

CHAPTER I: LITERATURE REVIEW

Introduction

The impact of human service work roles in which workers are constantly exposed to the wants and needs of other individuals, has received much attention owing to the frequently reported deleterious effects of the stresses associated with such work (Cherniss, 1980; Maslach, 1982). However, it is suggested that the demands posed by work specifically involving interaction with trauma survivors in a supportive capacity, are even more extreme (Straker, 1993). This is because the trauma counselling role exposes these workers to the generic stressors of attending to human needs as well as the potentially damaging emotional demands associated with exposure to traumatic material (Straker, 1993). As the current study focuses on trauma counsellors, the review of the literature must be contextualised according to the field of trauma and its unique human impact. Although the potentially negative outcomes of interaction with survivors of trauma form the focal point for investigation, it is noted that this interactive experience is also often felt to be an enriching one. As reported by Pearlman (1995), contact with trauma survivors in a supportive capacity often leads to a deeper understanding of the human condition and results in personal growth of the helper (Pearlman, 1995). Similarly, Straker (1993) asserts that trauma work is rewarding in its own right because:

[w]orkers entering into the world of trauma survivors are profoundly affected by them, often finding new depth within themselves. They also, however, run the risk of early burnout and even secondary traumatisation.

Indeed, interacting with trauma, even vicariously, has potentially serious repercussions for psychological well-being (p. 32).

‘Burnout’ and ‘compassion fatigue’ are syndromes specifically related to chronic exposure to the demands inherent in work roles requiring interaction with people and trauma. While *burnout* is an outcome associated with the constant pressure of attending to people in a human service capacity, *compassion fatigue* is an outcome associated with the experience of secondary trauma as a result of interacting with trauma survivors in a supportive capacity (Cherniss, 1980; Figley, 1995; Maslach, 1982). Accordingly, trauma counsellors are at a particularly high risk of developing burnout and compassion fatigue because their work role incorporates the characteristic demands associated with exposure to people in a human service capacity and specifically in the provision of trauma support (Chrestman, 1995). Both burnout and compassion fatigue, as ‘syndromes’, comprise a set of symptoms indicative of the fact that a worker is suffering from emotional exhaustion and secondary traumatisation respectively. These conditions both have serious negative implications for human service workers if not addressed. These negative implications are also not limited to the well-being of counsellors and they may have a negative organisational impact by potentially resulting in a high counsellor turnover (Figley, 1995; Maslach, 1982). As such, a vast amount of literature defining and exploring the effects of these syndromes across human service professions, has emerged (Figley, 1988).

Prior to reviewing the literature pertaining to these syndromes and the manner in which it may be extrapolated to South African trauma counsellors, however, the concept of trauma

shall be discussed with reference to the South African context of crime. In addition, the trauma-counsellor's role in relation to trauma survivors shall be examined. In doing so, the literature regarding the impact of traumatic exposure as well as the connection between posttraumatic stress disorder and secondary trauma shall be drawn. Having derived an understanding of the central concepts that make trauma a complex field of study, the phenomena of compassion fatigue and burnout as reactive syndromes to such exposure, shall be defined and reviewed. Similarly, as the relationship between these variables and the counsellors' intent to leave is investigated, the concept of withdrawal cognition and intent shall be defined. Thus, a comprehensive understanding and definition of the dependent variables in the study is provided.

Having explored the literature pertaining to compassion fatigue and burnout, the review alters its focus to an exploration of the individual factors, both personal and situational, that have been selected as the independent variables of study. The definition of 'personal factors', as adopted in the current research, refers to the characteristics unique to individuals, for instance personality characteristics and life experience. Conversely, the term 'situational factors' refers to characteristics that may vary across individuals and that are influenced by context-specific variables, for instance social support networks. In the current study the personal factors explored include the personality construct *sense of coherence* as well as *prior exposure to trauma*. Alternatively, the situational factors explored include *social support*, *job involvement* and *organisational commitment*. In reviewing the literature regarding these constructs, each shall be comprehensively defined and identified as appropriate for study as predictive of the susceptibility to burnout and compassion fatigue.

The Field of Trauma and Trauma Responses

The context of trauma in South Africa: The incidence of posttraumatic stress disorder

Reports of shootings, murders, bank robberies and sexual assault predominate South African headlines on a daily basis, adding credence to the assertion that South Africa is currently one of the most violent countries outside of a war zone (SAPS, 2000). Hence, 'crime' has become a term inextricably related to South African society, a fact largely attributed to the socio-economic and racial inequities caused by the violent, political past of apartheid's ideological reign (Wilson, 1998). Besides being rampant, the nature of South African crime is one in which violence and victimisation are central, the experiences of countless survivors of crime thus being characterised by the traumatic instigation of aggravated assault and bodily harm (SAPS, 2000). As such, the number of crime survivors experiencing symptoms associated with their traumatic experiences are high, thereby necessitating the focus of attention on the complex functioning and impact of trauma in South African citizens. According to the DSM IV (1994), a traumatic experience is defined as:

exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or threat to one's physical integrity, or witnessing an event that involves death, injury or threat to the physical integrity of another person, or learning about unexpected or violent death or injury experienced by a

family member or close associate. The person's response to the event must involve intense fear, helplessness or horror (p. 425).

Given the extreme nature of the stress encountered through exposure to a traumatic incident, these experiences are generally characterised as existing beyond the realm of normal, daily human experience (Dunkle & Potter, 1996). As a result, the effects of trauma frequently manifest as a characteristic cluster of intense, often incapacitating, symptoms (Dunkle & Potter, 1996). The incidence of a syndrome related to traumatic exposure, having first been recognised and acknowledged in post-Vietnam war veterans, has thus become a widely accepted phenomenon and is termed *posttraumatic stress disorder* (PTSD) (Figley, 1988). According to Van der Kolk and Greenberg (1987), PTSD arises as a result of the survivor's inability to integrate the traumatic experience meaningfully into his/her life experiences, thereby remaining fixated on the trauma and pre-occupied by the attendant feelings of fear, anger and anxiety. Correspondingly, Dunkle and Potter (1996) regard PTSD as an anxiety disorder characterised by emotional disturbance constituting a normal human response to an experience that is beyond the range of normal, daily events. In acknowledging PTSD as a 'syndrome' characterised by a cluster of symptoms denoting such emotional disturbance, the DSM IV (1994) delineates the symptomatic parameters of PTSD as:

include[ing] persistent re-experiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness and persistent symptoms of increased arousal. The full symptom picture must be present for more than one month and the

disturbance must cause clinically significant distress or impairment in social, occupational or other important areas of functioning (p. 425).

While in agreement with the DSM IV's symptomological description of PTSD, Dunkle and Potter (1996), however, assert that PTSD symptoms have a limited time span in order to be considered a normal human response. Accordingly, they argue that PTSD symptoms that persist beyond six months are dysfunctional and indicate a complicated response to trauma. Such a response is not infrequent in the South African context given the exposure of many South Africans to continuous traumatic stress (Dunkle & Potter, 1996). Such chronic exposure, for instance through the repeated exposure to traumatic material in daily news reports, constant threat of injury or the repeated victimisation are endemic to this society characterised by the high incidence of crime (Straker, 1993). Having described the nature of South African crime and the repercussions of such crime to the incidence of trauma in the lives of South Africans, it follows that thousands of South Africans, as survivors of violent crimes, experience PTSD. Furthermore, given the distressing and often debilitating impact of symptoms associated with this psychological response, the importance of the role of trauma counsellors in assisting survivors of trauma who require support in overcoming PTSD, is obviated.

The trauma counselling role

As has been indicated, trauma counsellors are exposed to high numbers of traumatised individuals, owing to the sheer number of crimes involving victimisation in South Africa. Hence, it follows that the experiences of trauma counsellors may vary, depending on the clients they encounter, the frequency with which they counsel or the context in which

they work. However, the trauma counselling role is rendered conceptually distinctive from any other form of counselling or formal psycho-therapy owing to its primary focus on the impact of incidents pertaining directly to traumatic events, as opposed to any broader psychological issues. As a result, trauma counselling tends to involve shorter-term, supportive intervention from counsellors (Scott & Stradling, 1994). Trauma support intervention involves activities that range from crisis intervention to a more restorative form of support work. Firstly, crisis intervention involves the provision of instrumental support to the counsellee directly after the trauma has been experienced. Such support activities may include, for instance, the counsellor providing assistance in contacting relatives or in calling for medical assistance (Scott & Stradling, 1994). Secondly, the more emotionally supportive aspect of counselling has a restorative focus in that its primary goal is to assist clients in coping with and overcoming PTSD. This is referred to as a restorative process as its primary objective is to facilitate the restoration of the client's social and occupational functioning (Scott & Stradling, 1994).

As the underlying cause of PTSD is the inability to integrate the traumatic experience meaningfully, it follows that the role of the trauma counsellor is to assist the traumatised client in overcoming the intrusive fixation with the experience by placing it within a meaningful context, thereby allowing its assimilation into the client's life events (Van der Kolk & Greenberg, 1987). In order to achieve this it is instrumental that the counsellor facilitate the trauma survivor's process of working through the traumatic experience and the symptoms and feelings associated with it. Dunkle and Potter (1996) define 'working through' as a process involving the "ventilation of feelings through telling and re-telling the story" (p. 61). Accordingly, the primary role of the trauma counsellor is to facilitate

repeated and detailed recounting of all aspects of the experience, demonstrating a willingness to hear and contain the worst parts of the trauma. Active listening and encouragement validates feelings and experiences, thereby allowing for emotional release and the consequent decrease in pre-occupation with the trauma and the fear and anxiety caused by it (Dunkle & Potter, 1996). Thus, central to the counsellor's effective fulfillment of his/her role is the ability to listen and engage repeatedly with the details of trauma and the attendant emotions. In order to achieve this level of engagement, it is suggested that an ability to identify with the client and enter his/her subjective emotive reality is required. Straker (1993) states that the:

capacity for receptivity and for openness to the other presupposes that the listener [is capable of integrating] the myriad of powerful emotions that working with the survivors of trauma elicit, most particularly the emotions of horror, helplessness, sorrow and anger....These emotions facilitate the identification and empathy crucial to all healing relationships (p. 34).

Therefore, it is clear that the nature of the counselling role itself promotes the prolonged, indirect exposure to the traumatic experiences of survivors as counsellors are "always knee-deep in the extreme intensity of trauma-inducing facts" (Figley, 1995b, p. 20). Furthermore, intrinsic to the role is a requisite level of engagement beyond passive listening. Such engagement allows the counsellor to identify and relate to the feelings experienced by the trauma survivor, thereby placing an extreme emotional demand on the counsellor. Figley (1995) terms the specific stress resulting from interaction with trauma survivors as a care-giver or supporter as *compassion stress*. In spite of being trained to

confront traumatic material, the impact of such exposure and the emotional demand placed on counsellors is such that they are “not immune to the painful images, thoughts and feelings associated with exposure to their clients’ traumatic memories” (McCann & Pearlman, 1990, p. 132). As the DSM IV (1994) clearly acknowledges the potential emergence of PTSD as a result of “learning about unexpected or violent death or injury of a family member or close associate” (p. 425), it follows that counsellors engaging on such an emotional level with trauma survivors are a high risk group with regard to the development of PTSD symptomology.

In keeping with Figley’s (1995) assertions, while trauma counsellors are vulnerable to developing PTSD symptomology, differences in their exposure to traumatic material result in mild differences in the manner in which this symptomology manifests [See Appendix I]. The differences in symptomological manifestation emerge owing to the indirect and prolonged exposure of trauma counsellors to traumatic material as opposed to the direct and short-term exposure of survivors to a traumatic incident (Figley, 1995). This outcome of long-term exposure has been referred to across the literature as *vicarious* traumatisation, *secondary traumatic stress disorder* and *secondary traumatic victimisation* (Figley, 1995; McCann & Pearlman, 1990; Straker, 1993).

Secondary traumatic stress disorder (STSD): Perspectives regarding the psychological processes underlying the experience of STSD

In reviewing the literature regarding the impact of trauma and interaction with trauma survivors, divergent explanations regarding the mental processes underlying the development of secondary trauma, emerge. For instance, the experience of secondary

traumatisation by mental health professionals has been described as the product of the psychodynamic concept of *countertransference* as well as the product of altered *mental schemas* (McCann & Pearlman, 1990).

Countertransference: The impact of prior exposure to trauma

Countertransference refers to the emotional response of the therapist/counsellor toward the client as a result of the material presented and the manner in which it relates to an unresolved, possibly unconscious, aspect of the counsellor's past (Figley, 1995b). Thus, as reasoned by Freudenberger and Robbins (1979), identification with survivor trauma, whereby the counsellor manifests STSD symptoms likened to those of clients, may be attributed to the fact that "old scars and injuries are constantly rubbed anew" (p. 287). Countertransference is regarded as undermining to the therapeutic relationship because the ensuing emotional reaction toward the client causes the counsellor to misinterpret the client and respond inappropriately by doing so in accordance with his/her own traumatic feelings (McCann & Pearlman, 1990). According to this understanding of the psychological process underlying the counsellor's manifestation of STSD, however, it would appear that the experience is not secondary or indirect in nature at all but is rather a re-activation and re-experiencing of direct trauma previously encountered. This provides an indication of the potential of prior exposure to trauma in counsellors of increasing their susceptibility to traumatisation as a result of the indirect exposure to trauma's capacity to reactivate past memories, experiences and feelings (Farber, 1985 cited in McCann & Pearlman, 1990). Hence, the rationale emerges for the inclusion of prior exposure to trauma as a variable of investigation in the current study with regard to its impact on counsellor susceptibility to the syndromes related to STSD.

Constructivist self-development theory

While the concept of countertransference is useful in elaborating upon the impact of prior exposure to trauma on counsellors' responses to trauma survivors, however, it is argued that the construct is incapable of accounting for secondary trauma where no prior trauma has been experienced. Accordingly, McCann and Pearlman (1990) refute this explanation of secondary trauma as inappropriate because it refers to any feelings and thoughts that may be experienced by the counsellor toward the client, thus being too broad a concept to account for the specific impact of indirect exposure to trauma. McCann and Pearlman (1990) thus introduce a theory that specifically addresses the psychological impact of exposure to trauma, this being termed *constructivist self-development* theory. According to this theory, the experience of vicarious traumatisation varies across individuals because it is regarded as a product of the interaction between situational (environmental) factors, such as the nature of the traumatic stressor, and individual factors, such as coping style (McCann & Pearlman, 1990). The central premise of this theory is that the experience of trauma disrupts and alters the phenomenological reality of individuals, thereby altering their assumptive defences and interpretation of the world (Pearlman, 1995).

It is argued within this perspective that individuals have cognitive structures, termed schemas, which are constituted of beliefs, assumptions and expectations regarding the world and the self in it (Pearlman, 1995). These schemas address psychological needs for safety, trust, power, esteem and intimacy by providing defensive beliefs that the world is safe and the individual, invulnerable (Pearlman, 1995.). Accordingly, traumatic life events are reputed to contradict three basic life assumptions, these being the belief in

personal invulnerability, the belief in self-worth and the belief that the world is both meaningful and benign (Janoff-Bulman, 1985 cited in McCann & Pearlman, 1985). When these defensive beliefs are shattered the psychological need for safety remains unfulfilled and the individual is subject to feelings of anxiety and insecurity.

Constructivist self-development theory proposes that the process of cognitive alteration experienced by an individual manifesting STSD is identical to that experienced by trauma survivors manifesting PTSD (Rosenbloom, Pratt & Pearlman, 1995). However, the term *vicarious traumatisation* is employed instead of STSD. Hence, as the effects of vicarious traumatisation involve cognitive alteration they are cumulative, permanent and may be emotionally intrusive (Rosenbloom et al., 1995). In contrast to countertransference, which is considered a negative therapeutic response, the experience of vicarious traumatisation is considered a normal by-product of prolonged exposure to secondary traumatic stress, a stressor inherent in the counsellor's work role (Rosenbloom et al., 1995). Furthermore, while these cognitive changes may impact on counsellors' relationships, work and feelings "whether [they] are ultimately destructive to the helper or the therapeutic process depends on how the therapist or counsellor assimilates the material into the self and makes sense of the experience" (McCann & Pearlman, 1990, p. 136). This is because the effects of vicarious traumatisation are modifiable and, while permanent, may be altered from being negative and intrusive toward becoming positive and enriching if adequately addressed (Rosenbloom et al., 1995).

The impact of prolonged exposure to secondary traumatic stress in care providers

Having explored the literature regarding the underlying processes explaining the outcome of secondary trauma in those exposed to traumatic material indirectly, the review proceeds to an examination of the manifestation of this cognitive alteration in trauma counsellors, namely compassion fatigue and burnout.

Compassion fatigue

Figley (1995), having introduced the term compassion stress to denote the strain associated with exposure to traumatised individuals within a supportive capacity, further introduced the term *compassion fatigue*. While the term 'compassion stress' is employed inter-changeably with 'secondary traumatic stress', the term 'compassion fatigue' is equated inter-changeably with 'secondary traumatic stress disorder' (Figley, 1995). Compassion stress is distinguished from STSD because it may emerge suddenly in response to specific traumatic material and may, similarly, disappear shortly. According to Figley (1995), however, prolonged exposure to traumatic stress, as in the case of trauma counsellors, may result in the experience of compassion fatigue. Specifically defined, compassion fatigue is both "a natural and disruptive by-product of prolonged exposure to compassion stress" and constitutes a state of "biological, social and psychological exhaustion and dysfunction" (Figley, 1995, p. 45). Accordingly, compassion fatigue is pervasive, long lasting and evokes changes in mental status that may manifest as anxiety, depression and many trauma-related symptoms. These changes of cognitive reality may be equated to McCann and Pearlman's (1990) conception of the cognitive process of vicarious traumatising and STSD. However, the experience of

compassion fatigue differs from pure PTSD because it is dichotomous, thereby involving both emotional exhaustion related to the occupation of a supportive role as well as the disruptive experience of secondary traumatisation.

Figley's (1995b) trauma transmission model: Compassion stress and the emergence of compassion fatigue

As compassion fatigue is directly related to exposure to compassion stress, the manner in which compassion stress functions to elicit compassion fatigue as an outcome must be understood. This provides an understanding as to the responsive process engaged in by trauma counsellors with regard to compassion stress. In order to illustrate the process Figley (1995) constructed a trauma transmission model (depicted on p. 18) which explains the components that determine compassion stress as well as the progression from compassion stress into a state of compassion fatigue, where cognitive alteration and PTSD manifest.

According to Figley's (1995b) model of compassion stress, the construct is the product of an interaction between six variables [See figure 1, p. 18]. Firstly, the level of the counsellor's *empathic ability*, which refers to the ability to register the pain experienced by others, determines the amount of *empathic concern* and *emotional contagion* experienced by the counsellor. While empathic concern refers to the motivation to act in a manner that reduces the suffering of the trauma survivor, emotional contagion refers to the counsellor's simultaneous identification with and experience of similar feelings to those experienced by the survivor (Figley, 1995b.). It is the combination of empathic concern and emotional contagion which gives rise to, and determines, the counsellor's

empathic response. The empathic response, in turn, refers to the effort engaged in by the counsellor to reduce the survivor's suffering and, it is argued, involves the facilitation of the 'working through' process in terms of the counselling role. Depending on the effectiveness of this effort two outcomes may occur. If the effort is effective in reducing the suffering of the survivor then a *sense of achievement* is experienced by the counsellor and the compassion stress caused by the survivor's suffering is reduced. However, if the effort is not successful then *disengagement* occurs, whereby more compassion stress is evoked as the survivor's suffering is not reduced and the counsellor continues to be exposed to this stress without an instrumental sense of actively helping the individual (Figley, 1995b).

Thus, the perceived instrumentality of the empathic response is primary in determining the intensity of compassion stress as well as its duration. This relates to Pearlman's (1995) suggestion that STSD occurs as a result of empathic engagement. Figley (1995) then discusses the four variables that determine the outcome of compassion fatigue in his model of compassion fatigue [See figure 2, p. 18]. Compassion stress, coupled with prolonged exposure, whereby the counsellor feels unable to alleviate the suffering of the survivor and has an ongoing responsibility to that survivor will result in the counsellor fixating on his/her client's suffering. As a result, the counsellor may experience traumatic recollections associated with the traumatic material presented by the client. Where the disruptive recollections become extreme and exposure to compassion stress prolonged, compassion fatigue may be experienced. Furthermore, Figley (1995b) asserts that the degree of life disruption being experienced by the counsellor, such as a change in lifestyle, may also exacerbate the risk of compassion fatigue.

Trauma Transmission Model (Figley, 1995b, p. 250)

Figure 1: A Model Of Compassion Stress

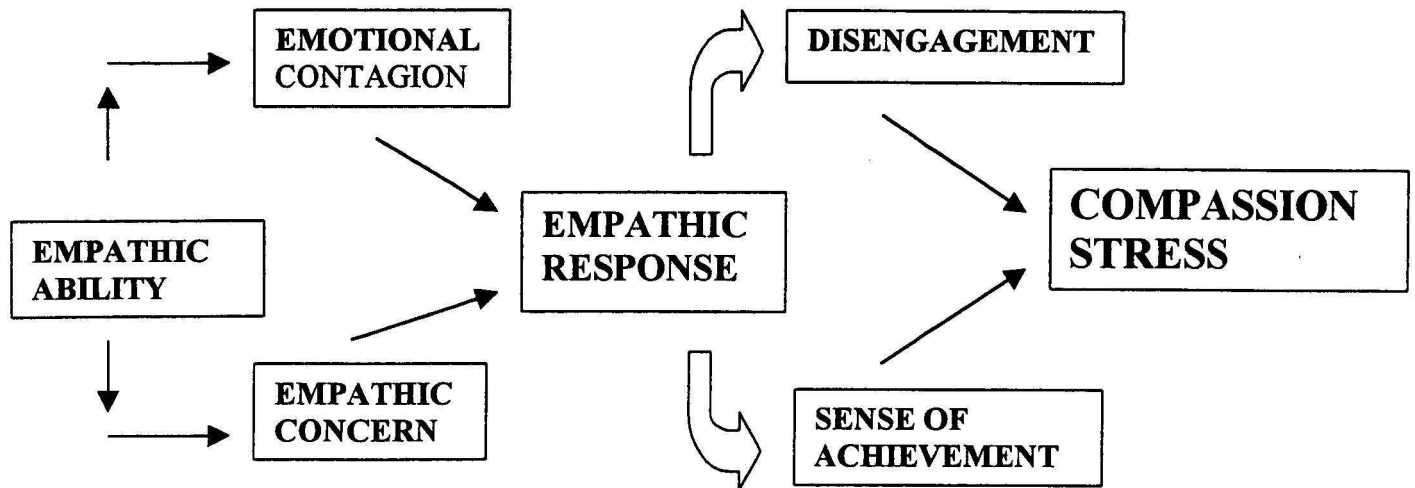
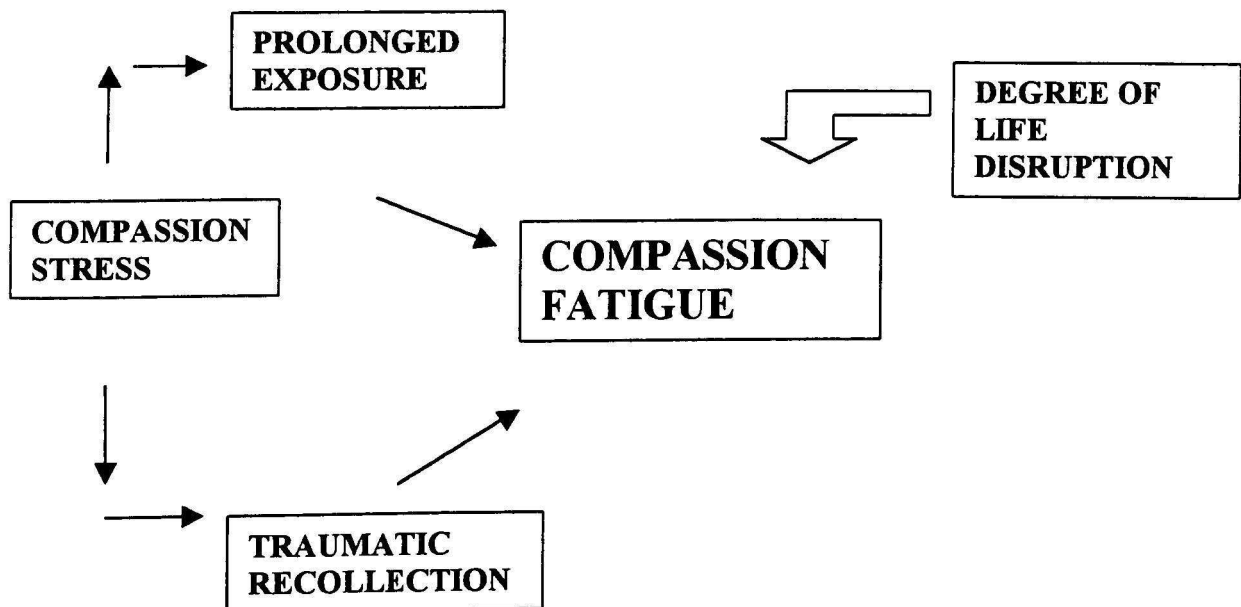


Figure 2: A Model of Compassion Fatigue



Symptomatic and work-related manifestations of compassion fatigue

According to Figley (1995a), compassion fatigue manifests as a variety of outcomes that affect the lives and well being of trauma care-givers and, it follows, for trauma counsellors in the current study. These manifestations may be categorised as either *intra-subjective* or *inter-subjective* (Figley, 1995a). While intra-subjective outcomes refer to the counsellors' individual experiences of secondary trauma, both physically and mentally, inter-subjective outcomes refer to the effects that the trauma exposure has on the counsellors' social lives.

The intra-subjective responses of compassion fatigue include helplessness, feelings of vulnerability, powerlessness, anger, frustration, guilt, shame, anxiety and irritability (Figley, 1995b; Straker, 1993). These feelings are associated with the experience of secondary traumatisation, whereby the counsellor may feel threatened in his/her own capacity as well as on behalf of his/her clients. Repercussions with regard to the impact on the counsellors' work are also present (Rosenbloom, Pratt & Pearlman, 1995). The counsellor is likely to manifest feelings of inadequacy and incompetence as a result of being overwhelmed by the traumatic material of clients to the extent that he/she can no longer listen and engage in the manner necessary to be effective within a therapeutic capacity (Rosenbloom, Pratt & Pearlman, 1995). The quality of his/her counselling may also suffer as a result of this disengagement because the counsellor may inadvertently discourage clients from comprehensively working through their feelings as a result of his/her own inability to tolerate the intense, trauma-induced feelings (Rosenbloom, Pratt & Pearlman, 1995). In addition, physical ailments may develop as a result of the eating and sleep disturbances that often manifest as a result of STSD.

The inter-subjective symptoms of compassion fatigue include withdrawal and alienation from others. Alienation is frequently related to intra-subjective symptomology, whereby the care-giver's poor tolerance as a result of the chronic stress causes irritability, explosive outbursts and aggression toward self and others (Van der Kolk & Greenberg, 1987). In extreme cases of traumatisation care providers manifest anhedonia and emotional constriction, thereby becoming unable to tolerate the wide range of feelings necessary to maintain intimate relationships and suffer consequent estrangement from intimate friends and sexual partners (Briere, 1987; Figley, 1995b). Further impact of these symptoms on the counselling work role may manifest as high levels of absenteeism and, if not addressed, the need to abandon the care giving role. With reference to the current study this indicates the importance of gauging the impact of compassion fatigue on the intent to leave of trauma counsellors. As the most predictive antecedent of human behaviour tends to be behavioural intent, the impact of compassion fatigue and burnout on counsellor turnover shall be assessed in terms of the impact of these variables on counsellors' intention to leave (Tett & Meyer, 1993). Hence, in the current study intention to leave is defined as a "conscious and deliberate willfulness to leave the organisation", comprising "the last in a sequence of withdrawal cognitions", thereby being the most predictive of actual turnover (Tett & Meyer, p. 262).

Burnout

Having explored the phenomenon of compassion fatigue, the review shifts to an assessment of the phenomenon of burnout, a second syndrome associated with human service providers and, thus, relevant to the investigation of the impact of work on trauma counsellors. Informally defined, burnout refers to "a state of mind that frequently affects

individuals who work with other people...and who pour in much more than they get back from their clients, supervisors or colleagues” (Pines, Aronson & Kafry, 1981, p.3). Accordingly, the tragedy of burnout is that individuals who are committed and involved in their work, regarding it as a vocation rather than a job are at the greatest risk of developing the syndrome. Cherniss (1980) argues that it is these committed individuals who, when they develop burnout withdraw psychologically from their work, reducing the amount of effort they exert in relation to their clients because “what used to be a calling becomes merely a job” and “any enthusiasm, excitement or sense of mission is lost in work” (p. 16). According to Pines et al. (1981) burnout is characterised by “physical, emotional and mental exhaustion”, manifesting as “physical depletion, feelings of helplessness, hopelessness, emotional drain and the development of a negative self-concept and negative attitudes toward work, life and other people” (p. 15).

Maslach (1982) maintains that the primary characteristic trait of burnout appears to be the concept of withdrawal from work as a result of a loss of concern for people with whom one is working and is often evident through a detached and mechanical approach toward clients. Thus, three components of burnout are evident, these being *depersonalisation*, whereby the helper can no longer feel compassion for the population they are working to assist, *emotional exhaustion*, whereby the helper feels he/she has nothing left to offer and cannot provide support and *reduced personal accomplishment*, where the helper feels a failure owing to the incapacity to meet minimum goals in his/her exhaustive state (Capner & Caltabiano, 1993; Pines et al., 1981; Reilly, 1994). In addition, symptoms of burnout include chronic fatigue, tension, anxiety and depression [See Appendix II]. Evidently, a high incidence of burnout in trauma counsellors would have serious,

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negative implications for trauma support services in South Africa. This is because the withdrawal and depersonalisation of burnt-out counsellors would undermine the empathic engagement required to assist trauma survivors in assimilating their traumatic experiences (Straker, 1993). Similarly, the widely documented outcomes of burnout in health services include poor staff morale, high absenteeism rates, tardiness and an increase in turnover (Pines et al., 1981).

Compassion fatigue versus burnout

As is evident from the discussion, burnout and compassion fatigue have many symptoms and factors in common. Figley (1995) acknowledges that both compassion fatigue and burnout cause feelings of isolation, helplessness and confusion. However, it appears that further overlaps between the two syndromes may be drawn when the definitions of burnout and compassion fatigue are compared. While Figley (1995) draws a distinction between compassion stress and burnout, he fails to further this distinction between compassion fatigue and burnout. Hence, while burnout is argued to differ from compassion stress because it emerges gradually and is difficult to overcome, compassion stress may emerge suddenly in response to traumatic material (Figley, 1995). Figley (1995) then appears to undermine the applicability of this distinction to compassion fatigue in relation to burnout by stating that compassion fatigue occurs as a product of prolonged exposure to compassion stress, thus implying that it too emerges gradually. Similarly, definitive overlaps become apparent in the comparison of the two syndromes with burnout being defined as physical, emotional and mental exhaustion (Pines et al., 1981), and compassion fatigue as a state of biological, social and psychological

exhaustion (Figley, 1995). Hence, the two syndromes appear to refer to the experience of emotional exhaustion and its implications for both well-being and daily living.

However, it is suggested that two features distinguish the phenomenon of compassion fatigue from that of burnout. Firstly, in addition to a component of empathic and emotional exhaustion, compassion fatigue incorporates the experience of secondary traumatisation, symptoms of STSD forming part of the syndrome. Taking cognisance of this distinctive feature, an individual who works with difficult populations but is not exposed to traumatic material may experience long-term emotional and empathic exhaustion without simultaneously experiencing cognitive alteration in relation to traumatic exposure. Such an individual would be suffering from burnout but not from compassion fatigue as the symptoms of STSD would be absent. Secondly, in spite of the lack of clarity between the adopted terms, Figley (1995) implies that burnout may still emerge more gradually and pervasively than compassion fatigue, thus constituting a more extreme form of exhaustion related to human service work than that experienced in the case of compassion fatigue. Accordingly, it is argued that burnout may be equated to an extreme form of the exhaustive component of compassion fatigue, thereby often being present in extreme cases of compassion fatigue but not necessarily so in milder cases. In keeping with this perspective, it is suggested that the only distinction between the component of exhaustion in compassion fatigue and burnout, is a matter of degree. Hence, an individual suffering from compassion fatigue will only be suffering from burnout simultaneously if the attendant degree of emotional exhaustion is sufficiently extreme.

Similarly, compassion fatigue, while equated to STSD by Figley (1995) may be argued to be distinct from this in its pure form. This is because compassion fatigue incorporates the exhaustion associated with the provision of support and is not merely a response to traumatic exposure, but traumatic exposure in a helping capacity. Thus, compassion fatigue, burnout and STSD, though very related concepts, are distinctive and must be studied as such. In summary, it is suggested that what distinguishes compassion fatigue from burnout is its inclusion of the effects of STSD as well as a lesser degree of emotional and empathic exhaustion.

The Correlates of Compassion Fatigue and Burnout

Personality orientation: The role of resiliency

The complexity involved in individuals' responses to trauma arises from the fact that many individual variables interact with the traumatic stressor, thereby altering the nature and outcomes of the experience (McCann & Pearlman, 1990). Hence, different individuals may be affected to a differing extent by the same traumatic material, this principle extrapolating to the susceptibility of trauma counsellors to compassion fatigue and burnout (Hodgkinson & Shepherd, 1994). Accordingly, several theorists have addressed the question of whether certain individuals possess specific personality or cognitive traits that increase their resistance to the effects of stressful encounters (McSherry & Holm, 1994).

A contemporary theorist arguing for the perspective of research into the origins of such resiliency and well-being is Aaron Antonovsky. This is because "[a]n important element

of Antonovsky's theory is that this origin of strength moderates potentially harmful effects of tension" and predisposes one to health (McSherry & Holm, 1994, p. 477). While traditional investigation of health has occurred from a *pathogenic* perspective, whereby the origins and causes of specific diseases are investigated, Antonovsky (1979) argues that a broader approach to the investigation of the origins of health should instead be adopted. This is referred to as the *salutogenic* approach. However, according to Strümpfer (1990), while Antonovsky's salutogenesis constitutes a very physical conception of health, his theory nevertheless incorporates the social and psychological 'wellness' of individuals. This broadness is derived from Antonovsky's (1979) conceptualisation of health as occurring along an ease/dis-ease continuum, whereby the physical state of an individual with regard to any health or mental ailment or combination thereof, determines his/her position between *ease* and *dis-ease*. The inclusivity of the theory is evident in Antonovsky's (1979) rejection of the term *disease* as being too specific a referent of health, and adopting instead the term *dis-ease* to depict human breakdown in any form. Thus, Antonovsky's (1979) conception of health appears to refer to a holistic, global conception of well-being as opposed to that of health, as denoted by the absence of (a) specific ailment(s).

In accordance with the pervasive impact of resiliency on well-being as occurring beyond only physical health, Strümpfer (1995) introduces the term 'fortigenesis'. This term, acting as an alternative to 'salutogenesis', refers to the origins of strength and resiliency in individuals. Strümpfer (1995) argues that:

[i]Introducing the construct of 'fortigenesis' merely states that, in searching for the origins of health, Antonovsky could not help but point to the closely related origins of the strength needed to be effective at other end-points (p. 82).

This argument is especially applicable in the current study of trauma counsellors as the focus is on what provides them with the strength to assimilate the traumatic material of clients without succumbing to the anxiety disorders arising from prolonged exposure, these being compassion fatigue and burnout. Thus, the necessity of investigating the factors that predict susceptibility to these syndromes, coupled with the broadness of Antonovsky's (1979) theory in encompassing psychological well-being, renders the application of his theory to the current research appropriate and invaluable. Furthermore, the 'sense of coherence' construct is argued to be 'universally meaningful', traversing barriers of gender, social class, religion and culture because "it does not refer to a specific type of coping strategy but to factors which, in all cultures, always are the basis for successful coping with stressors" (Antonovsky, 1993, p. 726). This renders the construct more applicable to the multi-cultural South African context.

Orientation to life: The sense of coherence

According to Antonovsky (1987), individuals all approach life from a specific perspective. This perspective informs the manner in which they interpret and cope with the stimuli and experiences presented to them by the environment. More specifically, how individuals interpret and cope with the environment is in accord with their personality and cognitive disposition. This orientation to life is referred to as the *sense of*

coherence and becomes fairly stable, be it high or low, after the age of thirty (Antonovsky & Sagy, 1986). The sense of coherence (SOC) construct was refined by Antonovsky (1987) as follows and denotes:

a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that 1) the stimuli deriving from one's internal and external environments in the course of living are structured, predictable and explicable 2) the resources are available to one to meet the demands posed by these stimuli and 3) these demands are challenges worthy of investment and engagement (p. 19).

Thus, while SOC refers to a global personality construct, it is multi-dimensional in that it is comprised of three essential components, these being *comprehensibility*, *manageability* and *meaningfulness* (Antonovsky, 1993; Antonovsky, 1991). These three components of the SOC are defined and explored here because, being definitive of the construct, they determine the manner in which SOC may promote resiliency when functioning as a whole. The reason for further arguing that SOC will minimise traumatic stress, rather than itself becoming shattered due to disrupted schemas, is because of Antonovsky's (1979) assertion that, while a particular experience or extreme situation may temporarily alter one's SOC, "such changes occur around a stable point on the continuum" (Antonovsky, 1979, p. 19). Thus, the level of schematic disruption caused by exposure to traumatic material is likely to be minor in counsellors with a high SOC.

Comprehensibility comprises the first component of the definition and refers to the extent to which the environmental stimuli that are experienced by individuals, both internally and externally, are perceived to be “ordered, consistent and structured rather than chaotic, random, disordered, accidental and inexplicable” (Antonovsky, 1987, p. 17). Although events may be unexpected, distressful and confusing, as in the case of death and war, Antonovsky (1987) asserts that individuals with a high SOC will be capable of making sense of these events. Thus, the instrumentality of comprehensibility in determining trauma counsellors’ ability to cope with traumatic stimuli, as a component of SOC, becomes apparent. Secondary traumatisation arises from the inability to integrate the traumatic material into life experience, owing to its random and contradictory nature with regard to defensive cognitive schemas (Dunkle & Potter, 1996). It follows that the construct of comprehensibility provides a defense against the destructive shattering of defensive schemas by providing the individual with the capacity to order and make sense of traumatic material. Consequently, it may be argued that the traumatic material is less likely to be a threat to these life assumptions because the high SOC individual, having the capacity to order and make sense of contradictory events, will be more likely to assimilate the traumatic material (Van der Kolk & Greenberg, 1987).

The second component, that of manageability, refers to the extent to which an individual perceives the availability of resources that assist him/her to meet environmental demands adequately, thereby minimising their stressful impact (Antonovsky, 1987). These resources are termed generalised resistance resources (GRRs) and may be categorised as follows: *artefactual-material*, these referring to aspects such as wealth, power and status, *cognitive*, these being knowledge, intelligence, *ego identity*, *coping strategies*, these

being plans of action for overcoming stressors, *inter-personal-relational*, these being social support and commitment (Antonovsky, 1979; Strümpfer, 1990). Hence, the manageability component of SOC is also exceptionally crucial to the current study because it refers to an individual's perceived capacity to cope with stressors, this influencing the manner in which they interpret difficult experiences and determining the extent to which they view themselves passively as victims of unfair life circumstances (Antonovsky, 1979). While Antonovsky (1987) acknowledges that "[u]ntoward things do happen in life", he asserts that, when they do occur, a high SOC individual "will be able to cope and not grieve endlessly" (p. 18). It follows that trauma counsellors with a high SOC will be less prone to the experience of compassion stress as they will perceive themselves as able to alleviate the survivor's suffering or harness the resources necessary to cope with feelings of disengagement, thereby being less susceptible to the outcome of compassion fatigue. As a result there is no prolonged exposure to compassion stress and the outcome of compassion fatigue is minimised.

Similarly, it may be argued that the manageability dimension of SOC plays a primary role in minimising the susceptibility of trauma counsellors toward burnout. This is precisely because the manageability component refers to an individual's perceived capacity to cope with stressors owing to their more positive interpretation of difficult experiences and the lesser extent to which they view themselves passively as victims of unfair life circumstances (Antonovsky, 1979). It follows that counsellors with a high sense of manageability will be less likely to perceive themselves as unable to cope with the demands of their helping role, thus being less likely to find it over-taxing and being less susceptible to burnout.

The third component of SOC, that of meaningfulness, refers to the extent to which an individual regards certain aspects of life to be meaningful, thus meriting commitment, effort and engagement toward meeting its stressful demands (Antonovsky, 1979). Hence, an individual with a high SOC will be inclined to meet personal crises as challenges to be “assigned meaning and overcome with dignity” (Antonovsky, 1979, p.19). This component also appears to be instrumental to the individual’s ability to assimilate exposure to trauma meaningfully into life experience. Furthermore, it is asserted that this component of SOC will minimise susceptibility toward burnout in trauma counsellors. This is because counsellors with a high SOC and, it follows, sense of meaningfulness will be more likely to consider their helping role meaningful, thereby being more important than the stressors it poses. As burnout specifically refers to a loss of the vocational investment in the work role, the ability to invest meaning in this role is likely to counteract the inclination toward burnout.

Antonovsky further stresses that the three dimensions underlying the SOC occur within boundaries in that only specific areas of life need to be regarded as manageable, comprehensible and meaningful for an individual to have a highly coherent orientation (Strümpfer, 1990). Similarly, world aspects and events that occur beyond these boundaries do not influence the orientation toward coherence. However, he argues that the minimum areas of inclusion regarding which the individual must have coherence are his/her inner feelings, immediate personal relations, major life activity and existential issues such as death, failures and shortcomings (Antonovsky, 1987). Trauma counselling, as a major life activity, or work role, that impacts on inner feelings and brings individuals into contact with existential issues, clearly incorporates life aspects regarded by Antonovsky as central to the level of coherence, thus being included within coherence

boundaries. In accordance, it is argued that outcomes for individuals related to their trauma counselling role will be affected by their level of coherence and that the investigation of the impact of coherence on these outcomes is, thus, appropriate. Antonovsky (1987, 1991, 1993) consistently suggests that the SOC functions as a global construct combined of the three dimensions and that separate analysis of these dimensions would yield inaccurate findings. This is owing to Antonovsky's (1993) finding that the sense of coherence scale does not load factorially according to the three dimensions. Thus, he argued that the investigation of the SOC as a global construct when employing the Orientation to life (OLQ) scale, yields statistically more meaningful results. Although recent studies suggest that there is theoretical merit in exploring the dimensions separately, this approach was not adopted in the current study (Antonovsky, 1993b; Ortlepp & Friedman, in press). This was because the central objectives of the study were to establish statistically meaningful correlational relationships between the variables, employing the OLQ measure.

Having proposed the rationale regarding the appropriateness of investigating SOC as a potential origin of resilience in trauma counsellors against compassion fatigue and burnout, further evidence is provided regarding the importance of this construct in determining resilience against extreme stressors. Flannery & Flannery (1990) found that SOC correlated negatively with life stress, thus lessening the impact of this stress in terms of symptoms such as anxiety and depression in an American sample of adult college attendants. Flannery, Perry, Penk and Flannery (1994) later confirmed these findings through replication.

In spite of the connection between SOC and daily life stress, however, the instrumentality of the role of SOC in reducing the impact of extreme stressors, for instance trauma, requires further investigation. According to Antonovsky and Sagy (1986), in a sample of Israeli adolescents facing residential evacuation, SOC was found to correlate negatively with anxiety in response to stress situations within the realm of normal exposure, for instance an exam scenario. However, no relationship between the construct and emotional responses to the acute stress of the evacuation, was found. This implies that SOC may not be as instrumental as anticipated with regard to the response to traumatic stimuli. However, Ortlepp and Friedman (2000) found that SOC acted consistently as a main effect, manifesting an inverse relationship with susceptibility to compassion fatigue in a South African sample of non-professional debriefers in the banking industry. As such, it is suggested that the role of the personality construct requires further empirical investigation with regard to its impact on resilience, especially with regard to trauma.

The role of social support

It is apparent that the social lives of people are perceived as key factors in understanding the quality of their lives as well as the status of their physical and psychological health and the manner in which they cope with personal and social change (Barrera & Ainley, 1983, p. 133).

Barrera and Ainley's (1983) assertion provides an indication of the attention that social support has received in the literature as being of instrumental importance in determining human resiliency to stressors and general well-being. Accordingly, the construct has invited vast debate regarding both its definition, operationalisation and the manner in

which it functions to minimise stress-related outcomes. Cobb (1976) elaborated on the importance of social support with regard to stress-related outcomes within a working context, intimating that social support is actively involved in protecting individuals from the negative outcomes of acute job stress and strain. Similarly, Greenglass, Burke and Konarski (1996) found support for the utility of social support in specifically minimising burnout as an outcome. According to their findings both supervisor and co-worker support were found to contribute to the prediction of burnout in Canadian teachers. These findings add credence to the investigation of the impact of social support with regard to burnout as an outcome in South African trauma counsellors. This is because they provide evidence that social support may play an active role in minimising the effects of prolonged activity in a human service capacity, thereby influencing the susceptibility of South African trauma counsellors to the experience of compassion fatigue and burnout.

Sarason, Levine, Basham and Sarason (1983) define social support informally as “the existence or availability of people on whom we can rely, people who let us know that they care about, value and love us” (p. 127). In keeping with this view, Hupcey and Morse (1997) argue that the distinctive characteristic of social support is that it is assistance or support provided by individuals who have a personal relationship with the recipient. This specifically implies that the assistance is received from individuals with whom the recipient conducts regular interaction and engages on an emotional level, these forming a specific support network (Sarason, Sarason & Pierce, 1990). Accordingly, Flannery (1990) describes social networks as “the social structures of daily life in which the person is embedded. These might include one’s biological family, extended family, marriage and children, work relationships, church and community links” (p. 598).