. In a linear regression model, which explained 12.7% of the changes in coping scores when coping was the dependent variable, coping results showed that forensic social workers scored on average 12.097 points lower than occupational social workers and that White social workers scored 9.223 on average lower than Black social workers when controlling for other variables.

Some participants (4 or 13.33%) felt that they were not coping with secondary trauma exposure and three (10%) of these participants admitted that they wanted to leave SAPS's employ. Interview participants identified various coping strategies and resources that incorporated different dimensions

of an individual, namely, physical, emotional, cognitive, social and spiritual. The physical coping strategies identified by interview participants included: engaging in sporting and recreational activities; having breakaways and rest periods, increased indulgence in food or alcohol; and taking medication for depression and anxiety. Emotion-focused coping resources were identified, including attending counselling and engaging in creative activities which, in turn promoted emotional expression. Only eight of the interview participants indicated that they had attended counselling to help them cope. Cognitive coping strategies that emanated from the interviews included: establishing professional boundaries, the use of psychological defences and desensitisation to the trauma. Most of the participants (25 or 83.33%) identified family, friends or spouses as vital social support systems. In addition some of the participants identified support from colleagues and the community as essential resources. However, some of the participants did not feel that they received much support either from colleagues or from the community. For many of the practitioners, deriving a sense of purpose through their work as well as drawing upon existing spiritual beliefs helped to guide and sustain them in the wake of repeated trauma exposure.

12.3.10 Participants' Levels and Understandings of Resilience

Levels of resilience were measured by Wagnild (2009)'s Resilience Scale and most participants scored either a medium (64 or 50%) or high (52 or 40.63%) level of resilience and only a few (12 or 9.38%) had low levels of resilience. None of the male participants had low levels of resilience and most females had medium levels of resilience (57 or 44.53%). Although males tended to have higher average resilience scores than the females there was no statistically significant difference.

In a linear regression model where resilience was the dependent variable, the model explained 9.8% of the changes in the resilience scores. When controlling for other variables, forensic social workers scored an average of 7.93 points lower than occupational social workers, indicating that they were less resilient than occupational social workers. Captains were also found to be more resilient than warrant officers and had an average score of 5.56 higher on the resilience scale. Results also showed that there was a negative and highly significant relationship between vicarious trauma and resilience ($r=-.443$; $p<0.01$) as well as burnout and resilience ($r=-947$; $p<0.01$). Furthermore, a positive and highly significant relationship existed between resilience and compassion satisfaction ($r=0.450$; $p<0.01$).

Interview participants identified numerous factors that contributed to their personal resilience. These included: firstly, having specific personality attributes such as: an easy-going disposition, patience, perseverance/determination, resourcefulness, assertiveness, an internal locus of control, a strong and secure sense of self and being able to express emotions; secondly, having a deep sense of spirituality,

contributed to practitioners' sense of existential purpose in their work; thirdly, empowerment which occurred through increasing professional knowledge and skills; developing organisational knowledge and establishing boundaries; fourthly, through acceptance of the strengths and limitations of the self and others; and lastly, through support from various communities which included the work, religious community and socio-cultural communities.

12.3.11 Summary of the Participants' Recommendations

Participants provided the following recommendations: to SAPS to improve the work environment and to SAPS social workers about how to reducing the effects of secondary traumatisation.

12.3.11.1 Participants' recommendations to SAPS

Participants' suggestions to SAPS were categorised in four predominant themes, namely: improving available resources; promoting social workers' mental health and professional development; creating a platform for professional recognition; and improving the communication within SAPS. The most frequently identified recommendation of the participants was to increase the resources such as transport and cellular phones so that they could adequately fulfil their work tasks. Improving the physical presentation of the social workers' office was also emphasised as traumatised children or police officers should be able to feel comfortable, especially when talking about events that are traumatic.

12.3.11.2 Participants' recommendations to reduce the effects of secondary traumatisation

The most frequently identified strategy to reduce the effects of secondary traumatisation was that of professional counselling services offered by psychologists and/or social workers. Furthermore, most participants indicated they would prefer to attend counselling with an independent or external professional who was knowledgeable about the effects of secondary trauma as they did not want to attend counselling with a professional who was internal to SAPS due to concerns about confidentiality and anonymity.

Additional strategies to reduce the effects of secondary trauma, included: employing more social work staff in order to reduce the individual's trauma exposure; appointing social workers who would be able to cope with the trauma exposure; monitoring trauma exposure; providing educational trauma workshops for staff; organising retreats to provide social workers with time to recharge and reflect; and implementing care for the care-giver programmes.

12.3.12 Summary of the Multivariate Analysis

All reliability analyses indicated acceptable or good internal consistency of construct dimensions with the exception of the original vicarious trauma dimensions. Analysis of the rotated factor structure suggested that the two factors split neatly along the 'self' and 'other' vicarious trauma items, and therefore this overall construct was separated into these two sub-dimensions. In the hierarchical regression analysis with vicarious trauma (other) as the dependent variable, coping emerged as the most powerful predictor of vicarious trauma, whereas resilience emerged as the post powerful predictor for vicarious trauma (self) in the hierarchical regression analysis with vicarious trauma (self) as the dependent variable. In the third hierarchical regression with burnout as the dependent variable, the role of coping and resilience had diminished in comparison to the other models and instead levels of secondary traumatic stress added significant value to the model, indicating that secondary traumatic stress was a predictor of burnout.

These relationships were further explored through Structural Equation Modelling. The two models were identical apart from the vicarious trauma variable. In the first model vicarious trauma (self) was incorporated whereas in the second model vicarious trauma (self) was replaced by vicarious trauma (other). In the first model, the greatest predictors of vicarious self were coping *(β* = -.71, p<.01) and resilience (*β* = -.54, p<.01). In the second model, many of the effects were similar in size or at least provided effective interpretation to the vicarious trauma (self) model. As with the regression model, possibly the most striking effects were those relating to resilience. Unlike the vicarious trauma (self) model, resilience had almost no direct association with either secondary traumatic stress or vicarious trauma (other). This lack of direct association severely reduced the effectiveness of resilience as a predictor of vicarious trauma (other), although it did not reduce its total effect on burnout to any great extent. The investigation of the moderation effects of coping revealed that only a few moderation effects were found. These included the finding that coping moderated the traumatic stress exposure and vicarious trauma (self) relationship and that coping moderated the resilience and burnout relationship. What these moderation models showed was that resilience was only a strong negative predictor of burnout when coping resources were low. In fact, higher resilience seemed somewhat positively associated with burnout when combined with higher burnout. However, these effects cancelled each other, explaining the overall flat effect of resilience on burnout in the regression and path models.

12.4 CONCLUSIONS

Undoubtedly a social worker employed within SAPS, whether in an occupational or forensic capacity will be exposed to secondary trauma. Continual trauma exposure has been positively correlated with higher PTSD (Friedman, 2006) and secondary trauma levels (Bride, 2007b; Killian, 2008) which can adversely affect health and well-being. This finding highlights the need for social workers to try to limit their levels of trauma exposure. Such an approach compliments the self-care strategy of maintaining a balanced life and ensuring that one incorporates enough positive aspects in one's daily living, so that the world is not only presented as cruel and harmful (Seaward, 2002; Skovholt, 2001).

Practitioners appeared to be affected more by certain cases, especially where the outcome was fatal for the client. Cases where children died from abuse and neglect were especially difficult for forensic social workers. Police suicides and family murders were particularly emotional cases for occupational social workers, as they struggled to assimilate the death of their client and whether they had accurately assessed the situation and provided sufficient assistance for clients in these situations. Krog recalls (2002) how German theologians after the Second World War identified four categories of guilt: namely, criminal guilt – for those who had killed and tortured others; political guilt – experienced by the people who voted the politicians into power; moral guilt – for those who remained silent during the killings and did not do enough to try to prevent them; and metaphysical guilt – where survivors felt guilty that they still existed while others had died. This analysis of guilt is particularly relevant when trying to understand the nature of guilt which some racial groups in South Africa may have as a result of apartheid and racially discriminatory practices. This understanding of guilt also highlights the metaphysical guilt that social workers may feel when their clients commit suicide. Furthermore, the culture of blame and wrong doing in these situations would seem to be exacerbated as social workers felt blamed and criticised by SAPS for the suicide instead of receiving the professional support they required.

What was apparent was that most social workers employed by SAPS experienced secondary traumatic stress. The majority of practitioners experienced at least one symptom of secondary traumatic stress; more than half experienced two symptoms and more than a quarter experienced all three symptoms. Only a few social workers did not experience any secondary traumatic stress symptom, which indicates that secondary traumatic stress is a concern for social workers at SAPS. Furthermore, most participants had average or high levels of vicarious trauma and only a few participants had low or very low average scores of vicarious trauma. These findings showed that secondary and vicarious traumatisation among SAPS social workers are of particular concern. Moreover, if practitioners experience secondary trauma symptoms they may be more vulnerable to feelings of exhaustion and

depersonalisation and consequently their work performance may be adversely affected. The organisation's negative response to employees who are experiencing secondary trauma or burnout can further exacerbate the situation, resulting in the employee feeling more exhausted and incompetent. Moreover, if management lacks awareness regarding the causes and consequences of burnout, they may not be able to demonstrate the appropriate responses and assist the employee to return to an appropriate level of functioning.

Most participants had limited knowledge or understanding of terms such as transference and counter-transference. Despite explanations of these terms subsequently being provided for participants, most of them appeared to be oblivious of the complex dynamics that may occur within the helping relationship. Although these terms emanated from psychoanalytic theory, the importance of the helping relationship is understood to be applicable to almost all theoretical approaches and needs to be considered especially when assisting an adult or child who has been traumatised. What these findings also highlighted was that most of the participants had limited knowledge and understanding of trauma theories and different trauma counselling approaches and techniques. Advanced knowledge about trauma theories and interventions is generally beyond the scope of social work undergraduate training and would require social workers to attend additional and more advanced training courses.

The results from the work environment scale showed that the relationship aspects in the work environment were problematic; in particular colleague support levels were below average. When working in a traumatic environment the importance of collegial support should not be underestimated (Killian, 2008; Matsakis, 2005). Talking to colleagues about the effects of secondary trauma can help to normalise trauma responses, provide a balanced perspective and mitigate feelings of isolation and despair which are common trauma responses (Allen, 2005; Herman, 1997).

Few would dispute the fact that working within the SAPS environment does not come with particular inherent challenges. It is not only important 'to learn the ropes' but also to wisely assess how one would confront issues and challenges, in order to achieve the best results. What is also apparent is that working in SAPS as a social worker, requires an individual with a certain tenacity and temperament. SAPS has undergone enormous transformation since the advent of democracy (Dixon, 2012; Tait & Marks, 2011). The constant change in top leadership, limited resources and ongoing criticism from the public, are all likely to affect the stability of the organisation and the morale of employees. Working for SAPS could present numerous challenges and new social workers would need to understand the SAPS culture and build relationships and rapport with operational staff.

Furthermore, new social work recruits could benefit from not working alone initially but under the guidance of a senior social worker.

Findings showed that coping strategies and techniques employed by the social workers differed from person to person; highlighting the subjective nature of coping as well as the fluid nature of coping resources and how an individual's coping strategies and resources could also change over time. What was apparent was that the constant exposure to trauma required social workers to consciously employ specific coping strategies that were effective in reducing the negative effects of traumatisation. Moreover, the findings from the regression analysis and the structural equation modelling highlighted the importance of establishing and developing coping resources in order to reduce the effects of vicarious trauma practitioners' belief structure and schema about themselves and others.

What was also apparent was that demographic variables such as the race and rank of the participant played a significant role in the way that the individuals experienced and coped with the secondary and vicarious trauma. White participants experienced higher levels of STS and burnout than Black participants. Furthermore, Black participants experienced higher levels of compassion satisfaction and indicated greater satisfaction with the work environment than White participants. Coloured participants also scored significantly lower than Black participants in the levels of vicarious trauma. Considering South Africa's traumatic and discriminatory past it is not surprising that racial groups experience trauma through different lenses. Antjie Krog (2002) relates how a psychologist accounts for different traumatic responses of the Black and White journalists who covered the Truth and Reconciliation Commission. For an extended period of time during their coverage of the Commission journalists were exposed to harrowing accounts of human rights violations by both victims and perpetrators during apartheid. However, the Black journalists said that they were not affected by the Commission's work as they had grown up with human rights abuses all around them.

> On the board the psychologist draws an iceberg, with its tip sticking out above the water. This tip, he says, is the part of themselves people show to the world – friendship, integrity, compassion, love, honesty and so on. Hidden from the eye are other things: hatred, dishonesty, anger…But normally within the iceberg there is continuous movement between these two spaces: as a person you can easily access anger and show it, then you become yourself again. The moment you experience something traumatic, then the ice packs in between these two spaces and you can longer access anger, hatred, jealousy. Every traumatic experience packs the ice thicker. But your body is not stupid - your body knows. And the

> cooped-up emotions manifest in physical symptoms…you have to drill holes in those ice layers...and you have to prevent other layers from forming by debriefing ourselves and asking yourself… "How do I feel about it?"...We should talk to one another (Krog, 2002, p.169).

This analysis helps one to understand how those who are exposed to excessive amounts of trauma, almost shut off and do not allow events to affect them. Black South Africans have been exposed to excessive amounts of trauma and it is possible that they may have become desensitised and developed numerous defences that enable them to cope better than their White counterparts, which has implications for advancing theories of trauma in divided societies. These findings highlight the fact that the trauma discourse of South Africa needs to be explored and understood through the different narratives of Black and White persons. What is apparent is that participants of different races need to listen and learn from each other in order to fully understand the nature of the South African trauma discourse. Such an approach has the potential not only to advance theroretical understandings of trauma in polarized societies but also to assist our scarred and fractured society to achieve true healing, reconciliation and social justice (Chikane, 2015).

The predominance of female social workers in the two samples underscores the feminisation of the profession and would seem to be of relevance in a male-dominated profession of policing. However, although there were often differences in average scores between men and women, most of these results were not significant which showed that the gender of the participant did not generally have a significant influence on the participants' experiences of secondary trauma. Where gender differences were apparent was on the vicarious trauma self-trust scale where the scores of women revealed significantly greater distortions in self-trust than the scores of men. Gender differences were also apparent in the perceptions of the work environment as men scored significantly higher on managerial control and task orientation than their female counterparts. One can conclude overall that gender differences in this study were mostly not statistically significant. This finding suggests that gender differences in terms of the experiences of secondary trauma and the work environment were not particularly pronounced.

There were numerous statistically significant differences apparent between the forensic and occupational social workers. Forensic social workers experienced significantly higher levels of vicarious trauma than occupational social workers and forensic social workers had greater distortions regarding self-intimacy than occupational social workers. In addition, forensic social workers had less coping resources and lower levels of resilience than occupational social workers. Figley (1995) identifies how working with traumatised children can be one of the most difficult scenarios for the mental health

practitioner, as children amplify the vulnerability and fragility in human nature. This finding underscores the need for particular support structures to be established for the forensic social workers in order to reduce the effects of secondary trauma.

There were numerous significant differences that existed between the different ranks of the participants. Participants of higher ranks reported greater trauma exposure and had significantly higher secondary traumatic scores. Lieutenant colonels also had significantly higher burnout levels than warrant officers. Captains felt significantly more supported than warrant officers. Captains were also found to be more resilient than warrant officers.

Most of the proactive strategies suggested by the participants incorporated strategies that SAPS needed to implement in order to reduce secondary traumatisation. Only five participants (4.20%) highlighted the practitioners' responsibility to incorporate proactive strategies. These included: trying to limit secondary trauma exposure, drawing upon personal social supports and physical exercise. Most social workers indicated that they thought attending counselling was the most important coping strategy in dealing with secondary trauma. However, despite this understanding most practitioners did not attend counselling, even though the police medical aid makes provision for mental health services. Instead most participants felt that SAPS should organise counselling for them as they indicated that they did not have the time or money (should they be required to financially contribute to any counselling costs not paid for by medical aid). Participants had a myriad of suggestions about improving the work environment and how to cope with secondary traumatic stress. These findings highlight the need to involve social workers at SAPS in the drafting and implementing of a self-care policy which would help to promote empowerment and responsibility for their own mental health.

Multivariate analysis revealed the complex relationships that existed between the numerous variables in the study. As vicarious trauma was a key outcome variable, and the factor analysis suggested the split along the 'self' and 'other' lines, these two sub-dimensions were used in separate hierarchical regression and structural equation models. Resilience had the greatest predictor effect of vicarious trauma self, highlighting the role that an individual's personal characteristics have in terms of how much the trauma is likely to affect the individual's beliefs or world view. However, coping emerged as the most powerful predictor of vicarious trauma (other), indicating the need to increase coping resources of the practitioner in order to reduce vicarious trauma (other).

The structural equation models showed that coping and resilience had the strongest path effects in both models and that both these variables were the strongest predictors of vicarious trauma (self).

Secondary traumatic stress was a far stronger predictor of vicarious other than vicarious self. These models reinforce the understanding that vicarious trauma needs to be conceptualised as comprising two distinctive dimensions, namely, other and self. The differences in path analysis showed that the constructs 'self' and 'other' are influenced to different degrees by secondary trauma, coping and resilience. Furthermore, coping was found to moderate the relationship between traumatic stress exposure and vicarious trauma (self) as well as the relationship between resilience and burnout. These findings reinforce the need for practitioners to be aware of the fundamental role that their coping resources play in helping to navigate the negative effects of their work.

Finally, the results showed that there were different levels of secondary traumatisation, vicarious traumatisation and burnout within the SAPS social workers. Each of these constructs was measured using a different scale and although there are apparent overlaps and similarities in the constructs, the findings indicated that there are also significant differences between these constructs. In this way, this study contributes to the debates and understandings of these terms and furthers the discourse that while there are similarities, there are differences in the predominant focus area of each construct, suggesting that they are related terms existing on a continuum. The structural equation models further contribute towards understanding of the complex interactions between these constructs.

12.5 RECOMMENDATIONS

The following recommendations are provided for social work policy, social work education, social work practice and research.

12.5.1 Recommendations for Policy

Organisational support is a trajectory that is necessary not only for the police officers but for the SAPS social workers as well. Acknowledging the importance of self-care is an important dimension that needs to be incorporated within the social work culture at SAPS. Establishing a self-care policy that is specifically tailored and appropriate for the social workers within SAPS could be the foundational cornerstone in cultivating a positive self-care environment for these practitioners.

A self-care policy should ideally include primary, secondary and tertiary intervention strategies that SAPS needs to employ and this policy should be understood to take place alongside the personal self-care strategies that the social workers employ. Incorporated within the policy should be provision for retreats and break-aways, so that practitioners can experience a period of rest away from the trauma and increase their perspective about situations that may be troubling them. As Father Francis Cull,

Archbishop Desmond Tutu's personal spiritual advisor explained, "In a military sense, a retreat is a time when you withdraw in order to regroup and recoup. So, in a religious, spiritual sense it is a time when you go into a place of solitude and silence, where you can be still and where you can come to terms with your inner journey. Where you can concentrate and focus on your own resources and the task ahead" (cited in Krog, 2002, p. 21).

A social work supervision policy also needs to be established with SAPS, as the role of supervision should not be underestimated in helping the social worker cope with work demands. Moreover, as Van Breda and Feller (2014, p.482) explain, "Supervision remains the crucible for professional development, therefore investing in supervisors' development is critical". The policy should include the specific strategies SAPS needs to undertake to ensure that the supervisors are appropriately developed and trained.

Not every social worker will be able to effectively work within the SAPS environment. Selection procedures (which include an assessment of an individual's resilience), can guide the employer in selecting the most suitable social work applicant and ensuring that the appropriate personality-job fit is obtained. It is therefore recommended that these aspects be incorporated into the SAPS recruitment policy for social workers.

12.5.2 Recommendations for Social Work Education

As the world of traumatology expands and continues to develop it is imperative that social workers are educated and informed about the latest developments and treatment approaches. Education about the effects of secondary trauma and the importance of limiting excessive trauma exposure need to be incorporated into the curricula of social work training institutions as well as the SAPS initiation training programme. The content of the trauma training should be updated regularly and social workers encouraged to attend refresher courses.

In line with the principle of continuing professional development, SAPS social workers should receive on-going training about traumatology so that these practitioners can develop a greater understanding of the effects of both direct and indirect traumatisation. In addition it is recommended that SAPS management be educated about the causes and consequences of secondary traumatisation and burnout so that they can demonstrate the appropriate responses and help affected employees to return to effective levels of functioning.

Student social workers need to be educated about the occupational stressors of social work, as social work is a profession with inherent challenges. Furthermore, as most social work practice settings entail working with vulnerable clientele and/or traumatised populations, exposure to secondary trauma is almost inevitable. Therefore, included in undergraduate curricula for social work training should be an exit level outcome, which addresses students' understanding and readiness to cope with the stressors and secondary trauma exposure inherently interwoven within the fabric of the profession.

Students should also be encouraged to attend their own counselling during their undergraduate training for two reasons. Firstly, as they are developing as counsellors, the opportunity to attend their own counselling would help them to understand what it is like for a person to attend counselling and help to enhance their insight into the dynamics and complexities of the counselling relationship. Secondly, attending counselling can potentially provide students with the opportunity to work through any traumatic events they may have experienced in their personal lives, so that they have greater insight into their own responses in relation to clients.

12.5.3 Recommendations for Social Work Supervision

Social work supervision within SAPS needs to be formalised so that practitioners can receive support, be afforded administrative guidance and deepen their knowledge and skills, particularly about working in a traumatic environment. To this end, individual as well as group supervision, should be made available for social workers, as many of them indicated that they did not feel comfortable sharing openly with their colleagues. Accordingly, it is recommended that social work supervisors at SAPS be appropriately trained in supervision and trauma theories so that that they can sufficiently guide and educate supervisees. Moreover, it may be helpful for support systems to be established for supervisors and social work management within SAPS in order to decrease their own sense of isolation within the work environment. Social workers should be encouraged to complete stress and trauma audits and develop individual stress and trauma management plans. These strategies will hopefully facilitate the social workers' understandings of their own strengths and vulnerabilities and encourage self-reflection and self-awareness.

12.5.4 Recommendations for Social Work Practice

The amount of direct trauma exposure to which social workers at SAPS are subjected needs to be monitored, and where possible direct trauma exposure should be curtailed, in order to reduce the levels of traumatisation they may experience. For example, a social worker whose client commits suicide should not be required to attend the suicide scene, assist the family and debrief the clients'

colleagues as well. In serious cases, such as suicides, whenever possible and mindful of resource constraints, more than one social worker should be appointed to assist with the case. If forensic social workers are paired with another practitioner, they can request assistance from their partner when necessary.

Acknowledging the importance of self-care is an important dimension that needs to be incorporated within the social work culture at SAPS. In order to achieve this goal, individual counselling should be arranged for the social workers with external service providers in order to help social workers understand and work through the consequences of their work. These counselling sessions should be made available especially when the individual is confronted by particularly difficult cases. Additional opportunities to increase self-awareness and provide opportunities for self-growth also need to be incorporated within the culture of SAPS social workers. Although there is merit in SAPS formalising a counselling programme for its social workers, SAPS social workers should also be encouraged to be proactive and establish their own necessary supports in order to develop and become resilient practitioners. It is recommended that SAPS social workers should attend additional trauma counselling training, so that they are familiar with various trauma counselling approaches and can intervene in a more individualistic, sensitive and appropriate manner. In particular, social workers need to learn about the important and often complex dynamics occurring in the counsellor-counsellee relationship. Recognising power differentials and ethical issues that may arise in the counselling relationship is an ongoing responsibility for the social work practitioner.

In order to promote a more cohesive work environment, various programmes need to be established to improve the relationships between social work colleagues and to foster a more supportive work environment. Team building exercises, mentorship programmes and buddy systems could be established to increase the levels of support within the social work section. It is particularly important for new social workers to be closely mentored, so that they can learn the systems and procedures appropriately in the SAPS environment. As forensic social workers in the current study experienced significantly higher levels of vicarious trauma, specific strategies need to be established within SAPS to assist these social workers to enhance their levels of resilience and help reduce their levels of vicarious traumatisation. In particular, these social workers can be assisted to develop realistic expectations of their professional roles and they should be encouraged to talk about their work with a colleague or professional who can help provide a balanced and holistic perspective.

The managerial support offered to social workers in circumstances where the social worker's client has committed suicide needs to be carefully considered. It is imperative to assess whether a social

worker whose client has committed suicide is ready to assume his/her counselling responsibilities as they may have been professionally and personally adversely affected by the situation.

Taking into account the macho environment of SAPS and the fact that there would still appear to be a significant degree of stigmatisation within SAPS about attending counselling, the physical location of the social worker's office should be strategically considered. Moreover, the physical presentation of a social worker's office needs to be regarded as a fundamental part of the social work counselling and assessment process. For this reason, it is recommended that appropriate resources should be allocated to make social work offices comfortable and inviting places for clients who have been traumatised.

Finally, one cannot ignore that South Africa is a wounded society requiring an incredible amount of healing before systemic problems such as crime and child abuse can be ameliorated. Taking into account that social work practice is based on an ecosystemic understanding and that the South African government has adopted a social development approach to social work practice, SAPS social workers should be encouraged to be involved in at least one community programme that addresses the aetiologies of trauma and child abuse. For example, forensic social workers could be involved in a school programme educating children about their rights and child abuse. Occupational social workers' involvement could entail participation in programmes that address the causal factors of the violence and trauma levels, such as poverty, inequality and lack of education. Involvement in such programmes would incorporate the more advanced stages of occupational social work practice and address the occupational social workers' role as citizen. Interventions of this kind would highlight the nexus between occupational social work and social development. Furthermore, community initiatives such as the recent solidarity march against police killings that was held in Johannesburg by traditional leaders and religious community sectors, promote the mobilisation and participation of civil society and reinforces the principle of ubuntu. SAPS social workers could have a fundamental role to play in driving such initiatives and enhancing community participation and responsibility, in order to address the myriad of social and economic problems. Addressing the traumatisation of the nation is the responsibility of all sectors and role-players within South African society.

12.5.5 Recommendations for Future Research

It is hoped that this study will further interest and inquiry into the nature of secondary trauma that social workers in South Africa experience. Suggested recommendations for future research include the following:

- Longitudinal studies of secondary traumatic stress and vicarious traumatisation levels of the SAPS social workers need to be undertaken on order to establish whether the levels of secondary traumatic stress and vicarious traumatisation in SAPS social workers change over time;
- Secondary traumatic stress levels need to be explored in different social work fields in South Africa, especially where social workers are employed in environments similar to SAPS such as the SA Defence Force; Department of Correctional Services; and organisations that address child abuse;
- Critical to the development of the South African trauma discourse, additional research needs to explore how different racial groups in South Africa experience trauma, so that the complex trauma narrative of South Africa can be further understood and so lead to the development of appropriate trauma interventions;
- Research into the multilayered effect of police suicides needs to incorporate the effects of police suicides on the social work practitioners in SAPS in order to ensure that the necessary supports are established for social workers whose clients commit suicide;
- A further line of enquiry would include the effects of transgenerational trauma, which would create greater awareness of the effects of apartheid on the people of South Africa;
- A fruitful area of research would include SAPS social workers' experiences of 'shared trauma' so that the holistic extent of the trauma impact is understood; and
- Participants' experiences of posttraumatic growth and vicarious resilience need to be explored in greater detail and with more depth, in order to help other social workers understand the opportunities and potential learning experiences that occur as a result of their work with trauma survivors.

12.6 CONCLUDING COMMENT

So often the work of social workers is not acknowledged or recognised and instead social workers are predominantly mentioned in the media in a negative light - for cases that have gone wrong or for responsibilities that may not have been completed to the level of another's expectation. SAPS social workers, in particular, are often criticised for the quality and quantity of social work services provided to SAPS employees. However, these social workers are often the neglected professionals who, like police officers, often work with few resources in an extremely stressful environment.

Working within a traumatogenic milieu, can exact a perilous toll for the social workers not only on a professional level but also on a personal level. These social workers have to navigate their way

through the stressors and demands of their work and ensure that they do not lose their compassion for clients or compromise the quality of services offered. At times, just as a piece of coal is located in darkness and the depth of the earth, this journey may seem dark and dreary with very little promise of light at the end of the tunnel. However, just as a diamond is a piece of coal that has survived intense pressure, each social worker has the potential to turn his or her professional and personal experiences into life learnings and growth opportunities. As social workers learn to assimilate the trauma of others into their own worlds, so the challenge is that they do not lose hope or the belief that they can make a difference in the life of a child or police officer and instead realise the valuable contribution they can make in the lives of others.

Their sacrifices and challenges are almost never heard or sufficiently acknowledged. As the African Proverb explains, **"Until the lion tells his side of the story, the tale of the hunt will always glorify the hunter".** Perhaps social workers need to be encouraged to find their voices, share their stories, explain their narratives and not be afraid to show society that they, just like any other professionals, are inherently fragile human beings who often at a great sacrifice to themselves, are also trying to help make the world a better place. In the words of Ruth Westheimer (n.d.),

"Our way is not soft grass, it's a mountain path with lots of rocks.
But it goes upwards, forward towards the sun".

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APPENDICES

APPENDIX A

PART ONE: THE QUESTIONNAIRE

Due to copyright issues only a few items have been provided for research tools that were not freely available and the researcher needed to purchase the research tools.

University of the Witwatersrand, Department of Social Work

SECONDARY TRAUMATIC STRESS:
A Case Study of the Social Workers Employed at the South African Police Service



A PhD Study

FRANCINE MASSON

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Private Bag 3, Wits 2050, South Africa ● Tel: +27 11 717-4472 ● Fax: +27 11 717-4473 ● www.umthombo.wits.ac.za

Dear Colleague/Social Worker

I am a lecturer in the Social Work Department at the University of the Witwatersrand and am currently conducting research for my PHD under the supervision of Professor Eleanor Ross. The focus of my study is to explore how social workers who work for the South African Police Service in Gauteng experience indirect trauma. It is hoped that this research will contribute to the understanding of trauma and yield recommendations to SAPS about managing trauma in the workplace.

Participation in this research is totally voluntary. Should you decide not to participate in the study this will not be held against you in any way. You may withdraw from the study at any point and you may refuse to answer any questions that you feel uncomfortable answering.

This research study has two phases. The first phase consists of standardized questionnaires which assess aspects such as secondary trauma, burnout and coping resources. The questionnaire will take about 60 minutes to complete. Please just mark the appropriate answer with a cross (X). There are no right or wrong answers so please answer as honesty as possible. In the second phase qualitative interviews will be conducted with 30 participants, selected from participants who are willing to be interviewed. Please indicate on the following page if you are willing to be interviewed.

The interviews will be conducted at a venue and time that is convenient to participants. The interviews should take about an hour and a half. Please be assured that all information will be treated as completely confidential. Should you experience any emotional distress due to the sensitive issues that may be discussed in the interview, counselling will be arranged for you. I have arranged for this service to be provided free-of-charge by a social worker who works in private practice and is not connected to the SAPS in any way. With your permission the interviews will be tape recorded for analysis purposes. The only people who will have access to these recordings include my supervisor and myself. After completion of the research the data (tape recordings and questionnaires) will be kept for five years in a secure place before they are destroyed, which is the timeframe stipulated by the ethics committee of the University. Should any publications occur as a result of this research the data will be kept for two years after publication as is stipulated by the ethics committee of the University.

Please feel free to ask me any questions or raise any concerns that you may have pertaining to the study (My details are provided below). Should you wish to receive a summary of the findings, this will be made available to you upon request.

Thank you in advance for your cooperation.

Yours sincerely

Francine Masson

Doctoral Research Student

011 717 4480

082 905 1209

Prof. Eleanor Ross

Supervisor and Head

School of Social Work

011 717 4472

Secondary Traumatic Stress: A Case Study of the Social Workers Employed at the South African Police Service

CONSENT FORM TO PARTICIPATE IN THE SECOND PHASE OF THE STUDY

I hereby consent to participate in the second phase of this research project. The purpose and procedures have been explained to me and I understand that participation is entirely voluntary and that I may withdraw from the study at any time without any negative consequences. Furthermore I understand that verbatim quotations may be used but that my identity will be protected, and that only the researcher, her supervisor and the transcriber will have access to the transcripts.

Name of Participant: _____
Date: _____
Cellphone Number: _____
Signature: _____

Secondary Traumatic Stress: A Case Study of the Social Workers Employed at the South African Police Service

CONSENT FORM FOR AUDIO – TAPING OF THE INTERVIEW

I hereby consent to the tape-recording of the interview. I understand that my confidentiality will be maintained at all times and that the tapes will be destroyed two years after any publication arising from the study or five years after the completion of the study if there are no publications.

Name of Participant: _____
Date: _____
Cellphone Number: _____
Signature: _____

Secondary Traumatic Stress: A Case Study of the Social Workers Employed at the South African Police Service

Please complete the following demographic information.

Section A: Demographic Information

1a. Rank within SAPS_____

b. Which province do you work in: _____

c. Nature of social work: (please tick the appropriate answer)

Forensic Social Work _____

Occupational Social Work_____

2. Age: _____

3. Please tick appropriate category

Male _____

Female _____

4. Ethnic Group (For statistical purposes only – not meant to be offensive)

Please mark the appropriate category

: Black _____

Coloured _____

Indian _____

White _____

5. Marital Status: (Please mark with an X the appropriate category)

Single _____

Cohabiting _____

Married _____

Divorced _____

Widowed _____

6. Number of children _____

7. Qualifications:

_____Year obtained:_____

_____ Year obtained:_____

_____Year obtained:_____

_____Year obtained:_____

8. How many years experience do you have as a social worker: _____Years

9a. Number of years working at SAPS:

_____Years

b. Number of years working in the trauma field as a social worker prior to joining South African Police Service:

_____

10. What areas of social work have you worked in prior to joining SAPS:

_____

_____

11. In the last six months what kind of traumatic situations have your clients experienced? (Please elaborate briefly).

_____

_____

_____

_____

12. What does your average day at SAPS entail?

(please tick the appropriate statements)

___ attending meetings

___ conducting training workshops

___ attending trauma scenes

___ counselling

___ administration

Section B: Norris's (1990) Traumatic Stress Schedule

The following questions ask you about traumatic experiences which you may have heard about in your client interventions. Please tick whether you have been exposed to the following experiences in the last six months.

	Experience	**Yes**	**No**	**Frequency in the last six months**
1,	Have your clients told you about situations where they were attending to scenes whereby someone tried to take something from someone by threat or force, such as a mugging, robbery or holdup?			
2.	Have any of your clients told you about incidents where they have been beaten or attacked?			
7.	Have any of your clients ever spoken about been forced to evacuate from their home?			

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SECTION C: Bride, Robinson, Yegidis and Figley's (2004) Secondary Traumatic Stress Scale

The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Please read each statement, then indicate how frequently the statement was true for you in the past *seven (7) days* by ticking the corresponding statement next to the statement.

		Never	**Rarely**	**Occasionally**	**Often**	**Very often**
1.	I felt emotionally numb.					
2.	My heart started pounding when I thought about my work with clients.					
3.	It seemed as if I was reliving the trauma(s) experienced by my client(s).					
4.	I had trouble sleeping.					
5.	I felt discouraged about the future.					

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SECTION D: Pearlman's (2003) Traumatic Attachment and Belief Scale

This questionnaire is used to learn how individuals view themselves and others. Please tick the response either strongly disagree, disagree, disagree somewhat, agree or strongly agree to which most describes how you think and feel.

		Strongly Disagree	Disagree	Disagree somewhat	Agree somewhat	Agree	Agree strongly
3	I don't feel like I deserve much.						
6	I never feel anyone is safe from danger.						
19	I don't trust my instincts.						
26	Trusting people is not smart.						
53	I hate to be alone.						

© 2003 Laurie Anne Pearlman

SECTION E: Hudnall Stamm's (2010) Professional Quality of Life Scale

Helping people puts you in direct contact with their lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. I would like to ask you questions about your experiences, both positive and negative, as a social worker. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these characteristics in the ***last 30 days***.

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

	3.	I get satisfaction from being able to help people.
	4.	I feel connected to others.
	6.	I feel invigorated after working with those I help.
	7.	I find it difficult to separate my personal life from my life as a social worker.
	19.	Because of my work as a social worker, I feel exhausted.
	21.	I feel overwhelmed by the amount of work or the size of my casework load I have to deal with.

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SECTION F: COPING

1. What strategies do you use to help you cope with hearing about or seeing constant traumatic situations?

_____
_____
_____
_____

2. Hammer and Marting's (2004) Coping Resources Inventory

For each of the statements that follow please tick the response (**Never, Sometimes. Often or Always)** which best describes you in the last **six months**.

		Never or rarely	Sometimes	Often	Always or almost always
1	I have plenty of energy.				
2	I say what I need or want without making excuses or dropping hints.				
4	I am comfortable with the friends I have.				
5	I eat junk food.				
8	I am comfortable talking to strangers.				
9	I am part of a group, other than my family, that cares about me.				
10	I accept the mysteries of life and death.				

© 2004 Hammer and Marting

SECTION G: RESIILIENCE

1. Do you think that you have any personal attributes or aspects of your personality that help you to cope with constantly hearing about traumatic events?

YES	NO

2. If yes, please elaborate.

_____
_____
_____

3. Wagnild's (2009) Resilience Scale

Please read the following statements. To the right of each you will find seven numbers, ranging from "1" (Strongly Disagree) on the left to "7" (Strongly Agree) on the right. Circle the number which best indicates your feelings about that statement. For example, if you strongly disagree with a statement, circle "1". If you are neutral, circle "4", and if you strongly agree, circle "7", etc.

1 = strongly disagree

2 = disagree

3 = slightly disagree

4 = neutral

5 = slightly agree

6 = agree

7 = strongly agree

1.	When I make plans I follow through with them.	1 2 3 4 5 6 7
2.	I usually manage one way or another.	1 2 3 4 5 6 7
8.	I am friends with myself.	1 2 3 4 5 6 7
14.	I have self-discipline.	1 2 3 4 5 6 7
16.	I can usually find things to laugh about.	1 2 3 4 5 6 7

© 2009 Wagnild

SECTION H: Moos's (2008) Work Environment Scale

This questionnaire assesses your work environment. Please tick true, false or not applicable next to each statement that best describes your work environment. Please be sure to answer every statement.

		True	False
1	Work is really challenging.		
2	People go out of their way to help a new employee feel comfortable.		
3	Supervisors tend to talk down to employees.		
5	People pay a lot of attention to getting work done.		
6	There is constant pressure to keep working.		
8	There's a strict emphasis on following policies and regulations.		
9	Doing things in a different way is valued.		
12	The atmosphere is somewhat impersonal.		
14	Employees will have a great deal of freedom to do as they like.		

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SECTION I:

1. **What suggestions would you make to reduce the effects of secondary trauma?**

_____
_____
_____
_____
_____
_____

2. **Have you ever attended your own counselling in order to cope with your work (Please tick the appropriate answer).**

YES	NO

If yes, please comment on the number of sessions attended.

_____
_____

3. **What, if anything, have you learnt whilst working for SAPS?**

_____
_____
_____
_____

4. **What recommendations would you make to SAPS to improve your work environment?**

   _____
   _____
   _____
   _____

5. **Any additional comments?**

   _____
   _____
   _____
   _____

6. **Please indicate if you would like feedback on the results of this research.**

YES	NO

If yes, please supply an email or postal address below:

_____
_____

THANK YOU FOR YOUR TIME!!

APPENDIX B

PART TWO: INTERVIEW SCHEDULE

Secondary Traumatic Stress: A Case Study of the Social Workers Employed at the South African Police Service

Thank you for agreeing to be interviewed. (Read through participant information sheet).

1. Tell me about the extent of trauma counselling that you have offered police officials /cases you have been exposed to as a forensic social worker.
2. Before you joined the SAPS did you counsel trauma victims? If yes please elaborate.
3. In what ways, if any, do you think that counselling police officers may have affected you?
4. In what ways, if any, do you think, that you have changed due to the continual exposure to traumatic material? If so, How do you think you have adjusted to these changes?
5. Did you experience any physical symptoms as a result of listening to police officers or children tell you tell you about the trauma they have experienced? Please elaborate.
6. How do you think the way you understand the world has changed, if at all, due to hearing about traumatic material during counselling?
7. Do you think these experiences have affected you negatively? If so, in what way?
8. What supports can you identity that have helped you deal with these changes in yourself?
9. Have these experiences affected you positively? If so, how?
10. Do you think that your constant exposure to traumatic material has impacted upon your therapeutic relationships? If yes please explain.
11. Have you found that over time you are less able to empathise with your clients? Please explain your answer.
12. How do you understand the terms 'transference' and 'counter-transference'? How, if at all has working in the trauma field impacted upon your therapeutic relationships with clients?
13. What factors can you identify within yourself, your work environment, your social environment, and your community that may helped you become more resilient in your responses to trauma?
14. Do you attend supervision sessions? Have you found this beneficial or not beneficial to your experiences of dealing with constant exposure to traumatic material? Please explain.
15. Have you ever attended your own therapy in order to help you deal with the traumatic nature of your work. If so, in what ways has it helped you or not helped you? Do you attend supervision sessions? Have you found this beneficial or not beneficial to your experiences of dealing with constant exposure to traumatic material? Please explain.
16. Would you attend counseling if SAPS provided the opportunity? If yes, how would you like these services to be structured?

17. Do you think your working environment (structure, organisational culture, leadership) has influenced the way you have been affected by constant exposure to traumatic material? Please explain.
18. How satisfied or dissatisfied are you with your job? Please elaborate.
19. What recommendations would you make to SAPS to improve the work environment?
20. What recommendations would you make to ameliorate the effects of the continual exposure to trauma?

APPENDIX C

ETHICS CLEARANCE CERTIFICATE

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)
R/14/49/1 Davies

CLEARANCE CERTIFICATE	PROTOCOL NUMBER H08/11/13
PROJECT	Secondary traumatic stress: A case study of the social workers employed at South African police service, Gauteng
INVESTIGATORS	Mrs P Davies
DEPARTMENT	Social Work
DATE CONSIDERED	14.11.2008
DECISION OF THE COMMITTEE*	Approved Unconditionally

NOTE:

This ethical clearance is valid for 2 years and may be renewed upon application

DATE 24.11.2008 CHAIRPERSON .....
(Professor R Thornton)

cc: Supervisor : Prof E Ross

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and ONE COPY returned to the Secretary at Room 10004, 10th Floor, Senate House, Universit

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

.....
Signature

This ethical clearance is valid for two years from date of approval.

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

APPENDIX D

AUDIT TRAIL

LIST OF AUDIT TRAIL CONTENTS

Classification	File Types	Evidence
Intention and Disposition	Research proposal	Written proposal Progress reports Feedback from reviewers Final proposal
Instrument Development an Collaboration	Questionnaires Interview Schedule	Results from the Pretest Questionnaire Booklet Final Interview Schedule
Raw Data	Audio recordings Transcriptions Completed questionnaires	30 Interviews 128 Completed questionnair
Data Analysis	Coded transcripts Excel file SPSS and SAS files Reflexive Journal	Atlas.ti summaries SPSS report SAS report
Process Notes	Daily logs Reflexive journal	Recorded activities for PhD Reflexive journal entries
Data Synthesis	Notes on emerging patterns Findings and Conclusions	Arrangement of findings, Concepts and categories in chapters of thesis