

**A PHENOMENOLOGICAL STUDY OF VICARIOUS TRAUMA EXPERIENCED  
BY  
CAREGIVERS WORKING WITH CHILDREN IN A PLACE OF SAFETY IN THE  
WESTERN CAPE**

By

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## **KEYWORDS**

- CAREGIVER FATIGUE SYNDROME
- CAREGIVER
- COMPASSION FATIGUE
- EMOTIONAL BURNOUT
- ONLINE CAREGIVERS
- PLACE OF SAFETY
- POSTTRAUMATIC STRESS DISORDER
- RESIDENTIAL CARE
- SECONDARY TRAUMA
- VICARIOUS TRAUMA



## **ABSTRACT**

Introduction: In past years the occurrence of vicarious traumatization has created great concern within psychiatric nursing practice worldwide (Stead & Dawning 1998). The literature review contributes to the understanding of vicarious trauma by providing evidence of its widespread existence, and the impact on the therapist's personal and professional lives. A need for further research was highlighted.

The aim of the study: was to investigate vicarious trauma experienced by caregivers working with children in residential care, who were victims of sexual abuse or assault. The objectives of the study were: to determine the occurrence of vicarious trauma among caregivers working with victims of sexual abuse or assault; to describe the experiences of caregivers working with children who were victims of sexual abuse; to describe the caregiver's experience of staff support within the facility

The research was conducted at a place of safety within the Western Cape, which provides 24-hour care to the children of both sexes under the age of 7 years who were exposed to sexual abuse or assault, neglect or abandonment. Purposive sampling of nine caregivers was done. The inclusion criteria were: participants (both permanent and contract workers) providing direct care to the children. The study adopted a qualitative method, which focused on exploring the subjective experiences or views of the participants regarding the topic. Semi-structured in-depth interviews were conducted (Appendix 4). Data were analyzed using content analysis.

The conceptual framework: crisis theory guided the description and interpretation of the data.

Findings revealed that the online caregivers experienced the following:

Emotional symptoms: frustration, anger and sense of helplessness due to lack of support from management, lack of communication between management and staff, hearing and seeing the plight and history of children.

Physical symptoms: tight chest, headaches and flu symptoms and low energy levels.

Impact of trauma on their personal and work relationships: The participants experienced work-related tiredness and a feeling of being emotionally drained. This left them vulnerable and less emotionally available to their colleagues.

Support at Work: the participants experienced minimal support from management.

Support at Home: participants experienced sufficient support from the families, friends and church in the community.

The participants made suggestions regarding improvement of support to decrease the physical and emotional symptoms and to improve their effectiveness at work.

The participants proposed the following supportive measures: a good, safe

and healthy environment for the children who are in need of care, training for all staff and team building.

The results indicate that caregivers who participated in the study experienced vicarious trauma. As researcher I am in agreement with the results and recommendation of Steed & Downing (1998), that there is a need for a broader conceptualization of the phenomenon, and the need for further research. Steed & Downing also noted that with the field of traumatology expanding, therapist's education and training becomes top priority.



## DECLARATION

I declare that the mini-thesis is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other University.

BARBARA PHILIDIA RUTH BOOYSEN



DATE

MRS FELICITY DANIELS

SUPERVISOR

## **DEDICATION**

This mini-thesis is dedicated to my family and close friends who supported me during my studies. To my mother Ellen Sophia Booysen for her prayers, support and encouragement. Thank you for the excellent role as a parent.

To a friend, former supervisor and colleague, Eugene Odendaal, for unconditional support, guidance, encouragement. Thank you for being there especially when things were tough.



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## **CHAPTER ONE**

### **ORIENTATION TO THE STUDY**

#### **1.1 INTRODUCTION**

In an investigation of vicarious trauma in the nursing sector / discipline, research literature indicates that vicarious trauma amongst caregivers at places of safety is found world-wide. Personal experience of the researcher while working at a place of safety in the Western Cape, concluded that these disturbing phenomena of vicarious trauma also occur locally.

#### **1.2 FORMULATION OF THE PROBLEM**



##### **1.2.1 Overview of the study site**

The facility identified for the study was established as result of mothers, with babies, who were arrested for contravening the pass laws. The babies could no longer be taken to prison and an alternative placement was needed. The 1976-1980 political upheavals somehow affected the functioning of the facility. In 1980 the facility was moved from one building to another within the Langa area in the Western Cape. Since there were no facilities for black children at the time, the services were extended to accommodate the abandoned, neglected, orphaned and abused children. Thus the place of safety came into existence.

In 1994 the building had undergone extensive repairs and renovations. Despite all the changes it was declared unsuitable. The Department of

Health relocated this service to another building in Langa. In May 2000 the health department vacated the building. A decision was made to close the place of safety but the decision was reversed and the facility moved back to the vacated building. Young as they are, these children's lives are abased by traumatic experiences. The results of the trauma differs from child to child. Some traumas have permanent results while others can be overcome.

Common issues found during admissions are:

- i) single parent families
- ii) being orphaned
- iii) abandonment
- iv) neglect
- v) abuse (physical, sexually and emotionally)

(This history is based on a report from the manager of the facility which participated in the study).

### **1.2.2 Background**

In March 2002, a Child Line social worker in the Western Cape commented that vicarious trauma is a serious and direct consequence of the caregivers' interaction with traumatised children. She recommended that the organisation's management should acknowledge the seriousness of vicarious trauma and provide regular support sessions as well as a safe environment for the caregiver. These, she added, can play an important role in counteracting the effects of the vicarious trauma phenomenon.



In August 2003, the Assistant Director at a place of safety in the Western Cape observed that the increase in vicarious trauma among online caregivers is real and a serious concern. No research has been done regarding the experiences of caregivers or the impact this trauma has on caregivers at places of safety in the Western Cape.

Due to the sensitive nature of the study, the research did not occur at the place of safety where the researcher is employed. The place of safety identified for the study was in a residential setting in Langa, within the Western Cape, which provides 24-hour care to twenty children (20) of both sexes under the age of 7 years. The children who are admitted have been exposed to sexual, physical or emotional abuse, neglect and often abandonment. These children are placed by a court order into residential care. Admission to the facility is normally a term of 3 to 6 months. After 6 weeks in the place of safety an assessment is done to recommend suitable and more permanent placement.

The staffing structure at the place of safety includes a professional support team, an administrative staff component and online caregivers. The professional team consist of two social workers, a professional nurse and a care manager who is a caregiver with management skills.

The online caregivers who provide direct care were non- professional staff with basic childcare training. The online caregivers (9 in total) work in pairs with 12- hour shifts. Their ages range from 36 – 54 years with childcare

experience of 10 – 15 years. The online caregivers do not live on the premises but live in the area where the study was conducted. The professional support team and online caregivers at the facility run programmes to equip the children with skills, which are essential for daily living and appropriate for their age group. These skills include prevention of sexual abuse, general safety, personal hygiene, HIV/AIDS awareness and arts and crafts. The professional nurse, social worker and care manager are responsible for providing support to the staff at the facility.

During the period September to December 2003, caregivers at the place of safety showed signs of more than one symptom of vicarious trauma. The researcher was presented with evidence, which included verbal feedback from the care manager who identified that the staff experienced symptoms of depression, stress and a sense of hopelessness. The care manager had previously arranged a two-day workshop for staff regarding compassion fatigue.

### **1.2.3 Problem statement**

Vicarious trauma, a world-wide phenomena, affects caregivers who are directly involved in the case management of traumatized individuals. In research conducted by Zimmering (2003), it was highlighted that the current state of empirical literature on vicarious trauma among caregivers is in its infancy. This phenomenon therefore requires further investigation.

#### **1.2.4 Research question**

What is the effect of vicarious trauma on caregivers working in a place of safety?

#### **1.2.5 Significance of the study**

Managers of Social Services will be provided with the research report reflecting the experiences of the caregivers working with traumatized children, and the occurrence of vicarious trauma amongst the caregivers. This will alert managers regarding the need for a plan of action to prevent or minimize these phenomena, and as a result prevent the loss of experienced and skilled workers.



### **1.3 AIM AND THE OBJECTIVES OF THE STUDY**

#### **1.3.1 Aim of the study was:**

To investigate vicarious trauma experienced by caregivers working with children in residential care, who were victims of sexual abuse or assault.

#### **1.3.2 Objectives**

The objectives of this study was to:

- determine the occurrence of vicarious trauma amongst caregivers working with victims of sexual abuse or assault
- describe the experiences of caregivers working with children who were victims of sexual abuse or assaults and

- determine the caregiver's views/ experiences of staff support within the facility.

## **1.4 INTERPRETATION OF KEY TERMS**

### **Caregiver Fatigue Syndrome**

Having to deal with more than the caregiver is able to cope with.

### **Caregiver**

Is a person who provides care to someone in order to meet their specific needs.

### **Compassion Fatigue**

Brownbill (2002) reported that compassion fatigue refers specifically to the emotional and physical stress the caregiver experiences when trying to help others overcome obstacles.



### **Emotional Burnout**

Pines & Arrison (1998) stated that emotional burnout is physical, emotional and mental exhaustion caused by involvement in emotionally demanding situations.

### **Online caregivers**

Is staff with basic training in childcare who provides direct care to children on a 24 -hour basis.

### **Place of Safety**

Is a facility/ institution that provides safe conditions for the person in need of care.

### **Post Traumatic Stress Disorder**

It is the effect of exposure to a clearly identifiable traumatic event that threatens the self, others, resources and a sense of control or hope.

### **Residential Care**

Residential care is a service to individuals who need temporary or long term care and who reside at the facility.

### **Safe environment**

For the purpose of this study "safe environment" for caregivers refers to a work environment where staff experience support from management and where staff client ratios make the workload manageable.

### **Secondary Trauma**

Secondary trauma is indirect exposure to trauma. This occurs through exposure to the narrative of a traumatic event.



### **Vicarious Trauma**

Vicarious trauma is the effect of a therapist's/ carers' exposure to other people's trauma.

## **1.5 RESEARCH DESIGN**

This exploratory study, utilising a phenomenological approach, describes vicarious trauma experienced by caregivers working with children in a place of safety. Data was collected by means of semi-structured interviews. A pilot study was conducted at a place of safety that did not participate in the research.

### **1.5.1 Study population**

All online caregivers (9) working at the place of safety.

### **1.5.2 Data analysis**

The researcher made use of a qualitative method to analyse the data. The researcher transcribed the audio-recorded data after the interviews were conducted. Content analysis was used to examine the information and to create a system for recording specific aspects of it.

**1.6 LITERATURE REVIEW:** A literature review was conducted to contribute to the understanding of vicarious trauma, by providing evidence of its widespread existence and the impact on the therapist's (carers) personal and professional life. A need for further research was highlighted. As the field of traumatology expands, the training of caregivers becomes a priority.

### **1.7 LIMITATION OF THE STUDY**

Due to time and budget constraints only a limited study was done at one place of safety in the Western Cape Province. It focussed only on the phenomenon of vicarious traumatization and the impact that it had on caregivers. The interviews were conducted over a period of three months as the participants worked shifts, which included night duty. One participant's interview was conducted by the professional nurse at the facility due to language barrier. (limited English) The participant requested that the

interview be conducted without the audio-recorder. Another participant's interviews had to be rescheduled, as she became emotional due to the trauma experienced, which was never addressed. The participant was referred to the person identified to conduct debriefing.

## **1.8 OUTLINE OF CHAPTERS**

Chapter 1: Introduction and background

Chapter 2: Literature review of the problem

Chapter 3: Research design that will include the pilot study, study population, data collection, data analysis.

Chapter 4: Presentation of data will be discussed with the theory.

Chapter 5: Summary of findings and recommendations



## **CHAPTER 2**

### **2.1 LITERATURE REVIEW**

**2.1.1 Introduction:** In this chapter the researcher gives an overview of the literature that contributes to the understanding of vicarious trauma and a description of crisis theory as a theoretical framework for this study. The literature also differentiates between vicarious trauma, secondary trauma and burnout to clarify what vicarious trauma is and what it is not. The literature was gathered from journal articles, internet and books.

### **2.2 Theoretical Framework: Crisis Theory**

“Crisis theory explains how the people cope with major life crises and transitions. During the crisis period the person may experience separation from families, friends, loss of key roles in his/ her life, distressing feelings of anxiety, guilt, anger and helplessness. With this crisis theory the belief is that the person is more receptive to outside influence at time of disequilibrium” (Moos, 1997:29).

Moos further states that a crisis begins with the person’s cognitive appraisal of the significance of the trauma, that leads to an awareness of the basic adaptive tasks to which the person applies his/her coping skills. “The individual’s cognitive appraisal of his plight, the perception of the task involved, the selection and effectiveness of relevant coping skills are influenced by two major sets of factors:




- a) background and personal characteristics
- b) features of the physical and socio-cultural environment”.

The background and personal characteristics are inclusive of age, intelligence, emotional development, previous coping experiences and religious beliefs (Moos,1997:29).

The caregivers physical and social environment can either contribute towards the stress or acts as a support.

## **2.3 PREVIOUS STUDIES**

### **2.3.1 Vicarious Trauma**

The literature review focuses on the phenomenon of vicarious traumatization, which for this study will relate to the impact of the childrens’ trauma on caregivers. 

There are various understandings regarding the concept of vicarious trauma: As quoted in the Iris Times (2004), “We are all vicarious voyeuristic, technological intruders and consumers of the minutide of misery all over the world on our screen, in our ears, in the immediacy of this information age and it is making us miserable, excavating our atavism, increasing our pessimism and shaking sacred certainties in the concept of civilisations. As a result, many of us are suffering from vicarious trauma”

De Ridder (1997) commented that vicarious traumatization is the name the psychologists and professionals of psychology has given to the phenomenon of becoming traumatised by extended or intense exposure to

the trauma of others.

Brownbill, Stanley & Rourke (2002) commented that vicarious trauma symptoms is seen as similar to posttraumatic stress disorder but the caregiver is the secondary victim and the client as the primary victim.

In research conducted by Steed & Downing (1992), it was noted that studies regarding vicarious trauma have only been emerging in the last few years. During the 1900's Schauben & Frazier's (1995), conducted a qualitative investigation into vicarious trauma on 148 female therapists working with victims of sexual abuse and assault. The results of this case study revealed that higher caseloads of sexual violence correlated with:

- a) more disruptive beliefs,
- b) more symptoms of post traumatic stress disorder,
- c) more self-reported vicarious trauma.

A similar study done by Pearlman & McCann (1995), highlighted the same issues reported by Schauben & Frazier. Both these groups of researchers reported that those who are not familiar with vicarious trauma, experience more psychological problems than their experienced colleagues. McCann & Pearlman further observed that vicarious trauma impacts on four major areas of the therapists' functioning, which include the cognitive schemata, psychological needs, memory and the therapists' frame of reference (Pearlman & Mcann, 1995).

Faber & Hiefert cited in Steed & Downing (1998) stated that previous conceptualisations of the impact of trauma work on professionals include “burnout”. Freme and Fagan (2002) agreed with the previous researchers that a serious consequence of vicarious traumatization is professional burnout.

Steed & Downing (1998) noted that although the phenomenon of vicarious trauma has received a great deal of theoretical and clinical attention, there is a paucity of empirical research investigating the impact of exposure to traumatic clinical materials on professionals working with trauma survivors. Freme & Fagan (2002) commented that vicarious trauma is a malignant process that can have dramatic and dangerous repercussions for the professional. They further noted that the emotional impact the caregiver experienced as a result of the terror and anguish can produce a unique set of symptoms remarkably similar to those of posttraumatic stress disorder. Helplessness, rage, depression, isolation, paranoia and hypervigilance are often present. Research has shown that these feelings of helplessness and being overwhelmed by the scale of unexpected disasters are psychological responses of identification with victims.

Benedek cited in Wain et al (2000) describes vicarious trauma as a counter transference reaction experienced by the therapist as the result of the victim’s retelling of the trauma. Tosone & Bialkin (1982) commented in cases of vicarious traumatization, therapists are forced to see the world

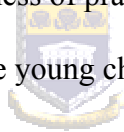
through the eyes of their clients. The effect of it is that this may lead to their unconscious identification with their clients' terror of annihilation, shattering their previous view of a safe world. These researchers recommend that when in these situations, therapists need to become aware of over-identification with clients and take responsibility for their self-care.

A review of traumatology literature revealed that there were only three empirical studies investigating the effects of vicarious trauma on professionals providing services to survivors of sexual abuse or assault.

Riba & Reches (2002) conducted a study to understand the experiences of nurses caring for victims of trauma. The participants of the study expressed the following: being anxious and afraid of what they were going to see; the younger nurses reported they will not be able to perform their job or function properly. The conclusion of the researcher was that the trauma nurses experienced was vicarious traumatization that leads to symptoms of depression and suicidal tendencies, panic attacks and alcohol abuse.

Alexander cited in Wain et al. (2000) suggested that besides the nurses, there is other hospital staff working with trauma victims who may have become hidden victims (occupational therapists, dieticians). Alexander recommended that the hospital administration must recognise the stress placed on the hospital staff who works closely with these victims and that intervention and support is needed.

The Infant Mental Health Promotion Project held a workshop in February 2003, which focussed on supporting practitioners working with young children in high- risk families. This project noted that infant mental health practitioners are frequently confronted with serious family situations, or that they feel helpless, hopeless and unsuccessful. In addition to the trauma experienced by these families this can also trigger trauma within the workers. Since the practitioner is to ensure the well being of the infant and parents, the practitioner may experience anxiety, anger, withdrawal and burnout. The ultimate result of this is that the highly trained practitioners withdraw from this kind of work or remain in employment but become ineffective. The conclusion of this study was that vicarious trauma has a negative impact on the effectiveness of practise of practitioners working with high-risk families, who have young children.



McKean cited in Steed & Downing (1998) conducted a study on police officers dealing with victims of sexual abuse or assault and found that symptoms of posttraumatic disorder were significantly more prevalent amongst police officers dealing with rape than those who deal with civil cases.

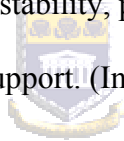
A similar study also cited in Steed & Downing (1998) conducted by Oliver & Waterman on twenty-one therapists, whom five years previously had been involved in treating sexually abused children in pre-school facilities. The study found that the therapists experienced symptoms of posttraumatic

stress disorder as a result of treating the children. Follette , Polunsky & Milback cited in Steed & Downing (1984) examined the impact of providing services to sexually abused survivors and found this to be significant for mental health professionals and police officers. Although these studies provide evidence on the effects of vicarious trauma on caregivers, an in –depth study of vicarious trauma in specific populations is warranted.

An observation made by Fischman & Lyon cited from Wain et al. (2000), was that the therapist’s response to the trauma endured by the clients may affect the therapeutic alliances and ultimately the effectiveness of the clinician. In addition Fischman & Lyon cited in Wain et al. (2000), commented that therapists working with victims who have suffered extreme trauma of torture maybe more vulnerable to intense affective reactions themselves.

Mc Cann & Pearlman cited in Wain et al. (2000) acknowledge that clinicians or caregivers who work with trauma victims may experience vicarious trauma. It is now recognised that practitioners who are repeatedly exposed to trauma and the suffering of others can develop symptoms of trauma themselves. The reaction is known as vicarious or secondary trauma. It was also noted that it is normal to feel vulnerable when listening to other’s pain but hearing it frequently can have serious effects on the practitioner.

Cited in the article “Annotations for bibliography on vicarious traumatization” Crotchers (2002) reported that caregivers working with the client exposed to trauma, and who engage in intense therapeutic relationships, can leave the staff vulnerable to vicarious trauma. Consequential to this exposure, staff reported symptoms of stress, decreased functioning, feeling of hopelessness, loss of faith and security in the world, feelings of vulnerability and incompetence. Vicarious trauma is seen as one of the more serious occupational hazards experienced by caregivers. Recent research has also suggested that the severity of vicarious trauma may also increase due to extensive factors such as cumulative exposure to trauma victims, serious organisational instability, personal problems, high staff attrition, and inadequate social support. (Infant Mental Health Project,2004)



Regehr cited from the Position Paper Infant Mental Health Promotion Project (2004) indicated that the following occupational class showed the highest number of symptoms and degree of traumatic stress: fire-fighters, paramedics and child protection workers. The possible conclusion for this statement is that the child protection workers have to make use of the empathy technique and bring change within families, yet they lack specific training or support for dealing with traumatic stress.

The mutual understanding and agreement of researchers is that therapists who treat trauma survivors/victims inevitably become aware of the

potential for trauma in their own lives and may be coping with their own traumatic experiences. Therapists are encouraged to assess their own experiences and to examine the impact of trauma treatment on their own lives.

### **2.3.2 Secondary Trauma**

Gibson, Swartz & Sandenbergh (2002) reported that it has been established that about 4 % of people will suffer from posttraumatic stress disorder in their lifetime, but the risk of being exposed to trauma and violence increases markedly depending on where you live and your socio-economic status.

Figley (1995) commented that compassion fatigue was the latest concept known in the field of secondary trauma and is seen as a more friendly term.



Pearlman & Saakvitue cited in Steed & Downing (1998), commented that they explored the relationship between the concepts vicarious trauma and secondary trauma and the treatment of clients who have experienced childhood sexual abuse. With several studies, which they have completed, they reported that there were similarities between vicarious trauma and secondary trauma, but that they are different. They identify vicarious trauma as a transformation in the therapist's inner experience resulting from empathetic engagement with the client's traumatic material. Secondary trauma focuses on the symptoms of traumatic stress, but it does not examine the impact on one's self-concept or conceptualisations of the world. The occupational group at risk for compassion fatigue similar to vicarious



trauma for example is police, crisis phone-line attendants. Danieli, Baranowsk & Bloom & Figley cited in Gentry (1997) commented that several theories have been offered but none have been able to conclusively demonstrate the mechanism which accounts for the transmission of traumatic stress from one individual to another. Figley further noted that the caregiver's empathy level with the traumatized individual plays a significant role in this transmission. Danieli, Baranowsk & Bloom cited in Gentry (1997) commented that while compassion fatigue has been written about in the rubric of psychotherapy as emotional contagion passed from client to clinician, there is growing evidence to support the trans-generational and societal transmission of this condition.



Zimmering et al. (2003) reported that empirical literature regarding secondary traumatization amongst caregivers is in it's infancy. The researchers commented that this phenomenon (secondary trauma) is often associated with the cost of caring for others' in emotional pain. Zimmering et al., further postulated that mental health care professionals specializing in the treatment of trauma listened to expositions of extreme human suffering and observed the emotions of fear, helplessness and horror registered by survivors on a constant basis. Counsellors and therapists who work with trauma victims may in time develop posttraumatic stress disorder symptoms themselves. These people are said to be suffering from vicarious or secondary traumatization. Gibson, Swartz & Sandenbergh (2002) noted that there are at least two ways that secondary traumatization can be caused:

- a) Repeated hearing of traumatic events can lead to fear, the questioning of life's meaning, and the feeling of being out of touch with people.
- b) Many people who wish to help those who have been traumatized feel helpless by the responses on the part of those they wish to help.

Recent research done indicates that occupational duties may cause psychological symptoms in the practitioner who is exposed to the survivor's trauma. Zimmering et al., (2003) observed that only 17 peer-reviewed articles on secondary trauma could be found. Of these, only 12 contained quantitative data, whereas the majority of these were descriptive (qualitative) in nature. Langberg (1997) reported that: to walk alongside a survivor, is to be touched by the trauma. Langberg further elaborated that people do not have to be the direct recipient of trauma in order to be traumatised. In Langberg's research, it is reported that those who enter into the trauma of others could experience sleeplessness, nightmares, intrusive images, anxiety, numbing and irritability. Beaton & Murphy cited in Trauma News (1999) commented that emergency traumatic stress and crisis workers absorb the traumatic stress of those in need of help. By doing this, they are at risk for experiencing compassion fatigue.

Schauben & Frazier cited in Zimmering et al. (2003) suggested that the greater the percentage of survivors in a therapist's caseload, the greater the number of secondary trauma symptoms reported. Pelkowitz cited from Figley (1995-2004) who reported from an unpublished study that nurses

working with prisoners in South Africa was especially vulnerable to compassion fatigue. The American Red Cross (2004) reported that disaster workers also have the potential to become 'secondary victims' and the reason for this, is that they are in some cases in physical danger and work long hours.

Struwig (2002) conducted a study in the rural area to establish whether compassion fatigue exists and how to address it. The study population consisted of 25 rural health care workers who attended a workshop on vicarious traumatization and compassion fatigue. A measuring scale developed by Figley & Stamm in the 1990's, named compassion satisfaction/ fatigue self-test for helpers was used. This test was in the form of a questionnaire which was completed prior to the workshop (pre-intervention) and 3 months after the workshop (post intervention). During the workshop a short lecture on intervention strategies and certain exercises were done. The conclusion was as follows:

- a) The risk for compassion fatigue amongst doctors, involved in the study, increased from 85,5 % to 92,3 %
- b) Health care worker's (community workers and nurses) risk for compassion fatigue decreased from 93,2 % to 89,1 %
- c) The results further indicated the doctors needed additional intervention to empower them to take better care of themselves.

- d) The health care workers in general realized their own risks for compassion fatigue and started building in specific actions to manage their risks.

Struwig (2002) was concerned that this field (compassion fatigue, burnout) should be explored more since failure to empower caregivers at the most primary level of health care, will add the ever growing population of professionals experiencing burnout and feelings of failure and incompetence.

Tosone & Bialkin (1982) commented that while there are numerous measures to evaluate posttraumatic stress disorder in clients, there are fewer ways to evaluate secondary traumatic stress disorder or shared trauma in clinicians. Tosone & Bialkin further noted that clinical social workers and other mental health professionals, who deal with the victims' trauma, constantly experience secondary traumatization, where they have reactions similar to those of their clients. They further noted that such secondary trauma forces that clinicians has to deal with is their own personal experiences, and the fact that living in a modern world is unpredictable. In conclusion, an extensive literature search indicated that there is indeed a dearth in research on secondary trauma globally.

### 2.3.3 Burnout

Cited in “ Annotations for bibliography on vicarious trauma and forms of traumatic stress in the workplace of psychiatric nurses “(2002), Jackson commented that burnout is different from vicarious trauma. The term ‘burnout’ is used for lack of an appropriate euphemism. Jackson defines “burnout” as having more than what is possible to carry. Vicarious trauma according to Jackson are symptoms in response to traumatic events. In addition to Jackson’s definition, Maslach & Schaufeli (1993) describes burnout as a process that leads to an emotional exhaustion, depersonalisation and diminished personal accomplishment. Researchers like Maslach, Freudenberger and others cited in Scott (2001) gave the name burnout to the special stressors associated with social and interpersonal pressures ( Maslach & Freudenberger,1997). Blair & Romonies cited in Anderson (2004) describes burnout as complex psychological responses to the stressors of constant interaction with people in need.

The findings of a study done by Gibson et al. (2002) describes burnout as a recognized syndrome, which affects people in the caring profession. Gibson remarked that because professionals give too much of themselves in their work they are unaware of their own needs. Casey cited in Scott (2001)) defined burnout as a unique form of chronic stress. The Journal of Nursing Jocularity (1992) reports that the causative factor for burnout is powerlessness. This idea has become more prominent in current literature

reviews. The journal indicates that powerlessness is not the only cause of burnout, but is however one of the most important contributing factors.

In the Journal of Nursing Jocularity (1992), it is reported that burnout is described as an individual's experience, which is specific to the work context. Thus the research over the past 25 years has maintained a consistent focus on the situational factors that are the prime correlates of this phenomenon. Researchers focussing on burnout have investigated the absence of job resources. The resource that the researchers studied most extensively has been social support, and the conclusion was that a lack of social support is linked to burnout. Lack of support from supervisors is especially important, even more so than support from co-workers (Annual review of psychology 2001).



Schaufeli, Maslach & Marek cited in Scott (2001) agree with the previous researchers that human service providers are described as a population particularly vulnerable to burnout, because of the nature of the interpersonal processes in their work with clients, and the organizational factors that generally accompany community-based social support organizations. According to Maslach & Schaufeli, burnout is composed of dynamic processes and systems, including those that are important to social support and supportive communicative behaviour, within a work group. Gibson as well as Swartz & Sandenbegh (2002) reported that the most frequent result of burnout is people leaving their jobs, which results in a situation where

Human Service organisations lose some of their best and most experienced workers. Several research reviews reveal that there is considerable agreement about the effects of burnout, but considerable disagreement about the cause.

Ainsworth & Fulcer (1981) commented that the problem of job stress and burnout is of special concern in professional childcare workers. The authors further noted that retention of workers and the quality of care provided by many long term workers are well-known problems in this field. Part of the problem is due to widespread, poor selection procedures, training, salaries and working conditions.



A significant contribution, however, also comes from the physical and psychological exhaustion experienced by childcare workers in the caring process. The end product of it appears to be high staff turnover, potential apathy and frustration for continuing workers, and the loss of some especially competent practitioners who are concerned with their effectiveness with children. It was found that although the childcare profession has begun to address the issues of job stress and work burnout, some resistance is still occasionally encountered. The possible reasons for resistance can be due to the arousal of painful memories, a sense of vulnerability and issues of responsibility, many would like to avoid. It can also bring agencies and systems face to face with the need for changes which may be more comfortable and convenient not to confront. Although

a childcare worker has been told of his importance and encouraged towards professional association and training, he is deprived of the economic and psychological circumstances necessary to engage in an exciting and productive career. (Ainsworth & Fulcher 1981)

Croucher (1982) reported that research indicated 25 years ago that clergy dealt with stress better than most professionals. However, he commented that studies in the 1980's in the U. S. indicated that there was an alarming spread of burnout in the profession. Croucher cited the following examples: A study done by Jerdon found three out of four parish ministers (sample: 11,500) reported severe stress causing anguish, worry, bewilderment, anger, depression, fear and alienation. The second example referred to Hart cited in Croucher (1982) describes burnout symptoms as follows:

- 1) Depersonalisation (treating yourself and other in an impersonal way)
- 2) Demoralization (belief you are no longer effective as a pastor)
- 3) Detachment (withdrawing from responsibilities)
- 4) Distancing (avoidance of social and interpersonal contacts)
- 5) Defeatism ( a feeling of being 'beaten')

## **2.4 Summary**

The literature review contributes to the understanding of vicarious trauma differentiating it from secondary trauma and burnout, and through providing evidence of its widespread existence and the impact it has on the therapist's personal and professional life. A need for further research was highlighted.



**2.5 CONCLUSION:** The following will be discussed in chapter 3:

Research design, study population, data collection, data analysis, ethical statement and limitation of the study.



## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

**3.1 INTRODUCTION:** In this chapter the research methodology will be discussed with the inclusion of a brief discussion of the pilot study.

#### **3.2 RESEARCH DESIGN**

This study adopted a qualitative method, which focussed on exploring the subjective experiences or views of the participants regarding the topic that was examined. This exploratory study, utilised a phenomenological approach, which sought to describe vicarious trauma experienced by caregivers working with children at a place of safety. The exploratory research focused on a specific area vicarious trauma, and aimed to obtain new knowledge by describing, comparing and classifying observations; it however did not attempt to manipulate or control the environment or to test interventions (Mouton, 2001). The phenomenological approach was a useful tool as it thrived for creativeness and allowed the researcher to identify a variety of perspectives during the individual interviews.

##### **3.2.1 Pilot study**

A pilot study was conducted at a place of safety that was not involved in the research. Semi-structured, in-depth interviews were done. The participants were directly involved in the care of the children. The purpose

of the study was to test the effectiveness of the questionnaire (reliability).  
No adjustments to the instrument was needed.

### **3.3 STUDY POPULATION**

All online caregivers working at the Place of Safety. All the caregivers were interviewed irrespective of whether they worked night or day duty.

#### **3.3.1 Criteria for participation in the study.**

- Only the staff who provided direct care to the children participated (shift workers).
- Both contract and permanent caregivers were included.



### **3.4 SAMPLE INPUT**

The online caregivers were all from a similar cultural background; they however had different support systems in place. The online caregivers who provide direct care are non- professional staff with basic childcare training. The online caregivers work in pairs and 12-hour shifts. Their ages range from 36-54 years old, with childcare experience of 10- 15 years. They do not live on the premises but live in the area where the study was conducted. Purposive sampling of all nine caregivers was done.

Purposive sampling is a type of non-probability sampling in which participants were selected because they were knowledgeable regarding the subject that was under investigation.

### **3.5 DATA COLLECTION**

Data was collected between the months of August- October 2004 at the Place of Safety in the Western Cape. Before commencing with any interviews at the facility chosen for the study, an introductory and information session was held with the caregivers and management of the facility to explain the purpose of the investigation, to clear up potential areas of misunderstanding, and to gain the cooperation of the staff, who were familiar with the children at the facility. (Appendix 2) The researcher made an appointment with staff on night duty to obtain their permission (Appendix 3) and explain the purpose of the study. Time was allowed for discussion and questioning.

### **3.5.1 Procedure**

The care manager at the facility identified all the online caregivers as participants. The researcher made appointments with the staff when on duty via the care manager. Each participant was seen individually. The interviews were conducted during the day and night after hours with prior arrangement with the care manager. Semi- structured in-depth interviews were conducted with the participants. An interview guide was used during the interview. (Appendix 4) The researcher was essentially the sole data collector. When one participant could not speak English, the professional nurse conducted the interview with the consent of the participant and translated the content of the interview into English. The researcher went through the interview schedule with the professional nurse before the interview, to ensure that she was clear regarding what was expected. During

the interviews the researcher explored specific responses, that led to further discussion. The data was captured using an audio-cassette recorder. Notes were taken at the time where questions were explored. Permission to make notes was obtained from the participant and they were reassured of confidentiality (the researcher explained to the participants there would be note taking at times for the purpose of clarity). The audio-tape was useful as it allowed the researcher to focus on the participant.

The participants were allowed to show evidence of pain during the interviews and the expertise of the researcher enabled her to recognise the pain and responded appropriately. The care manager and professional nurse of the facility agreed to be available to the participants after the interviews for debriefing. The participants who were not comfortable talking to them, were encouraged and assisted in arranging appointments with external counselling services that was made available by the department at no cost to the participants.

One participant's interview was stopped as she became too emotional as a result of reliving the trauma she experienced in the past, which was not dealt with. The participant was referred to the care manager for the debriefing.

The researcher was tolerant to the tensions that arose from the participants during the individual interviews. One of the participants experienced great anger during the interview and the researcher had to probe, assess and refer before being able to continue with the interview. Data collection was completed when all relevant information was collected.

### **3.5.2 Instrument**

Semi- structured in-depth interviews were done. An interview guide of open-ended questions was used (Appendix 4). Formulation of the questions was guided by the literature review and the objectives of the study. The interview guide contained questions regarding years of work experience, likes and dislikes of the work environment, absenteeism, support systems (Appendix 4). The interview guide was used in the pilot study. No adjustments were made to the instrument.

**3.5.3 Debriefing:** Uys & Middleton (2004) described debriefing as a form of crisis intervention that is used with groups of individuals who had experienced a stressful or tragic event.

Treece & Treece (1986) commented that participants who were debriefed after a study were less likely to regret taking part in a research study than those that were not debriefed. Debriefing sessions with the participants was held once the individual interview was completed. The professional nurse and the care manager at the Place of Safety were appointed for the task. They helped the participants cope with any negative feelings arising out of their experiences during the study, especially if they had been exposed to difficult situations of suffering, abuse or deprivation. The participants were also encouraged to access the ICAS Program (employee assistance program) which is available on a 24-hour basis to the staff from Social Services.

## **3.6 VALIDITY AND RELIABILITY**

### **3.6.1 Validity**

The researcher conducted semi-structured in-depth interviews with study subjects who actively constructed the features of their cognitive world. In this study the in-depth description of the data enhanced the validity of the study. The researcher adequately identified the parameters and established boundaries for the study. The questions that were used in the interviews were derived from the literature and the objectives of the study. The researcher, as far as possible, tried to obtain inter-subjective depth during the individual interviews in order that a deep mutual understanding was achieved.

The researcher was a listener, as the participants provided the majority of the research input. The same questions were used for all interviews and the researcher was the sole data collector with the exception of one interview where the caregiver was not comfortable with English. This participant was interviewed by the professional nurse. Being the sole data collector, with the exception of one, was advantageous since it ensured consistency in the use of interviewing methods and techniques (Smith 1994). During the data analysis extensive quotations were extracted from the transcripts of the interviews (Ratcliff 1995). The participants were informed that the transcribed data would be made available to them for verification and to give them the opportunity to respond to, or retract any or all of the recorded data if so desired. The researcher made the transcribed data available to her supervisor for checking. The researcher included all the primary data into

the final report. The inclusion of primary data in the final report allowed the reader to see exactly the basis upon which the researcher's conclusions were made. Comparing the personal notes from the beginning to see how data has changed from initial assumptions, allows for the identification of divergence from initial expectations. The researcher wrote accurately, since incorrect grammar, misspelled words, inconsistent statements could jeopardise the validity of a good study (Wolcott 1990).

### **3.6.2 Reflexivity**

As the approach to reflexivity is drawn from the humanistic approach, as a researcher I became self-conscious and self-questioning to enable me to formulate and reflect on my actions during this study. As a researcher I became aware within myself of what was happening and what can be done in the future regarding the specific study. It allowed me to explore new possibilities, explain apparent conditions and hidden dimensions regarding the self, social world and the individual. It also created an opportunity for me as the researcher to see how I can contribute to the construction of social and organisational realities and how to relate to others. With self-reflexivity the researcher was able to examine herself in terms of her values in the process of critical consciousness. As a researcher reflexivity assisted me to see beyond pre supposed assumptions and frameworks (Cuncliffe & Jun, 2002).



### **3.6.3 Reliability**

To ensure reliability and to meet the objectives of this study, the researcher defined the concept vicarious trauma and attempted to link the concept to the 'real world' (a place of safety). The researcher maintained objectivity to ensure that personal views had no influence on the participant's input.

During the individual interviews with the caregivers the questions were repeated for clarification. As noted in Treece and Treece (1986), evidence from data is only reliable to the extent that a person can be confident that similar findings would be obtained if the collection of data were repeated under identical circumstances. The researcher ensured the reliability by multiple listening of the audio-tape (Ratcliff 1995). The researcher was able to demonstrate to the participants that the data was not misinterpreted.



### **3.7 DATA ANALYSIS**

The researcher made use of a qualitative method to analyse the data. After the collection of the data, the researcher listened to the tapes several times to have a clear understanding and be able to identify themes. The researcher transcribed verbatim the audio-recorded data after the interviews were conducted. Each cassette was transcribed manually by an individual who signed a confidentiality agreement. The researcher read through the study notes and made comments in the margin that contained notions about what the researcher could do with the different parts of the data. Content analysis was used to examine the information and to create a system for recording

specific aspects of it. The process of labelling the various kinds of data and establishing an index was to be the first step in content analysis.

After the data was transcribed and read, the researcher listened to all the tapes again and read the notes taken during the interviews to make sure all data was captured. The researcher already had some predetermined themes according to the questions of the interview guide (Appendix 4). The data was encoded to facilitate the identification of common themes. The questions were tabulated and all the responses of the participants to the specific questions. This was to assist in the process of establishing if there were similarities to the participants' responses. After the data was completed under the headings of the questions, the researcher could start with the writing up process where the responses were identified according to the themes. After the data was written up, the notes taken during the interviews were burnt. Removing the tape from the cassette destroyed the cassettes.

### **3.8 ETHICAL STATEMENT**

#### **3.8.1 Permission to conduct the study**

Written permission to conduct the research was obtained from the Department of Social Services and Poverty Alleviation and the facility manager where the study was conducted. Written permission was also obtained from the manager and the participants at the facility where the study was conducted (Appendix 1).

### **3.8.2 Right to confidentiality**

As mentioned, participants were introduced to the topic of vicarious trauma prior to the study. The participants were well informed about the research process, research duration and schedule and how the results would be used and published. The researcher ensured that when the participants agreed to participate in the research project their anonymity was maintained and that no data would be associated to a person. When data was written up no names were attached to the results or responses. Participants were ensured of their privacy. Interviews were conducted in a quiet and private environment at the Place of Safety. The researcher did not collect more data than what is absolutely necessary. The researcher ensured that the participants' self-respect and dignity was maintained. Measures were in place to avoid any possible psychological or physical harm to the participants. The participants were able to withdraw from the research process at anytime regardless of whether the participant agreed to participate in the study. An agreement was that the results would be discussed with the participants before been given to management.

### **3.9 LIMITATION OF THE STUDY**

Due to time and budget constraints only a limited study was done at one place of safety in the Western Cape Province and focussed on the phenomenon of vicarious traumatization and the impact that it has on the caregivers. The participants of the study experienced problems with identifying their feelings.

**3.9.1 Timing of the data collection:** The data collection could only be done between August- October 2004 which included after hours, due to work commitments (night and day duty).

**3.9.2 Language used during the data collection:** All the interviews were conducted in English with the exception of one participant whose interview was conducted in Xhosa and translated by the professional nurse into English.

### **3.10 CONCLUSION**

This chapter dealt with the research methodology. Chapter 4 will focus on the presentation of data and the discussion.



## **CHAPTER FOUR**

### **DATA PRESENTATION AND DISCUSSIONS**

In this chapter the researcher will discuss the results according to the themes identified and the findings will be related to the theoretical framework identified for the study.

#### **4.1 Introduction**

The semi-structured in-depth interviews were conducted within 3 months (August to October 2004). All the participants met the inclusion criteria: all online caregivers (permanent and contract workers), day and night duty staff.

The participants consisted of nine caregivers who provide direct care to the children at a place of safety. The caregivers provide 24-hour care to twenty children of both sexes under the age of 7 years. A semi-structured interview guide (Appendix 4) was used to collect data during the interviews. During interviews the researcher explored specific responses, which led to further discussion. The data collection was based on the caregivers describing their experiences of vicarious trauma while working with children in a place of safety.

The researcher made use of a qualitative method to analyse the data. The data was transcribed manually. Content analysis was used to examine the information and to create a system for the recording of specific aspects. The

data was coded to facilitate the identification of common themes.

#### **4.2 SIGNIFICANCE OF CRISIS THEORY AS A THEORETICAL FRAMEWORK**

Crisis theory explains how people cope with major life crises and transitions. The individual's understanding of the crisis, their perception of tasks involved, and the selection and effectiveness of relevant coping skills are influenced by two major sets of factors as described by Moos (1997).

The caregivers physical and social environment can either contribute towards the stress or acts as a support. The caregivers' physical and social environment includes the work and home environment. Support includes: facility support and communication from management, community, family, friends. Support from management can be through counselling, supervision or support sessions.



The relevance of this theory in terms of the background and personal characteristics of caregivers is that they work 12-hour shifts. They do not live on the premises but in the area where the facility is located. The caregivers spend most of their time at work and when off-duty are involved with community work in the area. The caregivers have been working at the facility for a period of 10-15 years. The main function of the caregivers is to care for the children who are admitted due to physical or sexual abuse, neglect and abandonment.

When the children are admitted to the facility, they are physically and or emotionally neglected (poor nutrition, sores on body, dirty, crying, fever)

and as the facility is a short term placement (6 weeks to 3 months) the caregivers have to improve the personal hygiene, nurture and heal the wounds of the child before the child is transferred to another permanent placement.

As the caregivers spend most of their time at the facility (12-hour shifts) and in the same community on their days off, their physical and socio-cultural environment will to a large extent be related to the facility and community.

When taking into account the coping skills of the caregivers, it is relevant to note that they (caregivers) felt that they did not receive support from management. The effectiveness of the caregiver's social environment to assist the participant in the crisis will have an effect on their coping mechanism and determine the outcome of the trauma experienced. The caregiver's responsibility to cope will be determined by their understanding of the trauma and their perception of the environmental and personal factors (being confronted with the place/environment where the trauma occurs). How and what the person will use to cope and adapt will determine the outcome of the crisis. All these elements together with the caregivers experience will determine the outcome of the crisis, which in turn may change the initial personal and environmental factors.

### **4.3 EMERGING THEMES:**

It was established that most of the participants were absent from work between 2 days and 2 weeks during 2003.

#### **4.3.1 Experiences at the facility**

Most of the participants, when asked to describe their experience at the facility regarded it as positive. They enjoy caring for the vulnerable children, are able to see positive changes from the time they are admitted to the time they are discharged.

They treat each child as an individual with unique needs.

As one participant responded *“I enjoy caring for them by nurturing, bathing, feeding and doing activities with them”*.

*Another said: “I feel good by treating them as my own, giving them love and spoil(ing) them with sweets ”.*

#### **4.3.2 Symptoms experienced by caregivers when ill.**

Participants were asked to describe the symptoms they experienced and how these symptoms affected their functioning at home and work. The physical symptoms are related to their experience of the trauma of the children and their work environment.



#### 4.3.2.1 Emotional Symptoms

Gabriel (2001) commented that in their examination of trauma survivors at work, they found that continued exposure to a person actively experiencing trauma may result in permanent shifts in the practitioner's cognitive schemata. Gabriel further noted that the cognitive changes include heightened feelings of vulnerability, extreme sense of helplessness and or exaggerated sense of control, chronic suspicion about the motives of others, loss of sense of personal control and chronic bitterness.

This is in line with what one participant said: “ *I feel frustrated when working under pressure, short staff (when) and no consultation with management or supervisor occurs*”.

And the response of another: “ *When the management don't communicate with the staff regarding their performance, changing of off duties: as a caregiver you feel frustrated, anger, sense of no worth and bitter* ”.

The frustration that was directed at management was related to participant's awareness that they are unable to change the client or participant's situation at the facility.

When asked what the participant enjoyed least of their jobs, one participant responded “*To keep working with these children is very difficult from time to time. You meet with different children and at the same time they are short term at the facility and future placement is foster care or children's home and it is tough and you feel sad* (when they leave)”.

Another participant further noted “ ***that the children are admitted with their mouths that are swollen and full of pus and you as the caregiver try to clean their mouths and help with the healing process. And when the healing process occurred the child is discharged to a permanent place***”.

This frustration seemed to be directed towards others: parents/families, management and society in general.

Another response was “ ***the children are babies, toddlers, who are abused, sexually and physically, abandoned, neglected by their parents and families and they are unable to say how they feel and that the legal system does not protect their children enough***”.

The participants alluded to the fact that their high workload and lack of support systems influenced their emotional symptoms as they experience strain. The Mental Health Promotion Project: vicarious trauma in the workplace (2004), commented that the workplace strain depletes coping mechanisms and workers are more vulnerable to vicarious trauma. Most of the participants related their emotional symptoms to being withdrawn, frustrated, angry and fearful as a result of being short staffed, receiving no support from management and existing miscommunication.

A participant reported fear of not being able to protect the children at all times. This is related to an incident when a baby died at the facility.

The participant’s response was as follows: “***I wasn’t able to save the child***”

***and help him not to die even when he was ill”.***

Other symptoms used to describe the emotional experiences when off sick, included fear and nightmares. Some participants experienced flashbacks of trauma that occurred that year (burglaries, death of a baby, poor condition of children on admission).

Pearlman & Saakvitne cited in Steed & Downing (1998), commented on this in the statement that a therapist’s self-protected belief about safety, control, predictability and attachment are challenged through working with trauma survivors.

As the researcher I experienced that the participants had the need to express their emotions, for example: cry or express anger, and yet be professional. During the interviews the researcher experienced that most of the participants were aware of their strong feelings of anger, frustration and demotivation, but one caregiver felt it would be disloyal to their employer to allow these feelings to surface. In relation to the crisis theory the participants alternative way of coping was to withdraw or be angry which resulted in them experiencing nightmares and anxiety, indicating an occurrence of vicarious trauma.

This study is in agreement with Pearlman & Saakvitne (1995), who suggested that vicarious trauma has an impact on both personal and professional domains of functioning.

#### 4.3.2.2 Physical symptoms

The majority of the participants experienced physical symptoms such as headaches, flu symptoms, tight chest, sore chest, sinusitis, dizziness, low energy levels, physical tiredness due to the staff shortage.

Two participants responses regarding the physical symptoms were:

***“ I went to the doctor because I had headaches and sinusitis that caused me not to concentrate and work as I usually do. My work performance was not good ”.***

The second participant said ***“ I had a headache and had no energy to do anything at home and work ”.***



Most of the participants mentioned that they experienced physical symptoms as described by De Ridder (1997), including headaches, stomach pains, insomnia and aggressive behaviour.

A participant said ***“I shouted at my child when she did not do as I told her. I just wanted to sleep and be alone and forget everything”.***

Participants were further probed on how these symptoms affected their functioning at work. The following response was given:

*“ I was angry and felt aggressive and just wanted to resign immediately because they (management) didn’t consult me with (before) changing my duties”.*

Annscheutz (1999) noted a few mild symptoms including headaches, colds, muscle aches, physical fatigue and more serious symptoms for example asthma, coronary heart disease, heart attacks, diabetes, inability to perform one’s job and experience a positive personal life. Crisis theory indicates that the caregivers ability to cope will be determined by their understanding of the trauma and the perception of the environmental and personal factors and that the outcome will depend on the person’s coping and adaptation skills. The participants were able to identify their feelings and the origin of it, but were however unable to change it. As a result they experienced physical symptoms (headaches etc.) and often used sick leave to recover or as a means to cope.

A participant responded *“ I went to the doctor with a sore, tight chest and was diagnosed with asthma in March 2003”.*

#### **4.3.3 The Impact trauma had on personal and work relationships.**

Most of the participants experienced work-related tiredness and a feeling of being emotionally drained. This impacted on their interpersonal relationships, leaving them vulnerable and unable to support their colleagues and families who also often experienced emotional strain.

#### **4.3.3.1 Impact trauma had on relationships at work**

A participant reported being anxious and afraid to report for night duty due to the trauma she experienced, which was not dealt with (death of baby & burglarly).

The response of the participant was “ *I am scared of coming on night duty because I have flashbacks of the dead baby and the burglaries*”.

Others responded to the question of how it affected them at work as follows: “ *I was physically and emotionally tired and just wanted to sleep and not wake up. I could not help my children with their school work at home as I felt depressed* ”.

“ *I was so angry for (at) management for not consulting with me regarding changing my (off) duties, that I wanted to give up and resign*”.



The participants also experienced being demotivated, withdrawn, having low moral, tired and not being energised to perform their tasks on duty. These symptoms are similar to those identified by De Ridder (1997), which included being overwhelmed, demoralised, withdrawing from friends and families, fear and distrust of others. The results are also similar to those found by Schauben & Frasier cited in Zimmering et al. (2003), who in a study with female therapists working with victims of sexual abuse/assault. They found: more disruptive beliefs, more symptoms of posttraumatic stress disorder and more self-reported vicarious trauma.

#### **4.3.3.2 The impact trauma had on relationships at home.**

When the researcher asked participants to describe the impact their experiences had on their relationships at home, she sensed that participants might have minimized the impact of the symptoms.

A participant responded: “ *I experience headaches and it makes my head spin but when I am at home I can cope and these symptoms is in my head*”.

Another participant responded: “ *I experienced my chest is tight at work but when I am at home it was better*”.

The researcher is in agreement with Crotchers (2002), who reported that caregivers working with the client exposed to trauma, can become vulnerable to vicarious trauma. Crotchers further noted that due to this exposure, the staff reported symptoms of stress, decreased functioning, feeling of hopelessness, loss of faith and security in the world, sense of vulnerability and incompetence.

Crisis theory is influenced by two major sets of factors which is the features of the physical and socio-cultural environment. As the caregivers spends most of their time at the facility (12-hour shifts) and in the same community on their days off, their physical and socio- cultural environment would to a large extent be related to the facility and community. When taking into account the coping skills of the caregivers, it was relevant to note that the impact the trauma had on their relationship at work, indicated that they did not experience support. The outcome of the crisis was that they experienced frustration, anger, fear at work. Their method of coping was

being afraid to report on night duty (flashbacks) and at home the participants were unable to care for their children and withdrew from society.

#### **4.3.4 Support systems**

Annual Review Psychology (2001) commented that their researchers have investigated the absence of resources in the experience of burnout. The resource that has been studied most extensively has been social support. There is a consistent and strong body of evidence that a lack of social support is linked to burnout. Sufficient support from supervisors is especially important, even more so than support from co-workers.



Within literature regarding social support, there is also a “buffering” hypotheses that suggests that social support should moderate the relationship between stresses and burnout, i.e. the relationship will be strong when social support is low but weak when support is high.

##### **4.3.4.1 Support Systems at work.**

One participant’s response relating to support she received from the management when she experienced a personal crisis was as follows “*I received counselling when I had a crisis. My daughter was raped and later I lost my sister and management supported me*”.

Another participant’s response regarding the support, and whether it was adequate: “*Management only talk(s) a little (seldom) to the staff especially when you do something wrong and not when you do*



*something right”.*

Majority of the participants were of the opinion that the support from management was zero to minimal, but has improved since the end of 2003 due to the appointment of a supervisor in the care section.

A participant’s response to the improvement of support “ *The supervisor encourages us and say(s) well done, don’t worry things will get better at work”.*

Although most of the participants are in agreement that support has improved they feel that major improvement is needed.

A participant’s response to this was as follows “ *The management must say when we do good things and not only talk to us when we do things wrong”.*



Annual review of Psychology (2001) has commented that support from supervisors is important and a lack of it is linked to burnout.

#### **4.3.4.2 Support systems at home/community**

The participants responded to the question regarding outside support systems as follows:

- i) **Church-** Most of the participants experienced their church involvement as positive. They were able to give and receive support from the minister and members. One participant’s response to the question was “ *I am involve in church choir where I help kids staying*

*out of trouble in the community by teaching them how to sing, which I enjoy very much”.*

*“The church minister supports me by listening, encouraging and praying for me when things are difficult at work”.*

**ii) Friends/peers:** The participants were able to identify a specific friend whom they could talk to and who supported them.

One response was as follows *“ My friends will listen, comfort and encourage me when I am down and not feeling happy”.*

**iii) Family:** The participants experienced support from their siblings and children. One participant said *“ I am able to speak to my twin sister who will listen to me when I want to talk about my problems at work”.*

Most of the participants experienced that they were able to talk to their children rather than the spouses as they feel some of them are understanding and supportive.

As one said *“ My daughter who is big will continue with the house hold duties if she sees I am tired (when) coming from work.”*

The observation made by the researcher from the interview regarding home/community support was that the participants referred more often to support from friends rather than from their husbands/partners.

In relation to the crisis theory, the effectiveness of the caregiver’s social environment was their ability to assist the participants in the crisis. The participants were assisted by the church, family and friends, with coping in

the difficult situation and the outcome was that they experienced support. However, support with their work environment, where they spent 12 hours per day, was regarded as minimal. Literature indicates that support from supervisors is even more valuable than support from co-workers (Annual Review Psychology, 2001).

All the participants were sensitised to the importance of maintaining support systems. The need to develop techniques to maintain healthy eating, exercise habits and self-care was encouraged.

The participants proposed the following supportive measures to be implemented by management, to enable them to provide a good, safe, healthy environment for the children who are in need of care and to improve the work environment for the employees:



- Training for all staff. (including management)

A participant's response regarding this was "***Management needs to attend workshops that will skill them to deal with the staff***".

- Improve communication between management and staff (open door policy/ verbal & written communication)
- The need to improve confidentiality
- Recognition of excellent work under the given circumstances.

A participant's response was "***Management must tell us and write down in the book when we do things well and praise us so that we can feel good and needed at work***".

- Ensure sufficient staff for all sections (care staff can only focus on

care for the children and not work in the laundry or cook food).

As one participant responded:” *I don’t want to work under pressure and if someone is not on duty to (have to) care for the children, make food and do the laundry* ”.

- Improve team work

In relation to the theory their coping skills depended on the two major sets of factors. The outcome of the crisis at work is that the participants experienced the support as minimal that that led them being vulnerable and experiencing physical symptoms. Their coping skills was reinforced in the community with their church and family who allowed them to function effectively due to the support they received. Within the community the participants experienced a sense of fulfilment as they were affirmed.

The proposed support measures are in agreement with The Mental Health Promotion Project: vicarious trauma in the workplace (2004) which noted the following: workloads and pressures for services have increased while opportunities for adequate training, support and supervision have decreased.

#### **4.4 Conclusion**

The results indicate that the caregivers who participated in the study experienced vicarious trauma including emotional burnout, compassion fatigue and secondary trauma. The results highlighted specific physical and emotional symptoms which the participants experience as a result of vicarious trauma, and the effect these symptoms have on their functioning and relationships. The researcher agrees with Steed & Downing’s (1998),

results and recommendations, that there is a need for a broader conceptualisation of the phenomenon, and the need for further research. They also noted that with the field of traumatology expanding, therapist education and training becomes a top priority.

In chapter five a summary of the findings will be given and the recommendation will be discussed according to the themes in chapter four.



## **CHAPTER FIVE**

### **SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATION**

#### **5.1 INTRODUCTION**

In this chapter the recommendation will be made according to the themes discussed in chapter 4. The aim of the research was to investigate vicarious trauma experienced by caregivers working with children in residential care, who were victims of sexual abuse or assault. The end result of the research is to ensure that the Department of Social Services and Poverty Alleviation, management of the facility and caregivers do not deny the existence of vicarious trauma. Management of the facility needs to have a framework to address difficulties caregivers experience within their work environment.

The researcher is in agreement with Gibson, Swartz & Sandenberg (2002), who state that one of the most important factors that improves an organisation's ability to cope with stress, is the amount of support it can offer to its members. These researchers further noted that support should be built into the structures of the organisation itself, and the task spread across a number of people.

They further noted that it is important that the organisation must warn and protect their staff against the possibility of vicarious trauma and to offer the necessary support.

Tompson (2003) contributed a valuable suggestion that caregivers must make sure that they are:

- mentally healthy
- interact in positive ways with colleagues
- stay flexible and be ready for the unexpected
- learn to know resources and people within the community to whom they can make referrals.

## **5.2 SUMMARY OF FINDINGS**

### **5.2.1 Emotional symptoms**

The impact of vicarious trauma on the participant can be divided into emotional and physical responses. The responses were derived from the question regarding the participant's description of the symptoms they experienced when ill.

The response of the participants towards hearing the history of the children, caring for the babies and toddlers who were admitted in a neglected condition, being short staffed and not being supported by management included frustration, anger, sadness, demotivation, anxiety, fear, lack of concentration, etc. The anger was mainly directed towards management of the facility.

The frustration directed at management was also related to the participant's awareness that they were unable to change the client or participant's

situation at the facility. The participants also verbalised that their workload and support systems influenced their emotional responses as they experienced emotional strain.

### **5.2.2 Physical symptoms**

The physical symptoms were related to the participants' exposure to the trauma of working with the children and work environment. The majority of participants experienced physical symptoms such as headaches, flu symptoms, tight chest, sore chest, low energy levels and were physically tired due to shortage of staff at the facility.

### **5.2.3 The impact which trauma had on personal and work relationship.**



#### **5.2.3.1 Impact of trauma at work.**

Most participants experienced work related tiredness and a feeling of being emotionally drained, which impacted on their interpersonal relationships, leaving them vulnerable and less emotionally available to their colleagues and families. The participants experienced being demotivated, withdrawn, low moral, tired and not being energised to perform their tasks on duty.



### **5.2.3.2 Impact of trauma at home**

Figley (1995) commented that hardly anyone believes that someone's trauma could turn them into a victim's as well. Most of the participants experienced the following: sleepiness, unable to concentrate or assist with their children's homework, not motivated to do anything, shouted at their children, withdrawn and wanted to be alone.

### **5.2.4 Support systems**

#### **5.2.4.1 Support systems at work.**

Response by participants regarding support from management, is that major improvement is warranted.

#### **5.2.4.2 Support systems at home/community**

Church, friends and family: Most of the participants experienced their church involvement as positive as they feel they can contribute to their community. The participants could identify specific friends and siblings they can talk to.

Some of the participants did not experience their spouses to be supportive and rather received the support from their children.

The participants made suggestions on how management can improve their support to create a good, safe, healthy environment for the children who are in need of care and improve the work environment of the caregivers.

### **5.3 RECOMMENDATION AND DISSEMINATION OF FINDINGS:**

#### **5.3.1 Self-awareness and self care**

A feedback session will be held at the place of safety. The findings of the study will be presented to the participants and a copy of the research report will be made available to them. The results of the study will also be submitted to the Department of Social Services with strong recommendations for the implementation of developmental and support programs which will address the mental, spiritual, emotional and physical needs of the caregivers at places of safety. The staff support program must include emotional support groups, assessing job satisfaction through questionnaires and in service training to identify and manage trauma experienced by staff.



Several literature have described how caregivers can protect themselves against vicarious trauma, emotional burnout, secondary trauma and a need for clear boundaries of the caregiver's personal and professional activities. The researcher agrees with other researchers including Mcann, Pearlman, Frazier & Schaul (1995), who suggested that clinicians need to take the same advise they give their clients, to nurture themselves and maintain their health through adequate nutrition, rest and exercise.

Caregivers must develop skills and hobbies that they can do on off days (the cost should not be too taxing on caregivers).

They further noted that personal therapy is highly recommended so that the caregiver/ therapist can stay aware of his/her own trauma history and vulnerability.

The caregiver must be taught how to identify and manage instances where they are vulnerable.

The caregivers must allow themselves to grieve when things happen to them and others for example, when children are discharged or in cases of a death.

Caregivers must learn to have a balanced life with other professional activities that provide opportunities for growth and renewal.

Caregivers must learn or be taught to be open in accepting short-term treatment where needed. Seek brief treatment plans to resolve symptoms by using an external resources. Tosone & Bialkin (1982) commented that when therapists experiences vicarious trauma, they need to become aware of over-identification with clients and take responsibility for their self-care.

Given that caregivers do not receive any formal training, the Department of Social services and Poverty Alleviation should consider an intensive induction programme to make potential caregivers aware of these suggestions. Furthermore each facility should allow space in their programme where activities of “caring for the carers” can be done, for example when children are discharged or in cases of death, the carer who has bonded with such a child requires care.

### **5.3.2 Improving the work environment**

The caregivers need a support system to deal with issues and to discuss their feelings and concerns in a trusting environment. This can be addressed by:

- Utilizing the service of professional support staff within the staff component. This service must be available at any time during the day.
- Regular (weekly) informal support meetings and debriefing sessions are necessary. Work of excellence can also be acknowledged during these meetings.
- Ensure that there is sufficient staff compliment on duty to minimize the level of work stress.
- Ensure that staff take annual leave.
- A staff satisfaction questionnaire should be completed by the caregivers on a monthly basis to determine their level of satisfaction regarding support.
- The physical environment must be improved. Ensure that there is a room that is conducive for the caregivers to spend their break times. Caregivers must be encouraged to take a break during their 12 hour shift.



### **5.3.3 Training and Supervision.**

Ongoing training for caregivers is needed, to enable them to work effectively with the children.

New staff should be included in an induction program to be able to share new ideas/ knowledge and to clarify the unknown.

Regular case discussions should be seen as a valuable training session, supportive measures should be included in the program for the staff to

provide direct care to the children. During these sessions caregivers can be given guidance on how to care for the children.

Quarterly meetings should be held related to legislation relevant to the workplace for example child abuse protocol, minimum standards, etc.

Awareness of best practise creates a safe environment in which the caregiver can work.

Opportunities should also be created for training in the form of workshops offered by other agencies for example, those related to HIV/AIDS etc.

Staff should be encouraged to develop themselves professionally within their discipline.

Ensure regular direct supervision. Supervisors must be allocated to small groups of caregivers. This enhances teamwork.



### **5.3 Recommendation for further research:**

As a researcher of this study I was able to confirm that caregivers employed at places of safety are as vulnerable as the social worker and police officers in the community. Awareness levels has also increased relating to vicarious trauma. This is evident at places of safety and that people are unable to deal with it appropriately (pilot study included)As a researcher I would strongly recommend that the Department of Social Service expands this research to the other places of safety within the Western Cape. This is confirmed by the literature review.

A recommendation would be that the facilities criteria for recruitment, interviews of caregivers should strongly include in the interviewing process to identify the support systems the applicant has. This will determine if the

applicant will be able to function effectively within the facility with the admission of the children (background). All new appointments should be included within a induction program that will include resources on how to identify and manage vicarious trauma. If these basic needs of the caregivers, yet essential are met, the person will be able to give more of him/herself.

#### **5.4 CONCLUSION**

The results of this study is supported in the article: “ Annotations for bibliography on vicarious traumatization” (2002), where Crotchers states that vicarious trauma is seen as one of the more serious occupational hazards experienced by caregivers. He further commented that the severity of vicarious trauma might also increase due to extensive factors such as cumulative exposure to trauma victims, serious organisational instability, personnel problems, high staff attrition, and inadequate social support all of which the researcher of this study has provided recommendations. A feedback session will be held with the place of safety who participated within the study. The results of the study will be submitted to the Department of Social Services with a strong recommendation for developmental programs which will address the needs of the caregivers at places of safety.

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## **APPENDIX 1: REQUEST FOR PERMISSION TO CONDUCT STUDY**

The Facility Manager  
Langa  
7800  
29.10.03

**Manager at the facility/ Micromanager at Department of Social Services and Poverty Alleviation**

### **REQUESTING PERMISSION TO CONDUCT A RESEARCH AT A PLACE OF SAFETY**

I am currently a M Cur Advanced Mental Health student at the University Western Cape, Nursing Department. My research study focuses on **vicarious trauma** among caregivers at Places of Safety. My request is to conduct a research at your place of safety. The focus would be on caregivers who provide direct care to the children.

The interviews will be conducted when the participant is on duty with prior arrangement with the supervisor. Participants will be interviewed individually. Arrangements will be made for debriefing after the interview. The results of the research will be made available to you before any information is published.

I would appreciate it if the management would favourably consider the request.

Thanking you in anticipation.

(Ms) B.P.R. Booysen  
MCUR Advance Mental Health Student

## **APPENDIX 2**

### **Information sheet for participants.**

**Title:** A phenomenological Study of Vicarious Trauma Experienced by Caregivers working with children in Places of Safety.

**Researcher:** Barbara Booysen

Mcur Nursing University of the Western Cape

As a Masters (Nursing) student at the University of the Western Cape, I am conducting a research study as part of my degree. My research proposal was submitted and accepted by the University of the Western Cape's Higher Degrees Committee. I wish to investigate vicarious trauma experienced by caregivers working with children in residential care, who were victims of sexual abuse or assault.

I will be audio-taping the individual interviews of the caregivers. These tapes will be transcribed and, on completion of the study, will be destroyed. Your name will not appear in the transcripts of the interviews, or in any reports relating to the research. The individual interviews will take place when each participant is on duty. After your taped individual interviews are transcribed to paper, you will be shown a copy, which you may read, and you may make changes to your responses if you wish.



Before participating, you will be asked to complete a form, which indicates your willingness to participate. You may withdraw from the study at any stage without being disadvantaged in any way. You are free to speak with others before consenting to participate in this study.

After the interviews the professional nurse and care manager at the facility will be available for a debriefing session.

Barbara Booysen  
MCUR Advance Mental Health Student

**APPENDIX 3**

**Participants Consent Form**

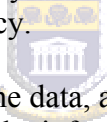
A Phenomenological study of vicarious trauma amongst caregivers working with children in a Place of Safety

Name of Person to be interviewed .....

Date of consent .....

Name of interviewer .....

I agree to participate in the research and understand that this will be an individual interview. I will be given the opportunity to read the transcript of my interview and be given opportunity to confirm it's accuracy.



I understand that the confidentiality of the data, and the need to anonymise data will be respected during the research itself, but the information collected may be used within a database for the proposed support services at Places of safety.

If at some stage I choose to withdraw from the study I may do so without redress, although an indication explaining my decision, if volunteered, would be welcomed.

I have received both verbal and written information and agree to participate.

Signature of consent

Date


.....

.....

## APPENDIX 4

### Individual Interview guide

Title: A Phenomenological Study of Vicarious Trauma experienced by caregivers working with children in a Place of Safety.

- 1) How long are you working at the facility?
- 2) What do you enjoy most about your job?
- 3) What do you enjoy least about your job?
- 4) Have you been absent from work during 2003? What was the longest period you were absent?  

- 5) What were the main reasons for your absenteeism?
- 6) If you were ill, describe the symptoms you experienced?
- 7) How did these symptoms affect your functioning at home and at work?
- 8) What according to you was the cause of these symptoms/ your illness?
- 9) Do you think the work you do at the Place of Safety contributed to the development of these symptoms and why?
- 10) Describe your experience of working with the children at the Place of Safety?

11) Do you receive any support from your employer to cope in the work environment?

12) If support is offered, what type of support do you receive?

13) Do you regard the support, if any, adequate?

14) What suggestions do you wish to make to the management team to improve the support within the facility?

15) Which other support systems outside of the work environment do you have available to you?

