Vicarious traumatization amongst lay-counsellors, working with adult survivors of sexual abuse

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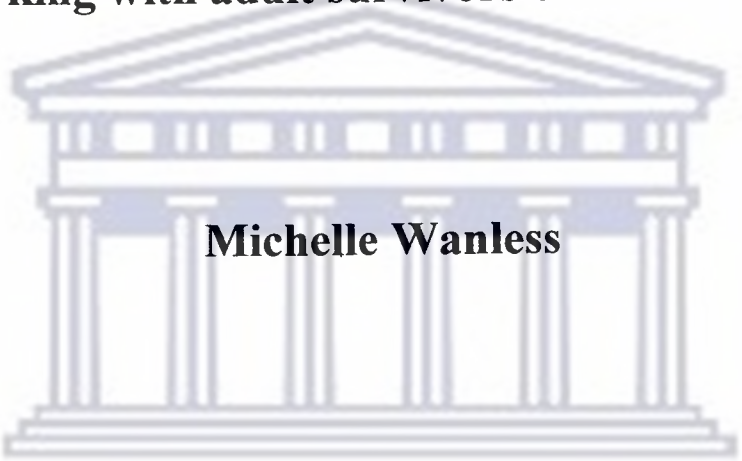

Submitted in partial fulfillment of the requirements for the degree of Mpsych (Counselling) in the Department of Psychology, University of the Western Cape

Bellville

August 2002

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DECLARATION

The author hereby declares that this whole thesis, unless specifically indicated to the contrary in the text, is her own original work.

Signature

25/08/02

Date

ACKNOWLEDGEMENTS

I would like to thank Professor Neil Broekmann for his for his assistance throughout this project. His encouragement and expertise were greatly appreciated.

I would like to thank Sven Welzel for his statistical assistance and The Traumatic Stress Institute (particularly Laura Ann Pearlman) for allowing me to use the Traumatic Stress Institute Belief Scale as well as allowing me to reproduce pertinent literature.

Most importantly I would like to thank the lay-counsellors who participated in this study for providing invaluable information regarding the experiences of their work. I hope the research will be of use to them and their organizations.

Last but not least, I would like to thank my husband for his love, encouragement and continued support.

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ABSTRACT

The literature on vicarious traumatization suggests that when counsellors engage empathically with clients' trauma material deleterious effects on the counsellor result. The present study explored the effects on lay counsellors of working with adult sexual violence survivors, looking at the relations among nature of the work, personal characteristics and vicarious traumatization. Further, qualitative data explored counsellor perceptions of the effects of working with survivors and coping strategies. Thirty-six counsellors and volunteers from Rape Crisis and the Comfort Room Project were asked to complete a questionnaire containing the Traumatic Science Institute Belief Scale, Impact of Event Scale, and demographic information. In addition, counsellors were asked to list negative and enjoyable aspects of their work as well as various coping strategies utilised. The data were analysed using descriptive statistics to assess the level of vicarious traumatization (indicated by distress responses and disruptions in cognitive schemas) and step-wise multiple regression analyses to investigate which of the specific demographic variables significantly predicted intrusion symptoms, avoidance symptoms and disrupted cognitive schemas. In addition, analysis of responses to the open-ended questions consisted of frequency counts of identified themes. Results indicated that counsellors were experiencing moderate symptoms of distress reactions as well as disruptions in their cognitive schemas. Comparisons of the TSI sub-scales revealed that counsellors were experiencing the least disruption in the area of self-esteem and the most disruption in the area of other-safety. Relationships between some personal and work related factors and vicarious traumatization were revealed. With regard to personal factors a high level of education acted as a protective factor against both distress

responses and disrupted cognitions and having personal therapy acted as a protective factor against disrupted cognitions. In addition, being older and having a personal trauma history were risk factors for disrupted cognitions. With regard to the nature of the work supervision acted as a protective factor against distress responses and disrupted cognitions, while working more hours acted as a risk factor for disrupted cognitions. In addition, having a higher caseload acted as a protective factor against disrupted cognitions but as a risk factor for distress responses. Qualitative findings not only supported the quantitative findings but also expanded on them to include broader considerations of factors involved in trauma work thereby suggesting that the conceptualisation of vicarious traumatisation could be limited and that the development of more comprehensive research instruments is needed. The study highlights the importance of support, on both an organisational and individual level, for rape trauma counsellors as well as the need to address broader systemic issues.

CHAPTER 1

GENERAL INTRODUCTION

1.0 Introduction

South Africa is a country in which violence is endemic and within this context violence against women appears one of the obvious ways in which it is carried out. Rape statistics in South Africa indicate that for the year 1998 there were 49 280 reported rapes nationwide, 4 851 sexual assaults and 179 incest cases giving a total of 54 310 sexual crimes reported in that year. Within the Western Cape alone there were 6 204 rapes reported within that year (SAP, in Rape Crisis, 1998). These statistics are not however a true reflection on the incidence of rape within this country as the definition of rape is narrow and in addition it is estimated that only 1 in 20 rapes are reported (Rape Crisis, undated). A study undertaken by the Institute of Security Studies (1999) revealed that 41 per cent of women did not tell anyone about their experiences of violence and that only 29 per cent of women did tell someone but that this was usually not officially reported to the police. Given the above estimations Rape Crisis in Cape Town believes that the true figure for crimes of a sexual nature could be over one million per annum (Rape Crisis, 1999).

Survivors of rape often experience negative physical, behavioral, and psychological effects (Rape Crisis, 1999) and there is a large demand for psychological services to address these issues. There are a number of non-governmental organizations (NGOs) that play an important role in providing services to survivors of sexual trauma. Rape Crisis is an NGO that deals with issues of violence against women and provides a free counselling service offered by volunteer lay-counsellors who have been trained by the

organization to help survivors overcome their abusive experiences. The Comfort Room Project has been set up by the South African Police where lay-counsellors have been trained by Rape Crisis to counsel women who are reporting incidents of rape.

Due to the traumatic nature of the material it is important to consider the negative effects of working with sexual crime survivors on the counsellors, so that effective interventions against the effects of this epidemic may be ensured. One term to have come out of the literature referring to the effects of working with trauma survivors is vicarious traumatization and is defined by Pearlmann and Mac Ian (1995, p. 558) as the 'transformation that occurs within the therapist as a result of empathic engagement with the clients' trauma experiences and their sequelae'. Further, studies have found that providing care to trauma survivors does have negative effects particularly with regard to helpers becoming susceptible to developing traumatic stress symptoms (Cornille & Meyers, 1999; Horowitz, 1974; Lansen, 1993; Lundin, 1995; Miller, 1998; Pearlman & McCann, 1995; Schauben & Frazier, 1995).

To date there is little empirical research examining the impact of exposure to traumatic material on counsellors working with trauma survivors (Schauben & Frazier, 1995; Steed & Downing, 1998). Within the South African context there are only two studies, that the author is aware of, that relate specifically to counsellors' responses to trauma work (Hendricks, undated; Moosa, 1992). Therefore there has been limited investigation to instruct our understanding and intervention in vicarious traumatization.

1.1 Rationale for the study

Unaddressed vicarious traumatization is detrimental to the counsellor and all of his or her relationships, both personal and professional. Due to the fact that vicarious traumatization affects the self of the counsellor it has the potential to emerge in the therapeutic relationship directly. Therefore it is important to identify and address the risk of vicarious traumatization in order to understand its effects on doing trauma work and on the survivors (Pearlman & Saakvitne, 1995).

In addition, the researcher herself is personally interested in the field of trauma counselling. Having volunteered as a Rape Crisis counsellor for two years she became aware of the stresses placed on trauma counsellors and the resultant high turnover rate of counsellors. It is hoped that a greater understanding of vicarious traumatization will guide the designing and implementation of training and on-going support programmes to improve ways of coping with trauma work.

1.2 Overview of chapters

The remainder of this thesis is organized into four chapters as follows. Chapter 2 starts by presenting a broad overview of the concept of trauma and then looks specifically at the physical, behavioural and emotional reactions that survivors of rape may experience as well as the challenges faced by people undertaking rape counselling. It then discusses the various conceptualisations of the effects of trauma work on the counsellor by reviewing the terminology found within the field of help-induced trauma. The chapter provides a definition of vicarious traumatisation and highlights some of the theoretical underpinnings of the construct. It then provides an overview of the existing literature on the effects of

trauma work on counsellors. It concludes with an overview of the rewards inherent in trauma work as well as various coping strategies counsellors utilise in order to ameliorate the negative effects of trauma work. Chapter 3 describes the methodology employed by the present study to collect and analyse the data. The chapter begins by identifying the participants in the present study and the procedures followed in order to carry out the research. It then provides a description of the overall research design used, as well as presenting the research tools – the Impact of Events Scale (IES) and the Traumatic Stress Institute (TSI) Belief Scale, describing the sub-scales and psychometric properties of each instrument. The chapter also details the methods used to analyse the data and the ethical considerations followed during the study. Chapter 4 reports on the quantitative and qualitative results that emerged from the present study's analyses. Chapter 5 discusses the limitations of the study and provides an explanation of the main findings. It further discusses the practical implications of the results as well as recommendations for future research.

1.3 Chapter summary

This chapter started by discussing the rape epidemic in South Africa, highlighting the stresses placed on counsellors who work within the field of sexual trauma and the need for further research. The chapter then describes the significance of the study as well as the rationale for the research undertaken. Finally, it concludes with an outline of the content of the remaining chapters.

CHAPTER 2

LITERATURE REVIEW

2.0 Introduction

This chapter begins by looking at how trauma affects victims, highlighting some of the common responses of adult survivors of sexual abuse and rape and then moves on to discuss the terminology within the broader field of help-induced trauma. The chapter will then provide a definition of the phenomenon of vicarious traumatization, highlighting the theoretical underpinnings of the construct. It will then highlight some pertinent research focusing on the negative effects of trauma work, as well as pointing out a lack of research, both abroad and in South Africa, specifically with regard to counsellors working with survivors of rape and sexual abuse. Finally, the chapter will look at the rewards of engaging in trauma work as well as highlighting ways of coping with the negative effects of the work.

2.1. Trauma

Herman (1998) holds that psychic trauma occurs when an individual is exposed to a traumatic event that overwhelms the normal systems of care that give people a sense of control, connection, and meaning and renders the victim helpless. When post-traumatic stress disorder was first included in the diagnostic manual, traumatic events were described as events that occur "outside the range of usual human experience", implying these events are rarely experienced (American Psychiatric Association, 1980). This disorder presumes that the person experienced a traumatic event, involving actual or threatened death or injury to themselves or others. Unfortunately, this definition has proven to be inaccurate as various forms of sexual and domestic violence are common

experiences for women (Brown, 1995). Therefore Herman (1998, p.33) believes that traumatic events are extraordinary rather because they "overwhelm the ordinary human adaptations to life".

In addition to the presence of a traumatic event three symptom clusters make up the diagnostic criteria for post-traumatic stress disorder, if they persist for longer than a month after the traumatic event and cause clinically significant distress or impairment. According to the American Psychiatric Association (2000) the symptom clusters constitute intrusions (where the traumatic event is re-experienced), avoidance (where the survivor tries to reduce exposure to stimuli that might bring on their intrusive symptoms) and hyperarousal (physiological signs of increased arousal, such as hyper vigilance).

Baldwin (1995) states that trauma symptoms can be adaptive and evolved to aid with recognition and avoidance of dangerous situations. Herman (1998) also highlights the fact that human responses to danger are adaptive in that they mobilize the person for strenuous action. She points out that the response to danger is complex, involving an integrated system of reactions, encompassing both body and mind. Threat arouses the sympathetic nervous system (resulting in a state of alertness), increases attention and evokes intense emotions. However, traumatic events go beyond stress reactions designed to mobilize a flight or fight response. Because the normal threat responses are not useful in such situations they remain in a changed and exaggerated state and have a profound effect on physiological arousal, emotion, cognition, and memory (Herman, 1998).

Eagle's (1993) review of the literature on post-traumatic stress underscores the complexity of the phenomenon and highlights the range of perspectives from which it

could be understood. She highlights the fact that some authors focus on the neurophysiology of trauma and posit that trauma disrupts neurological pathways and memory patterns (Perry 1993a, 1993, b; van der Kolk & Fisler, 1995; van der Kolk, 1998). These authors believe that traumatic life experiences have an impact on the parts of the brain involved in mediating stress responses. Baldwin (1995) reports that animal studies on severe or chronic trauma suggest the possibility of permanent physical damage to the hippocampus and changes in the amygdala. Others conceptualize traumatic stress responses as a form of maladaptive learning (Foa, Steketee & Osalov-Rothbaum, 1989; Keane, Zimering & Caddel, 1985). Still others view traumatic stress as an anxiety or dissociative disorder accompanied by psychiatric symptoms (American Psychiatric Association, 2000). Eagle (1993, p.4) argues that the complexity surrounding understandings of post-traumatic stress arises from its unique epistemology, which she defines as " a form of disturbance representing an interface of externally and internally based psychopathology". Where on the one hand distress is linked to an external stressor that evokes largely universal responses, and on the other hand the nature of the stressor evokes unique primitive responses linked to unconscious fears, temperament, prior history and subjective interpretation of the stress (Baldwin, 1995; Eagle, 1993). The latter helps to explain how people react differently to similar stressors and why some survivors develop post-traumatic stress, while others do not. For example, Baldwin (1995) notes that depression, dissociation and somatoform disorders are seen in some populations after exposure to traumatic experiences. He believes that individual differences related to subjectivity will affect both the severity and type of symptoms experienced.

2.2 Rape counselling

Brownmiller (1975) sees rape as a hostile act of violence, which involves the invasion of the body by force, as well as the violation of physical, emotional and rational integrity. Therefore, rape and sexual abuse can be defined as an overwhelming stressor and exposure to such events will invariably lead to negative psychological consequences for the survivor. Rape Crisis has prepared an information package that describes the physical, behavioural and intense emotional reactions that survivors of rape may have to cope with (Rape Crisis Information Package, undated). According to this literature rape is usually experienced as life threatening and as an extreme violation of a person. Rape Trauma Syndrome is the medical term given to the response that survivors have to rape (a particular kind of post-traumatic stress disorder). The physical symptoms experienced include sleep disturbances and eating disturbances amongst many others. The behavioural symptoms include tearfulness, difficulty concentrating, restlessness, withdrawal, avoidance, hyper vigilance, sexual disturbances, an increase in the use of substances and denial. The psychological symptoms include intrusive thoughts, flashbacks, nightmares, fear, anger, depression, shame and guilt, alienation, loss of control, loss of self-respect and loss of confidence (Burgess & Holmstrom, 1974; Katz & Mazur, 1979; Rape Crisis, 1999). The counselling provided by Rape Crisis and The Comfort Room Project offers survivors an opportunity to deal with these intense reactions by way of them being able to utilize the counselling relationship.

There has been extensive interest with regard to the psychological consequences of traumatic experiences for victims (Figley, 1985, 1988; Horowitz, 1976) with less of a focus on the consequences for the trauma therapist. According to Nelson (1997), it is through the process of empathic understanding that the nature of the material will affect

counsellors and he believes that due to the counsellors' role as witness, they will take in some of the pain experienced by the survivors. Figley (1995) supports the notion that empathizing with trauma survivors may increase counsellors' vulnerability to personally negative responses, which he terms compassion fatigue. Therefore there is a need to explore and understand the effects of trauma counselling on the counsellor. With regard to rape counselling specifically, Koss and Harvey (1991) warn that this type of trauma work is often challenging and emotionally intense due to the strong emotions experienced by the survivors. In addition, the counsellors working for Rape Crisis and the Comfort Room project engage in crisis counselling, which is regarded as more stressful than more long-term trauma work. Talbot, Dutton and Dunn (1995) believe that three specific factors make trauma crisis work more stressful: limited amount of time for individual intervention, lack of control over many aspects of the crisis situation, and the urgency and immediacy of the response.

2.3 Terminology

In order to understand some of the possible effects of rape counselling on counsellors, broader developments within the field of help-induced trauma will be reviewed. Previous conceptualisations of the impact of trauma work on counsellors have included burnout (Farber & Hiefetz, 1982; Freudenberger, 1974), and countertransference (Danieli, 1980; Singer & Luborsky, 1977). Maslach and Jackson (1986) define burnout as a syndrome comprising three components: emotional exhaustion, depersonalization, and reduced feelings of personal accomplishment. Symptoms of burnout include boredom, discouragement, loss of compassion, cynicism, and depression (Freudenberger & Robbins, 1979). Factors that contribute to its manifestation include professional isolation (Bermak, 1977) and a reduced ability to cope with one's environment because of the

ongoing stress of daily living (Maslach, 1982). Countertransference has traditionally been defined as the activation of the therapists' own unconscious conflicts, which involve the reactivation of the therapists' early experiences and memories (McCann & Pearlman, 1990). Within the traumatization literature it has been broadened to include the painful feelings, thoughts and images that may accompany the work. For example, Danieli (1981) found the following countertransference reactions among therapists working with Holocaust survivors: guilt, anger, grief and mourning, shame, numbing, denial and avoidance. Thus burnout generally focuses more specifically on the nature of the stressor or the external event and countertransference generally focuses on the personal characteristics of the therapist (McCann & Pearlman, 1990). According to Stamm (1997), the reaction to trauma work among therapists was originally subsumed under the construct of countertransference. However, McCann and Pearlman's (1990) paper highlighted some of the life-pervasive effects of working with trauma survivors and they suggest that the term countertransference is too narrow as it fails to address lasting pervasive schema alterations (McCann & Pearlman, 1990; Neuman & Gamble, 1995; Pearlman & Saakvitne, 1995). Black and Weinreich (1998) also believe the term to be too limited as it fails to explain the attack on the sense of self that trauma counsellors experience. Moreover the above two terms can be linked to any difficult client population.

Due to the fact that trauma counsellors are exposed to emotionally disturbing images of horror and cruelty when working with trauma survivors, the potential effects are considered distinct from those of working with other difficult client populations. Common terms in the literature that refer specifically to effects of working with trauma victims are compassion fatigue (Figley, 1995), secondary traumatic stress (Munroe, 1991, cited in Munroe, 1998), empathic strain (Wilson & Lindy, 1994), and vicarious traumatization

(Pearlman & Mc Ian, 1995). Secondary traumatic stress relates to the pathological response of being exposed to another's trauma and manifests as a syndrome almost identical to post-traumatic stress disorder (Figley, 1995). Stamm (1997) suggests that secondary traumatic stress is the broadest term, with the other terms serving as specific types of secondary traumatic stress. There are differences in how each of these authors conceptualize the effects of trauma work on the counsellor, however, the common denominator relates to the conclusion that trauma work results in negative counsequences for the persons providing the care. Pearlman and associates believe that vicarious traumatization is conceptually different from other trauma terminology as their approach does not merely focus on symptoms but includes a more holistic understanding of the impact of trauma on the counsellor (McCann & Pearlman, 1990; Pearlman & Mc Ian, 1995; Pearlman & Saakvitne, 1995). The present study uses the concept of vicarious traumatization as the construct was primarily derived from the work within the trauma area of sexual abuse (Steed & Bicknell, 2001).

2.4 Theoretical framework: vicarious traumatization from the constructivist self-development perspective

Pearlman and Saakvitne (1995, p.31) define vicarious traumatization as:

"... the transformation in the inner experience of the therapist that comes about as a result of empathic engagement with clients' trauma material".

Vicarious traumatization is based on a constructivist self-development theory, which states that the role of meaning and adaptation is more important than focusing exclusively on a set of symptoms, i.e., the individual is considered holistically. McCann and Pearlman (1990) synthesized contemporary psychoanalytic theories (self-psychology and object relations theory) with social cognition theories in order to provide a

developmental framework for understanding survivors' experiences of trauma and the impact of trauma therapy on the therapist. According to this theory an individual's adaptation to trauma is viewed as complex interactions between personal characteristics, aspects of the traumatic event, and social or cultural variables (Pearlman & Mac Ian, 1995). Constructivist self-development theory can be viewed as an interactive model as it holds that therapists' reactions to trauma material are influenced by both characteristics of the work situation and by their unique psychological needs and cognitive schemas. According to this theory the incidence and manifestation of vicarious traumatization comes about through the interplay of the counsellors' characteristics (personal trauma history, professional development, coping styles) with aspects of the work situation over time (nature of the material, work setting, social-cultural context). Pearlman and Saakvitne (1995) state that it is due to the complex interaction between these variables, that the effects of vicarious traumatization are unique to each individual. This assertion is supported by Steed and Downing (1998), who found that therapists' responses to trauma work differed depending on a number of factors relating to both their clients and to themselves.

The theory posits that the effects on counsellors will be pervasive and accumulative, whereby long-term exposure to traumatic material could result in disturbances in the counsellors' basic schemas about the world (Pearlman & Saakvitne, 1995), such as dependency/trust (therapists could become more distrustful or cynical of others), safety (heightened sense of vulnerability), control (feelings of helplessness and depression), independence (restriction in freedom of movement), esteem (sense of anger at loss of perception of others as benevolent), and intimacy (sense of isolation). Schemas are cognitive manifestations of psychological needs and the authors believe that the unique

way in which trauma is experienced, is partly a function of the specific schemas that are central for the individual. McCann and Pearlman (1990) believe that cognitive schemas are sensitive to disruption when a discrepancy between the client's traumatic memories and the counsellor's existing schemas emerge and any alterations are reflected in the perspectives counsellors may develop. In addition counsellors may also experience symptoms of post-traumatic stress disorder, which include intrusive thoughts and strong affective reactions such as anger. In line with primary survivors the nature, longevity and severity of these symptoms differ from person to person. Therefore, the theorists believe that working with trauma material will cause counsellors to experience lasting changes in their cognitive schemas, which will affect their feelings, relationships, and life. McCann and Pearlman (1990) further assert that vicarious traumatization impacts on counsellors' self-capacities, frame of reference, ego resources and memory system. For example, therapists who bear witness to accounts of victimization may internalise their clients' memories and in the process have their own memory systems altered.

Table 1 summarises the aspects of the self that are impacted upon by psychological trauma, as set out by Pearlman and Saakvitne (1995). They believe that specific areas within the trauma therapists will be impacted upon by the nature of their work and that there will be individual differences as to how each of these areas are impacted. So just as trauma has the capacity to change its victims, exposure to traumatic material has the capacity to permanently change those bearing witness to it.

TABLE 1

Constructivist Self Development Theory: Aspects of the Self Impacted by Psychological Trauma

Frame of Reference

Framework of beliefs through which the individual interprets experience; includes:

- World view
- Identity
- Spirituality

Self Capacities

Abilities that enable the individual to maintain a sense of self as consistent and coherent across time and situations; intrapersonal; includes ability to:

- Tolerate strong affect
- Maintain positive sense of self
- Maintain inner sense of connection with others

Ego Resources

Abilities that enable the individual to meet psychological needs and to relate to others; interpersonal; includes two types:

- Resources important to the therapy process
  Intelligence, willpower and initiative, awareness of psychological needs, and abilities to be introspective, to strive for personal growth, and to take perspective

- Resources important to protect oneself from future harm
  Abilities to foresee consequences, to establish mature relations with others, to establish boundaries, and to make self-protective judgements

Psychological Needs and related Cognitive Schemas

- Safety

The need to feel secure and reasonably invulnerable to harm by oneself or others

- Trust

The need to have the confidence in one's own perceptions and judgement and to depend on others

- Esteem

The need to feel valued by oneself and others, and to value others

- Intimacy

The need to feel connected to oneself and others

- Control

The need to feel able to manage one's feelings and behaviours as well as to manage another in interpersonal situations

Memory System

- Verbal
- Affect
- Imagery
- Somatic
- Interpersonal

SOURCE: From T*rauma and the Therapist* by Pearlmann and Saakvitne (1995, p62)

2.5 Effects of trauma work

As mentioned previously, there has been extensive interest with regard to exposure to trauma on survivors. As early as 1978, Figley suggested that people who provide care for trauma survivors (family, friends and professionals) are susceptible to developing traumatic stress symptoms or responses. There is now quite substantial literature supporting the notion that traumatic exposure does have negative effects for workers who help trauma and disaster survivors. These people include psychologists and other mental health professionals, as well as emergency workers – i.e., paramedics, police officers, firefighters, search and rescue teams, etc. Studies that investigated the effects of trauma work and exposure to trauma material found that helpers often present with the same range of symptoms as victims. These symptoms include post-traumatic stress disorder, anger, fear, suppression of emotions, feeling isolated, nightmares, disturbed sleep, flashbacks, irritability, anxiety, alienation, feelings of insanity, loss of control, emotional exhaustion, depressive symptoms, dissociative symptoms, and suicidal thoughts (Beaton &Murphy, 1995; Cornille & Meyers, 1999; Dunning & Silva, 1980; Dyregrov & Mitchell, 1992; Horowitz, 1974; Kassem-Adams, 1995; Lansen, 1993; Lundin 1995; Lyon, 1993; Miller, 1998; Munroe, 1998; Pearlman & McCann, 1995; Raphael & Wilson, 1994; Schauben & Frazier, 1995; Steed & Bricknell, 2001; Talbot et al., 1995). Although most research has found these symptoms to be at a sub-clinical level the presence of these symptoms certainly raises concern with regard to the well being of the helpers and the clients they serve.

In line with Pearlman and Saakvitne's (1995) claim that vicarious traumatization has the potential to cause lasting changes in the trauma therapist, Steed and Downing (1998) found a variety of negative effects of doing trauma work, which they believe may have a

pervasive impact on the helper's functioning in both personal and professional domains. They interviewed psychologists and professional counsellors working with sexual abuse or assault survivors. They found that therapists' responses to traumatic material were predominantly affective - anger (against the perpetrator and societal inhumanity), pain, frustration (directed at other as well as self), sadness, shock, horror and distress. Physiological effects included diminished energy levels, somatic complaints and sleep disturbance. Changes in cognitive schemas were also found, which included loss of faith in humanity, increased sense of vulnerability and change in sense of identity. Results also pointed to increased suspiciousness and distrust. Similarly, Cerney (1995) found that the effects of trauma work influenced the therapists' personal life, resulting in withdrawal and emotional problems.

The susceptibility to traumatic stress symptoms is not only limited to people who are directly involved with caring for the survivor but to anyone who is exposed to traumatic material (Baldwin, 1995). For example, Alexander, Chesney, Marshall, Campbell, Johnson and Wright (1989) found that the reactions- anger, nightmares, fear of injury, and sleep disorders- of five female nurses to coding rape research were parallel to those reported in the literature on rape survivors. Similarly, Urquiza, Wyatt, and Goodlin-Jones (1997) found that researchers who had worked with data related to victims of violence manifested vicarious stress responses.

The above studies show consistent findings with regard to the fact that trauma work could result in negative consequences for the helpers and that the effects of exposure to trauma material often parallel those found among the survivors. However, as Munroe (1998) points out, studies have shown mixed findings related to identifying protective

factors for trauma workers. As described by constructivist self-development theory, vicarious traumatization comes about via the qualities of the helper and the nature of the work over time to produce unique outcomes. Studies investigating the personal characteristics (age, gender, education, trauma history and personal therapy) of helpers that may influence vicarious traumatization have produced mixed findings. For example, several studies have found the presence of higher levels of symptoms for helpers with a personal trauma history (Cunningham, 1996; Cornille& Meyers, 1999; Kassam-Adams, 1995; Moran & Britton, 1994; Pearlman & Mc Ian, 1995). While other studies did not produce the same findings (Follette, Polusny & Milbeck, 1994; Munroe, 1991, cited in Munroe, 1998; Green, undated; Schauben & Frazier, 1995). With regard to education, both Green (undated) and Aylward and Green (undated) found a significant negative relationship between levels of vicarious traumatization and level of education attained, suggesting that participants with a high school education were more vulnerable than those who had attained a higher level of education. Cornille and Meyers (1999), Kassam-Adams (1995), and Martin, Mckean, and Veltkamp (1986) found higher traumatic stress responses in female rather than male trauma workers. Therefore with regard to personal characteristics personal trauma history seems to be a risk factor, however inconsistent findings invite further study of this variable. Education (a higher level) and gender (male) appear to act as protective factors.

Studies investigating the nature and extent of trauma work (hours, years, caseload and supervision) are summarized below. Pearlman and Mc Ian (1995) found that current (large caseload and hours) and accumulative (number of years) factors are linked to increase risk of stress responses in helpers. This finding has been replicated by several studies (Chrestman, 1995; Cunningham, 1996; Dunning & Silva, 1998; Hodgkinson &

Shepherd, 1994; Moran & Britton, 1994; Schauben & Frazier, 1995). Pearlman and Mc Ian (1995) found that newer trauma therapists experience more trauma symptoms than more experienced therapists. This finding is consistent with the burnout literature, which highlights the fact that young, inexperienced therapists show higher levels of burnout than their more experienced counterparts (Ackerly, Burnell, Holder & Kurdek, 1998; Deutsch, 1984; Gilliland & James, 1995). Pearlman and Mc Ian (1995) also found that therapists working for the shortest time and having no supervision had the highest scores relating to cognitive disruptions. Cornille and Meyers (1999) found that level of exposure on a short-term basis is more significantly correlated to symptoms than number of years working within a particular field. Steed and Bricknell (2001) found that therapists with the least and most experience reported higher levels of trauma responses, than those with a mid-range of exposure. However, some studies were unable to replicate these findings. For example, Munroe (1991, cited in Munroe, 1998) did not find a significant correlation between experience and symptom levels and Follette et al. (1994) found that caseload was not predictive of trauma symptoms. Therefore with regard to the nature of the work supervision seems to act as a protective factor. There have been inconsistent findings with regard to the constructivist self-development theory hypothesis that current (large caseload and hours) and accumulative (more hours) factors increase the risk of stress responses in helpers. From the above, it is clear that further research is needed in identifying contributing variables that may predict vicarious traumatization and thereby reduce risk, as well as protective factors that may ameliorate the effects of trauma work.

Furthermore, additional research relating to the population of the present study seems warranted, as although there has been substantial theoretical and clinical attention regarding vicarious traumatization, there is a paucity of empirical research examining the

impact of counsellors of working with sexual abuse and sexual assault survivors. To the author's knowledge there have only been four empirical studies investigating the effects of providing services to sexual abuse or sexual assault survivors. Martin, McKean, and Veltkamp (1986) investigated the effects on police officers of working with sexual assault survivors and found that post-traumatic stress disorder symptoms were more prevalent amongst officers who worked with rape survivors than those who did not. Oliveri and Waterman (1993) undertook a retrospective survey of twenty-one clinicians who had been working with sexually abused children in a preschool setting. Therapists reported that they had experienced post-traumatic stress disorder symptoms as a result of treating the children. Follette et al., (1994) studied secondary traumatization amongst 225 mental health professionals and 46 police officers providing services to childhood sexual abuse survivors. They found the impact of exposure to traumatic material to be significant for both mental health professionals and police officers. Schauben and Frazier (1995) undertook a quantitative and qualitative investigation of vicarious traumatization in 118 female therapists and 30 female rape crisis counsellors working with sexual violence survivors. They found higher caseloads of sexual violence survivors correlated with more disruptions in one's schemas, with post-traumatic stress symptoms, and more self-reported vicarious traumatization.

These four studies provide some preliminary evidence of the effects of trauma exposure on individuals providing services to sexual abuse or sexual assault survivors. However, these studies have some methodological shortcomings, which limit the findings. The first two studies had small sample sizes. In the Follette et al. (1994) and Schauben and Frazier (1995) studies, the populations studied were not homogeneous in that not all participants worked exclusively with sexual trauma. As mentioned previously Steed and Downing

(1998) investigated the effects on therapists working with sexual abuse or assault survivors, which they did from a phenomenological perspective. However, this study also had a limited sample size (12) and the therapist population was not homogeneous. Therefore there is limited information (empirical or phenomenological) to help us understand vicarious traumatization and to aid in effective intervention strategies. From this it is clear that further study of the phenomenon in specific counselling populations working with specific client populations is needed.

With the present study being located within the South African context, the need for further research becomes even more apparent as there are only two local studies, of which the author is aware, that look at counsellors' reactions or responses to trauma work. Moosa (1992) interviewed twenty therapists engaged in work with individuals traumatised by political violence. This study identified and discussed specific countertransference themes. Moosa found that therapists commonly reported general feelings of helplessness, hopelessness and inadequacy. Some therapists experienced feelings of anger and guilt as well as admiration for the courage shown by the trauma survivors. The study concludes that the countertransference experiences evoked by trauma work may range from facilitating reactions to resistances, which may result in errors in therapy.

Hendricks (undated) undertook a qualitative exploration of Rape Crisis counsellors' experiences of stress and coping. Ten counsellors were interviewed and only two reported instances that reflected a degree of vicarious traumatization. However, the researcher noted that there seemed to be a collusion of silence within this organization, where counsellors found it difficult to speak about feelings of vulnerability. Further

research is therefore needed not only to increase our knowledge base but also to increase awareness, thereby dispelling the myth of therapist invulnerability, so that so that active intervention strategies can be put into place.

2.6 Rewards and coping

Vicarious traumatization relates specifically to the negative effects of doing trauma work. However, there are many personal rewards that are inherent in this work. For example, a strong sense of personal meaning often results from the knowledge of being involved in helping survivors, a deeper sense of connection to others, increased self-esteem, support from colleagues, and bearing witness to human resilience (Schauben & Frazier, 1995; Steed & Downing, 1998). In fact, Steed and Downing (1998, p.7) suggest that the term vicarious traumatization is "inadequate as a conceptual framework for understanding the full range of effects of trauma counselling". They recommend that future research should investigate positive aspects of trauma work in order to reach a more comprehensive approach to trauma work.

The literature also refers to various coping strategies that counsellors often utilise in order to ameliorate the negative effects of trauma work. Munroe (1998) highlights the fact that research has consistently shown that exposure to trauma material affects helpers in both their personal lives and in their ability to deliver effective counselling. Therefore there is a need to actively counter the effects of vicarious traumatization not only for the sake of the helpers involved but also for the wellbeing of the clients. According to McCann and Pearlman (1990), the process of working through vicarious traumatization requires continual awareness, monitoring, and processing that parallels the therapeutic process of working with survivors.

Three primary intervention concepts in vicarious traumatization interventions are awareness, balance, and connection. The first step is to acknowledge that doing trauma work will affect you (Nelson, 1997; Guy & Liaboe, 1986) and to realize that it is "normal" to be affected. This is because denial is a negative coping strategy utilised by many in the helping profession and to foster an environment in which open discussion is encouraged and education given will help to lessen unnoticed negative effects. In this regard discussion and use of vicarious traumatization scales can be helpful not only in being able to identify symptoms of vicarious traumatization but also in helping counsellors to continually monitor their own responses to trauma work (Steed & Bicknell, 2001).

McCann and Pearlman (1990) believe that the effects of vicarious traumatization are accumulative and it therefore becomes important for helpers to strive for balance in their lives and connection to others in both a personal and professional capacity. This includes balance between personal and professional activities; balance between clinical caseload and other professional involvements; acknowledging personal boundaries; developing realistic self-expectations, seeking emotional support and humour (Lansen, 1993; McCann & Pearlman, 1990; Miller, 1998; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995).

Actively countering the negative effects of vicarious traumatization requires theoretical support, organizational support, as well as self-coping strategies. Using a theoretical framework for trauma work provides the counsellor with a means of healthy emotional insulation through intellectual structure and distance (Yassen, 1995) as well as for

understanding vicarious traumatization (constructivist self-development theory). Feminist beliefs form core guidelines for the counsellors of Rape Crisis, which offers a frame for understanding the occurrence of rape in our society and promotes a sense of a bonded force against injustice (Hendricks, undated). Therefore the feminist beliefs, which inform the organisation, could mediate counsellors' experiences of stress and coping.

The organizations in which counsellors work could help to counter the negative effects by setting up support groups to enable discussion of difficulties experienced and to educate around issues related to vicarious traumatization. Support groups also help to reduce counsellors' discontent and provide opportunities for counsellors to learn from one another (Miller, 1998; McCann & Pearlman, 1990). In addition, organizations can help by developing resources for referrals to adjunctive services and to engage in social action directed at ending violence and victimization, as this would help to counter feelings of inadequacy or bystander effect. A supervisor within the organization should be knowledgeable of these issues as they could help the counsellor to understand his or her experiences of vicarious traumatization and begin to develop ways of managing it.

Counsellors can also actively counter the negative effects of doing trauma work by employing various self-coping strategies. In general the literature suggests that counsellors should do the same self-affirming, self-protecting and self-nurturing strategies they would encourage their clients to do (Edwards, 1995; Levin, 1989; Miller, 1998; Neumann & Gamble, 1995; Susan, 1998; Voltz, 2000):

- Balance work with play
- Personal therapy
- Rest and play- reading, listening to music, engaging in enjoyable activities and hobbies
- Exercise
- Engaging in relationships that allow our full expression
- Nurture the nonprofessional aspects of our identity
- Reconnect with our bodies (basic health strategies)
- Reconnect with our spirituality:

    Religious practices, yoga, meditation

    Awareness of all aspects of our life (counters numbing)

    Note and reinforce the positive aspects of doing trauma work
- Limit exposure to violence in the media
- Proactive response for social justice to balance feelings of neutrality
- Work with intrusive imagery – detoxify by introducing new people to the scene or creating an alternative view for the scene to unfold
- Maintaining professional connection and continued education
- Setting professional and personal limits or boundaries
- Write about your experience

To conclude, empirical investigation on the effects of trauma work could lead to more effective coping strategies. Such strategies would obviously benefit the counsellor, but in addition it would also benefit organisations by reducing the high turn over rate among

sexual violence counsellors. This in turn would benefit the clients, as the counsellors would be more experienced with working successfully with trauma survivors.

2.7 Chapter summary

This chapter focused on trauma-related counselling by providing a broad overview of the concept of trauma and by looking at rape-trauma specifically. It then details the various terminology found within the field of help-induced trauma and provides a definition and discussion of vicarious traumatization. It then provides an overview of the existing literature on the effects of trauma work on counsellors. It concludes by discussing the rewards inherent in trauma work as well as various coping strategies counsellors utilise in order to ameliorate the negative effects of trauma work.

CHAPTER 3

METHODOLOGY

3.0 Introduction

This chapter sets out the methodology employed in the present study. It begins by stating the aims and objectives of the study and the research questions posed. This is followed by an explanation of the research design utilised for the present study. It then describes the sample and procedures used for data collecting, as well as detailing the demographic variables of the participants. Then the data analysis procedures of the study are presented. Furthermore, the research tools (the TSI Belief Scale and the IES), their sub-scales and psychometric properties are described. Lastly, ethical considerations are discussed.

3.1 Aims and objectives of the study

Firstly, the primary purpose of this study was to assess the levels of vicarious traumatization amongst lay-counsellors working with adult sexual violence survivors for the present sample. Due to the fact that the present study does not compare findings to non-counsellors, it will not be known if some of their experiences are not more general than just relating to trauma counsellors. Further objectives related to secondly, investigating relations among nature of the work, personal characteristics and vicarious traumatization; thirdly, obtaining qualitative data from the counsellors regarding their own perceptions of the effects of working with survivors; and finally, discussing implications for counsellor training.

3.2 Statement of the research problem

The present study sought to answer the following questions:

- What is the level of vicarious traumatization (indicated by post-traumatic stress symptoms and disrupted schemas or beliefs) in lay-counsellors?
- Are certain demographic variables (characteristics of the counsellors and nature of the work) related to obtained levels of vicarious traumatization found amongst the lay-counsellors?
- What are the most difficult or stressful aspects of working with survivors of sexual trauma?
- What are the most enjoyable or positive aspects of working with survivors of sexual trauma?
- What coping strategies are being utilised by the lay-counsellors to assist them with the demands of their work?

3.3 Research design

The study employed a survey research design using a written questionnaire, including both quantitative and qualitative methods of data collection. The first part of the study, which describes the levels of vicarious traumatization among lay-counsellors was exploratory in nature, using descriptive statistics such as means and standard deviations, in addition the reliability of the research instruments were investigated. The second part of the study aimed to describe the effects of various demographic variables on the level of stress responses among the lay-counsellors by use of a multivariate correlational approach. This approach was seemed applicable given the paucity of exploration within the South African context. Based on the vicarious traumatization and burnout literature (Pearlman & Mc Ian,

1995) the following independent variables were entered into stepwise multiple regression analyses to predict the dependent variables: age, education, marital status, trauma history, therapy, organizational supervision received, number of months counsellor has worked within the trauma field, number of hours per month worked, and survivors (caseload). It is reasonable to expect some overlap in the influence of some independent variables on the dependent variable. One advantage of the step-up approach is that the variables are brought into the equation in the order in which they contribute to the equation, with other variables not being entered unless they meet preset criteria (Howell, 1987). The third part of the study comprised of qualitative analyses of the participants' responses to three open-ended questions included in the questionnaire.

3.4 Sample and procedure

The sample consisted of a convenience sample of 36 lay-counsellors working in the field of adult sexual abuse and sexual assault. Counsellors from Rape Crisis (Observatory, Heideveld and Somerset West) and The Comfort Room Project (Grassy Park and Manenberg) were included in the sample. Further branches of Rape Crisis (Kayeletsha) and the Comfort Room Project (Rondebosch) were approached to take part in the study but elected not to participate. Out of the organizations that elected to participate there were 74 counsellors, which meant that the response rate for the study was 49%. According to Pearlman and Mac Ian (1995), the number of years doing trauma work is positively correlated with the effects of vicarious traumatization therefore one selection criterion was that the counsellors had worked for the organization for six months or longer.

Permission was sought prior to the onset of the research from the counselling coordinators of Rape Crisis and from the counselling coordinators of the Comfort Room Project. For this purpose a letter explaining the aims and objectives of the study as well as the research tools used, was sent to the director of Rape Crisis and the counselling coordinators of the Comfort Room Project. During their monthly counselling meetings, counsellors were briefly informed about the nature of the research and it was emphasised that participation was voluntary. Informed consent from the counsellors was granted to the researcher. Counsellors from Grassy Park filled in their questionnaires during their monthly meeting and the remaining counsellors completed them in their own time, which were collected by their coordinators. All the questionnaires were written in English.

3.5 Participants

The participants consisted of 33 (92 %) females and 3 (8 %) males. The average age of the sample was 39 years (SD= 9.97), ranging from 23 to 57. Their first language included English (n=18), Afrikaans (n=15), Xhosa (n=1), German (n=1) and Krio (n=1). Of the participants, 17 (47%) were married, 14 (39 %) were single, 2 (5%) were widowed, 2 (5%) were cohabiting, and 1 (3%) was divorced. Choice of religious preference indicated that the majority where Christian (n= 24, 67%), with the minority being represented by Muslims (n=7, 19%) and lay-counsellors who indicated "non-religious" (n=5, 14%). With regard to education 19 (53%) had a post-matric qualification, 8 (22 %) had a matric certificate and 9 (25%) did not have a matric. A personal trauma history was also investigated and the results show that 27 (75%) of the lay-counsellors did not have a personal trauma history. Whereas 1 participant reported childhood sexual abuse, 3 reported having been raped, 1 reported having experienced sexual assault, and 4 indicated "other" (for example, domestic

violence). In terms of dealing with trauma work in their own personal therapy, 10 (28%) counsellors indicated that they do receive therapy and 26 (72%) indicated that they do not. Twenty (56%) reported that their organizations provide supervision for their caseloads, whereas 16 (44%) reported that they do not receive any supervision. Variables related to work experience were also explored and the results are shown in Table 2.

TABLE 2
Descriptive Statistics: Work Experience

VARIABLE	M	SD	Range
No. years working with survivors	2	20.45	6 mths – 7 yrs
No. hours per month with survivors	23	25.54	2 – 100
No. survivors in past 6 months	20	43.92	2 - 270

3.6 Research Tools

A self-report questionnaire including four parts was used for the study (see Appendix A). The first part of the questionnaire consisted of information pertaining to counsellor demographics and characteristics (independent measures).

3.6.1 Demographic data

Participants were asked a series of questions that investigated their work with survivors. They were asked: (a) how many years have you been working with sexual trauma survivors, (b) how many hours per month do you spend working with survivors, (c) how many survivors have you worked with over the past 6 months. Further variables in the analysis included personal trauma history (Do you have a trauma history: rape/ attempted rape/ incest/ other sexual assault), age, religion, education (highest level), personal therapy to address the affects of their trauma work, and whether or not counsellors are receiving trauma-work related supervision.

3.6.2 Impact of Events Scale

Parts two and three consisted of separate independent measures, as there are no measures available to specifically assess vicarious traumatization symptoms. Part two covered the Impact of Events Scale (IES) designed by Horowitz, Wilner, and Alvarez (1979), a self-report measure (anchored to any specific life event) that taps the two broad domains of response to traumatic stress: intrusion (intrusively experienced ideas, images, feelings, or bad dreams) and avoidance (consciously recognised avoidance of certain ideas, feelings or situations). The scale is derived from the large body of observation of stress response syndromes put forward by Horowitz, rather than being based in a specific theoretical orientation and provides a dimensional method of capturing the severity of symptomatic distress (Weiss, 1996). The scale does not assess all post-traumatic stress disorder symptoms and therefore does not have diagnostic status, however it does parallel the signs and symptoms of intrusive cognitions and affects together with avoidance that characterises two of the clusters of PTSD. A revised version (IES-R) of the scale has included a hyperarousal sub-scale, however it has shown mixed results in reliability studies (Foa & Meadows, 1997). The IES-R contains the original items from the intrusion and avoidance sub-scales, making the measure comparable to the IES.

The scale takes ten minutes to administer and consists of 15 items, which are summed and rated from sub-clinical (0-8), mild (9-25), moderate (26-43) through to severe (over 43), where a sub-scale score of over 26 is considered to indicate a clinically significant reaction (Weiss & Marmar, 1995). The IES uses a 5-point Likert-type scale with anchors ranging from: 0 = *not at all* to 4= *often,* and scores are obtained by assigning the weights

0, 1, 3 and 5 to the frequency categories. Participants were asked to consider items with respect to "client material" and it is targeted to level of symptoms in the past seven days.

Foa and Meadows (1997), Steed and Bicknell (2001), and Weis (1996) while reviewing the psychometric properties of the scale classed it as a mature scale, possessing adequate reliability and validity. Horowitz et al. (1979) who constructed the scale, developed items for the IES directly from statements made by persons experiencing life changes and guided by their clinical observations they yielded the two sub-scales for intrusive and avoidance experiences. In their initial study of 66 individuals attending an outpatient clinic for the treatment of stress response syndromes, they were able to empirically validate by way of cluster analysis the two sub-scales: intrusion (Chronbach's alpha = 0.79) and avoidance (Chronbach's alpha = 0.82). In addition, the obtained correlations of 0.42 for the sub-scales indicate some degree of covariation while also indicating that they do not measure identical dimensions. In the initial study the reliability of the scale was supported by adequate test-retest reliability (0.87 for total stress scores, 0.89 for intrusion, and 0.79 for avoidance) and the finding that the scale is sensitive to repeated measurement over time as well as being able to reliably discriminate life events of different magnitude. The above initial study on the scale has been cross-validated by another study undertaken by Zilberg, Weiss and Horowitz (1982) who investigated two groups of individuals dealing with issues of bereavement. In terms of item relevance the study showed that all items were endorsed frequently, with a range of 44% to 89% and that factor analysis on the intrusion and avoidance sub-scales was replicated with identical item assignments. The sub-scales were shown to have high internal consistency where the alpha coefficient for intrusion was 0.86 and for avoidance was 0.88 (taken

from the pooled sample of patients and field subjects at the first evaluation time). The scale was also shown to be sensitive in that it was able to discriminate between different populations and to detect change over time.

The scale has been reported to have an internal consistency of 0.86 for both the intrusion and avoidance sub-scales in a study by Pearlman and Mc Ian (1995) on 188 trauma therapists and 0.86 for the intrusion subscale and 0.78 for the avoidance subscale in Steed and Bicknell's (2001) study of 67 therapists working with sex offenders. The above findings provide evidence that supports the interpretation of the IES scores as reliable and valid measures of subjective distress. However there have been no studies, of which the author is aware, that have used this scale within the South African context and therefore the applicability of the scale to the present context would need further exploration. The IES was used to identify level of distress reported by the counsellors with regard to listening to client material, thereby suggesting vicarious traumatization (Pearlman & Mac Ian, 1995).

3.6.3 Traumatic Stress Institute Belief Scale

Part three of the questionnaire covered the Traumatic Stress Institute (TSI) Belief Scale (Pearlman, 1996), which measures disruptive cognitive schemas or beliefs. The scale is based in constructivist self-development theory, and assesses disruptions in psychological need areas (beliefs about self and others), which come about from vicarious exposure to trauma material through helping relationships. These psychological needs motivate behaviour and are manifested cognitively as schemas. In conjunction with other measures it is also intended to diagnose the existence of vicarious traumatization (McCann &

Pearlman, 1990; Pearlman & Saakvitne, 1995a and b). The 80-item scale is made up of the following five need areas, which correspond to psychological need areas that are impacted by trauma (Pearlman, 1996). The five psychological need areas are further divided into self and other to give a total of 10 sub-scales in addition to the Belief Scale total score:

- Safety

  Self: the need to feel one is reasonably invulnerable to harm inflicted by oneself or others

  Other: the need to feel that valued others are reasonably invulnerable to harm inflicted by oneself or others

- Trust / dependence

  Self: the need to rely upon one's own judgement

  Other: the need to rely upon others to meet one's needs

- Esteem

  Self: the need to feel valued by oneself and others

  Other: the need to value others

- Intimacy

  Self: the need to feel connected to oneself

  Other: the need to feel connected to others

- Control

  Self: the need to manage one's feelings and behaviours in interpersonal situations

  Other: the need to exert control over others in interpersonal situations

Note. Reprinted by permission of Pearlman (1995)
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The Revision-L version asks respondents to rate such items as "I generally feel safe from danger" on a scale from 1 to 6, where 1 = "*disagree strongly*" and 6 = "*agree strongly*", and takes 20 minutes to administer (self-administered). The items have been used most extensively with adults and the current norms are available only for adults of 18 and older (Pearlman, 2001). Scores obtained include a total score (summed, after appropriate items have been reversed) and 10 sub-scale scores, where high scores represent relative disruptions in an area, and low scores represent relative composure. The sub-scale scores are average scores and are computed by reversing appropriate items (see Appendix A), summing item scores, and dividing the sub-scale sum score by the number of items in the sub-scale. There are no cut-off points to indicate clinically significant disruption, however the scale can be used in a variety of ways. Firstly, comparisons can be made among the various groups from whom the Traumatic Stress Institute (see Table 4 and Appendix C) collected data, as well as comparisons to other research using this instrument. Secondly, one could discuss participants who are one standard deviation above the mean value for their group. Lastly, one could compare sub-scale scores where higher scores indicate more disrupted schemas.

Pearlman (1996), while reviewing the psychometric properties of the scale did not class it as a mature measure but rather as one in which the basic properties are intact. Reliability refers to the relative stability of a test score. Table 3 provides the reliability estimates for the TSI Belief Scale version L.

TABLE 3
Belief Scale Internal Consistency and Test-Retest Reliability Estimates

	Internal Consistency	Test-Retest Reliability
Belief Scale Total	.96	.75
Self-Safety	.83	.72
Other-Safety	.72	.73
Self-Trust	.74	.70
Other-Trust	.84	.79
Self-Esteem	.83	.69
Other-Esteem	.82	.72
Self-Intimacy	.67	.74
Other-Intimacy	.87	.60
Self-Control	.73	.76
Other-Control	.76	.66

N = 260. Test-retest interval was between 1 and 2 weeks.
Source: Pearlman (2001)

Alpha reliability estimates provide information about the homogeneity of the content of the scale items, where values above 0.70 are usually considered to reflect acceptable internal consistency. According to Pearlman (in press), who constructed the scale, TSI Belief Scale internal consistency estimates range from 0.67 to 0.96 (median = 0.79). The test-retest reliability scores for the TSI Belief Scale range from 0.60 to 0.79 (median = 0.72) where according to Pearlman, estimates over 0.60 are generally considered to indicate test scores with adequate suitability for the repeated measurement of a psychological construct. These data indicate that TSI Belief Scale scores are reasonably stable measures. The scale has been reported to have an internal consistency of 0.93 in a study of 188 self-identified trauma therapists by Pearlman and Mac Ian (1995) and 0.85 in a study of 148 counsellors working with sexual violence survivors by Schauben and

Frazier (1995). Table 4 summarises the reliabilities of the total scale and sub-scales taken from four criterion groups as well as the means and standard deviations.

TABLE 4
TSI Belief Scale, Revision L: Normative Data
Total Scores as Percentages, Subscale Means, Standard Deviations, and Reliabilities

Total and Sub-Scale Scores	Inpatients & Partial Hospital Patients N=337	Outpatient Clients N=301	College Students N=786	Mental Health Treaters N=412
Total Belief Scale Score α= .96	.57 (.11)	.47 (.12)	.41 (.09)	.22 (.17)
Self-Safety α=.84	3.39 (1.10)	2.68 (.99)	2.19 (.68)	1.80 (.47)
Other-Safety α=.70	2.88 (.84)	2.57 (.72)	2.55 (.64)	2.11 (.53)
Self-Trust α=.85	3.52 (1.01)	2.93 (.97)	2.38 (.74)	2.00 (.56)
Other-Trust α=.83	3.45 (.98)	2.95 (.96)	2.65 (.82)	2.12 (.58)
Self-Esteem α=.86	3.43 (1.09)	2.68 (1.05)	2.00 (.69)	1.68 (.54)
Other-Esteem α=.74	2.95 (.80)	2.64 (.74)	2.47 (.61)	2.08 (.51)
Self-Intimacy α=.77	3.46 (.99)	2.75 (.90)	2.77 (.75)	2.06 (.56)
Other-Intimacy α=.84	3.72 (.90)	3.16 (.98)	2.26 (.76)	2.09 (.67)

Self-Control	4.10	3.40	2.60	2.23
α=.81	(.94)	(.96)	(.76)	(.66)
Other-Control	3.24	2.84	2.58	2.19
α=.73	(.82)	(.70)	(.72)	(.58)

*Note: - Total Scores are given as percentages of total possible points
- Standard Deviations are given in parentheses.
- Chronbach's alpha is noted with the symbol, 'α'.

**Note. Reprinted by permission of Pearlman (in press)

Validity refers to the effectiveness of a score in measuring what it claims to measure. According to Pearlman (in press) several kinds of validity evidence have been examined for the TSI Belief Scale. With regard to content validity, items were developed directly out of statements made by trauma survivors in therapy. Clinical psychologists working with trauma survivors were asked to assign the items to one of the need areas of the test. Items were retained if there was 100% agreement among the clinicians. Item selection and revision was an iterative process based on factor analysis, inspection of item-to-scale correlations, scale alphas and feedback from clinical researchers using pilot versions of the test. The inter-scale correlation values (see Appendix B) support the basic structure of the test. These values are generally in the moderate range, and indicate sufficient sub-scale coherence and independence to warrant separate scoring and interpretation of each sub-scale.

With regard to construct validity, correlations between TSI Belief Scale scores and other clinical measures have been obtained. For example, correlations of the TSI Belief scale scores with Briere's Trauma Symptom Inventory (Briere, 1997) were in the moderate to high range (Pearlman, in press). Correlations of the TSI Belief Scale with the Symptom

Checklist-90- Revised (Derogatis, 1977) and the Intrusion and Avoidance sub-scales of the IES also fell within the moderate to high range (Pearlman & Mac Ian, 1995).

With regard to discriminant validity, Pearlman (1996) reports that the scale has reliably discriminated among survivors of childhood sexual abuse, and other trauma in a psychiatric population (2 463 individuals in clinical settings) and that studies have found significant differences (more disruptions) in trauma survivors verses non-survivors (see Table 4 and Appendix C).

According to Pearlman (1996) Multigroup Factorial Invariance analyses have yielded two factors that are stable across populations. In the context of constructivist self-development theory these factors have been conceptualised as representing aspects of the individual's frame of reference, corresponding to the experience of identity (self) and world-view (other). The above findings provide evidence that supports the interpretation of the TSI Belief Scale scores as reliable and valid measures of trauma symptoms. However the researcher is unaware of any studies done using this measure on a South African sample, therefore the applicability of this measure to a sample that differs from the original American sample on which it was based needs further exploration, which was out of the scope of this pilot study. This measure was used in the present study to measure the beliefs participants held about themselves and others. In conjunction with the IES it was used to suggest the presence of vicarious traumatization amongst the counsellors.

3.6.4 Qualitative data

The fourth part of the questionnaire contained (a) two open-ended questions in order to obtain participants' own insights into the difficult and enjoyable aspects of working with sexual trauma survivors:

"List 3 most enjoyable / positive aspects of working with survivors of trauma"

"List 3 most difficult / negative aspects of working with survivors of trauma",

and (b) respondents were further asked to list any coping strategies they used to cope with work-related stress or to mention any suggestions they may have.

3.7 Data analysis

The data were analysed using Excel (a spreadsheet package) and Statistica (a computer-based statistical package). Firstly, descriptive statistics such as means and standard deviations were calculated in order to gain an understanding of the make-up of the sample. Secondly, descriptive statistics were used to assess the level of post-traumatic stress disorder symptoms and disruptive cognitive schemas (suggesting the presence of vicarious traumatization) amongst the lay-counsellors. Thirdly, in order to investigate the relationship between work-related and personal factors and symptoms of vicarious traumatization, step-wise multiple regression (step-up method) analyses were conducted. This was undertaken to determine which of the specific demographic variables (i.e., age, level of education, length of time working in the field, case load, number of work hours and personal trauma history) were significant predictors of level of post-traumatic stress (i.e., intrusion and avoidance) and disruptive cognitive schemas (i.e., safety, trust, esteem, intimacy, and control, which relate to self and others) experienced by the lay-counsellors. The following specific

hypotheses, based on findings from the studies reviewed above and the burnout literature, were investigated:

- Younger counsellors would experience more symptoms than their older counterparts.
- Counsellors with a high school education are more vulnerable to vicarious traumatization than those in the post-school education group.
- Female counsellors would experience more PTSD symptoms than their male counterparts (this had to be dropped due to low male N).
- Counsellors with a personal trauma history would have a higher level of symptoms than counsellors who do not have a personal trauma history.
- Personal therapy addressing the nature of their work would act as a protective factor.
- Newer counsellors would have more symptoms than counsellors who have worked in the field for a longer period of time.
- The larger the caseload of the counsellors, the higher the level of symptoms experienced by the counsellors.
- Higher symptom levels experienced by the counsellors would be positively correlated with greater number of hours spent counselling survivors.
- Counsellors who were receiving supervision from their organizations regarding their casework would have fewer symptoms than counsellors who were not receiving supervision from their organization.

Finally, qualitative data were obtained through the analysis of responses to open-ended questions regarding what the counsellors consider to be the enjoyable and difficult aspects of doing trauma work as well as any additional coping strategies used. The responses were

analysed for themes identified in the literature search (Schauben & Frazier, 1995) as well as themes particular to this population. Analysis consisted of frequency counts of the identified themes, which are then presented in more detail with a few direct quotations where they are thought to be relevant and informative. Morgan (1988) recommends using a combination of themes and direct quotations in contrast to using only one of the two methods alone as it provides added strength to the research findings.

3.8 Ethical Considerations

Permission was sought prior to the onset of the research from the counselling coordinators of Rape Crisis and the Comfort Room Project. Participants granted informed consent and were assured of anonymity and confidentiality, which was upheld. Each organization will receive a copy of the final research report after completion. Discussions were held with the coordinators and counsellors of Rape Crisis and the Comfort Room Project, detailing the phenomenon of vicarious traumatization, its effects on counsellors and coping strategies that could be utilised.

3.9 Chapter summary

This chapter covered the methodology employed in the present study. It described the participants, design, research tools, and data analysis of the study. In addition it addressed the procedure and ethical considerations used to set-up and carry out the study.

CHAPTER 4

RESULTS

4.0 Introduction

The aim of this study was to assess the levels of vicarious traumatization amongst lay-counsellors by determining levels of post-traumatic stress disorder and the degree of disruptive cognitive schemas. A second aim was to investigate the relationships between the age, gender, marital status, level of education, personal trauma history, supervision, length of experience (months), hours per month spent counselling and caseload of counsellors with levels of vicarious traumatization as measured by post traumatic stress symptoms and disrupted cognitive schemas. Finally, a further aim was to explore what counsellors considered to be the enjoyable and difficult aspects of doing trauma work and what coping strategies they employed to deal with the nature of their work. The chapter will begin by presenting the quantitative results and will follow with the qualitative results.

4.1 Quantitative data

4.1.1 Symptom levels

One of the aims of the present study was to assess the level of post-traumatic stress disorder and disruptive cognitive schemas (suggesting the presence of vicarious traumatization) amongst the lay-counsellors working with adult survivors of sexual violence.

The results of the IES showed that the mean of the total score was 31.05 (standard deviation of 19.23), the mean for intrusion sub-scale was 15.19 (standard deviation of 8.93), and the mean for the avoidance sub-scale was 15.86 (standard deviation of 11.21). According to the cut-off points for this scale the mean for the total score indicated that the counsellors were

found to exhibit symptoms at a moderate level (see chapter 3). With regard to the sub-scales counsellors were not found to exhibit symptoms at a clinically significant level (i.e., scores of 26 or more – see chapter 3), however the sample were experiencing mild symptoms in the domains of intrusion and avoidance. This means that the counsellors were experiencing a relatively high degree of symptoms related to the intrusion and avoidance categories found in post-traumatic stress disorder but still at a sub-clinical level, which is in keeping with research findings (Cornille & Meyers, 1999; Dunning & Silva, 1980; Dyregrov & Mitchell, 1992; Horowitz, 1974; Kassem-Adams, 1995; Lansen, 1993; Lundin, 1995; Lyon, 1993; Miller, 1998; Munroe, 1998; Raphael & Wilson, 1994; Schauben & Frazier, 1995; Talbot et al., 1995).

Cronbach's Alpha reliabilities for the IES total scale and the two sub-scales were computed for the overall sample (N=36) yielding the following results: IES Total: α= 0 .88; Introversion, α = 0.91; Avoidance, α = 0.83. The reliability may therefore be considered high as Cronbach Alpha >0.8, however future research would need to analyse this scale in more detail as only 36 test cases are available from this study.

The results of the TSI Belief Scale showed that the mean of the total score was 220.92 (standard deviation of 37.16) and comparisons of the mean score to the criterion groups for which the Traumatic Stress Institute has collected data over the past several years (see Table 4 and Appendix C) show that for this sample the counsellors were experiencing some disruption. Comparisons of sub-scale scores for the present study revealed that counsellors experienced the least disruption in the area of self-esteem and the most disruption in the area of other-safety. The Alpha coefficient for the total scale was 0.87. The results of the means

and standard deviations of the ten sub-scales are presented in Table 5 as well as the alpha coefficients.

TABLE 5
TSI Belief Scale: Means, Standard Deviations and Alpha Coefficients of the Ten Sub-Scale Scores as Averages

Variable	Mean	Standard Deviation	Alpha
Self - safety	2.55	0.09	0.84
Other - safety	2.92	0.11	0.86
Self - trust	2.28	0.09	0.87
Other - trust	2.74	0.13	0.85
Self - esteem	1.92	0.07	0.86
Other - esteem	2.64	0.07	0.86
Self - intimacy	2.48	0.13	0.87
Other - intimacy	2.30	0.10	0.87
Self - control	2.63	0.12	0.85
Other - control	2.32	0.11	0.85

The reliability of the scale may therefore be considered high as Cronbach Alpha >0.8, however this needs to be interpreted with caution due to the small sample size. Future research would need to analyse the reliability and validity of this scale in more detail, which was beyond the scope of this study.

4.1.2 Hypotheses

Individual differences have been shown to have an influence on vicarious traumatization. Table 6 and Table 7 show the correlations between demographic information and the scale scores for the IES and TSI Belief Scale respectively. For this sample factors having a significant association ($p<0.05$) with the IES scale scores were education, supervision and caseload (or number of survivors). Factors that had a significant association ($p<0.05$) with

the TSI scale scores were age, education, marital status, trauma history, personal therapy and supervision.

TABLE 6
Correlation matrix of demographic data and the IES

	INTROVERSION	AVOIDANCE	TOTALSCALE
AGE	.32	.26	.30
EDU	**-.33***	-.22	-.28
MARITAL	.1	-.06	.02
TRAUMA_H	-.17	-.31	-.26
THERAPY	.28	.12	.20
SUPERVIS	-.23	**-.40***	**-.34***
MONTHS	.07	.04	.06
HRS	.28	.19	.24
SURVIVOR	**.36***	.26	.32

NOTE: * = P<.05

TABLE 7
Correlation matrix of demographic data and the TSI Belief Scale

Variable	*S-S*	*O-S*	*S-T*	*O-T*	*S-E*	*O-E*	*S-I*	*O-I*	*S-C*	*O-C*	*TOTAL*
AGE	**.38***	.19	.15	**.57***	.28	.07	**.38***	.21	.27	**.34***	**.43***
EDU	-.31	**-.62***	-.27	**-.55***	-.20	**-.39***	-.29	-.07	-.16	-.23	**-.47***
MARITAL	**.41***	-.02	.22	.11	.23	.11	.26	.18	.29	.24	.29
TRAUMA_H	.21	-.01	**.44***	.14	.01	-.09	.04	.21	.07	.04	.16
THERAPY	-.04	-.33	-.07	-.24	-.24	**-.36***	-.02	-.05	.22	.11	-.14
SUPERVIS	-.15	-.16	.08	**-.42***	-.29	-.25	-.20	.32	-.11	-.08	-.19
MONTHS	.03	-.13	-.26	-.07	.01	-.31	.07	-.08	-.12	-.11	-.13
HRS	.14	.19	-.15	.13	.02	.02	.28	.01	.03	-.09	.10
SURVIVOR	-.12	-.04	-.04	.18	.01	-.07	-.11	-.08	.03	-.06	-.03

NOTE: * = P<.05

The following area of inquiry addresses the research question regarding the relationship between work related and personal characteristics and the presence of vicarious traumatization. In order to test this hypothesis, separate analyses were undertaken using a series of step-wise multiple regression tests to identify the association between the level of distress as reported in the IES, the level of disrupted beliefs as reported in the TSI Belief Scale and the cluster of personal and work related factors that were expected to contribute to symptoms of vicarious traumatization. Fourteen analyses were conducted with each

examining a different dependent variable: the IES Total Scale and its two sub-scales and the TSI Belief Scale Total with its ten sub-scales.

When the data on the IES Total Scale and the two sub-scales were analysed using step-wise multiple regression, none of the independent (predictor) variables were shown to significantly predict them (see Table 8, $p>0.05$). However, from Table 6 it is evident that individual characteristics as well as the nature of the work did have a significant influence on distress responses. Firstly, supervision did act as a protective factor ($r = -0.34$) in that those counsellors who were receiving supervision from their organizations had significantly fewer symptoms (IES Total Scale). In addition supervision was negatively related to the avoidance sub-scale, whereby counsellors that received organizational supervision experienced fewer avoidance symptoms ($r = -0.40$). Therefore the following hypothesis (see chapter 3) relating to the influence of supervision on distress symptoms was retained: *Counsellors who were receiving supervision from their organizations regarding their casework would have fewer symptoms than counsellors who were not receiving supervision from their organization.*

Secondly, education was negatively related to the introversion sub-scale, which suggests that a higher level of education acted as a protective factor against symptoms related to introversion ($r = -0.33$). Therefore the following hypothesis relating to the influence of education on distress symptoms was retained: *Counsellors with a high school education are more vulnerable to vicarious traumatization than those in the post-school education group.*

Thirdly, number of survivors (caseload) was positively associated with the introversion sub-scale, whereby the higher the counsellor's caseload the more introversion symptoms they experienced (r = 0.36). Therefore the following hypothesis relating to the influence of caseload on distress symptoms was retained: *The larger the caseload of the counsellors, the higher the level of symptoms experienced by the counsellors.*

The following hypotheses were rejected when applied to the IES Total Scale because they were not supported by the results (all $p > 0.05$):

- *Younger counsellors would experience more symptoms than their older counterparts* (r = 0.30).
- *Counsellors with a personal trauma history would have a higher level of symptoms than counsellors who do not have a personal trauma history* (r = -0.26).
- *Personal therapy addressing the nature of their work would act as a protective factor* (r = 0.20).
- *Newer counsellors would have more symptoms than counsellors who have worked in the field for a longer period of time* (r = 0.06).
- *Higher symptom levels experienced by the counsellors would be positively correlated with greater number of hours spent counselling survivors* (r = 0.24).

TABLE 8

Step-wise Multiple Regression Analyses for work and personal factors on IES.

Regression Summary for Dependent Variable: **INTROVERSION**

R= .59852890 R^2= .35823684 Adjusted R^2= .13608805
F(9,26)=1.6126 p<.16357 Std.Error of estimate: 17.876

	BETA	St. Err. of BETA	B	St. Err. of B	t(26)	p-level
Intercpt			27.325	17.799	1.535	.136
AGE	.197	.191	.381	.369	1.030	.312
EDU	-.212	.179	-4.813	4.069	-1.182	.247
MARITAL	-.086	.166	-1.538	2.959	-.519	.607
TRAUMA_H	-.299	.182	-13.109	8.013	-1.635	.113
THERAPY	.272	.171	11.555	7.275	1.588	.124
SUPERVIS	-.097	.192	-3.736	7.328	-.509	.614
MONTHS	-.223	.198	-.209	.186	-1.125	.270
HRS	.168	.223	.127	.168	.756	.456
SURVIVOR	.151	.206	.066	.090	.732	.470

Regression Summary for Dependent Variable: **AVOIDANCE**
R= .50250420 R^2= .25251047 Adjusted R^2= .15606021
F(4,31)=2.6180 p<.05399 Std.Error of estimate: 10.298

	BETA	St. Err. of BETA	B	St. Err. of B	t(31)	p-level
Intercpt			22.066	3.706	5.953	.000
SUPERVIS	-.238	.178	-5.301	3.960	-1.338	.190
SURVIVOR	.202	.157	.051	.040	1.283	.208
TRAUMA_H	-.224	.172	-5.723	4.415	-1.296	.204
EDU	-.168	.164	-2.225	2.166	-1.027	.312

Regression Summary for Dependent Variable: **IES TOTAL SCALE**
R= .55251168 R^2= .30526916 Adjusted R^2= .18948068
F(5,30)=2.6364 p<.04321 Std.Error of estimate: 17.315

	BETA	St. Err. of BETA	B	St. Err. of B	t(30)	p-level
Intercpt			41.001	6.243	6.567	.000
SUPERVIS	-.163	.174	-6.253	6.660	-.938	.355
SURVIVOR	.203	.160	.089	.070	1.272	.213
EDU	-.287	.163	-6.514	3.712	-1.754	.089
THERAPY	.224291	.160	9.496	6.812	1.393	.173
TRAUMA_H	-.232	.170	-10.160	7.457	-1.362	.183

*NOTE: Potential variables for inclusion were: age, education, marital status, trauma history, therapy, supervision, months, hours and survivors/caseload.

**NOTE: *=p<.05

When the data on the TSI Total Scale and the two sub-scales were analysed using step-wise multiple regression seven of the independent (predictor) variables were shown to significantly predict some of the sub-scales ($p<0.05$). This conclusion is supported by the data presented in Table 9 that reflects significant t-scores of less than 0.5 and Beta scores that are closer to 1, showing the extent to which the specific demographic variables have an effect on the specific cognitive schema.

TABLE 9

Step-wise Multiple Regression Analyses for work and personal factors on TSI Belief Scale.

Regression Summary for Dependent Variable: **SELF-SAFETY**
R= .65783660 R^2= .43274899 Adjusted R^2= .31538671
F(6,29)=3.6873 p<.00762 Std.Error of estimate: 4.0339

	BETA	St. Err. of BETA	B	St. Err. of B	t(29)	p-level
Intercpt			17.319	3.693	4.689	.000
MARITAL*	**.386**	**.146**	**1.744**	**.658**	**2.653**	**.013**
EDU	-.194	.154	-1.114	.886	-1.258	.219
TRAUMA_H	.178	.141	1.974	1.568	1.258	.218
AGE	.222	.159	.108	.078	1.389	.175
SURVIVOR*	**-.384**	**.178**	**-.043**	**.019**	**-2.167**	**.039**
HRS	.351	.177	.067	.034	1.977	.058

Regression Summary for Dependent Variable: **OTHER-SAFETY**
R= .69972803 R^2= .48961932 Adjusted R^2= .40455587
F(5,30)=5.7559 p<.00077 Std.Error of estimate: 4.5385

	BETA	St. Err. of BETA	B	St. Err. of B	t(30)	p-level
Intercpt			31.800	1.734	18.343	.000
EDU*	**-.551**	**.135**	**-3.816**	**.933**	**-4.092**	**.000**
THERAPY	-.179	.139	-2.326	1.812	-1.283	.209
HRS	.338	.185	.078	.043	1.829	.077
SURVIVOR	-.189	.169	-.025	.023	-1.120	.271
MONTHS	-.166	.159	-.048	.046	-1.042	.306

Regression Summary for Dependent Variable: **SELF-TRUST**
R= .56312374 R^2= .31710835 Adjusted R^2= .22899330
F(4,31)=3.5988 p<.01601 Std.Error of estimate: 3.5403

	BETA	St. Err. of BETA	B	St. Err. of B	t(31)	p-level
Intercpt			16.567	1.563	10.603	.000
TRAUMA_H*	**.389**	**.152**	**3.574**	**1.393**	**2.565**	**.015**
EDU	-.219	.149	-1.037	.710	-1.461	.154
MARITAL	.206	.149	.770	.557	1.381	.177
MONTHS	-.160	.151	-.032	.029	-1.056	.299

Regression Summary for Dependent Variable: **OTHER-TRUST**
R= .74077292 R^2= .54874453 Adjusted R^2= .47353528
F(5,30)=7.2962 p<.00014 Std.Error of estimate: 4.4807

	BETA	St. Err. of BETA	B	St. Err. of B	t(30)	p-level
Intercpt			18.619	4.383	4.248	.000
AGE*	**.329**	**.143**	**.204**	**.088**	**2.307**	**.028**
EDU*	**-.290**	**.138**	**-2.112**	**1.005**	**-2.101**	**.044**
SUPERVIS*	**-.306**	**.149**	**-3.751**	**1.821**	**-2.059**	**.048**
TRAUMA_H	.222	.139	3.121	1.958	1.594	.121
THERAPY	-.186	.125	-2.534	1.702	-1.489	.147

Regression Summary for Dependent Variable: **SELF-ESTEEM**
R= .43746206 R^2= .19137305 Adjusted R^2= .11556428
F(3,32)=2.5244 p<.07514 Std.Error of estimate: 3.3767

	BETA	St. Err. of BETA	B	St. Err. of B	t(32)	p-level
Intercpt			18.150	1.029	17.629	.000
SUPERVIS	-.263	.159	-1.870	1.138	-1.644	.110
THERAPY	-.252	.160	-1.992	1.266	-1.573	.126
MARITAL	.236	.160	.785	.534	1.471	.151

Regression Summary for Dependent Variable: **OTHER-ESTEEM**
R= .58915179 R^2= .34709983 Adjusted R^2= .23828314
F(5,30)=3.1898 p<.01995 Std.Error of estimate: 2.9087

	BETA	St. Err. of BETA	B	St. Err. of B	t(30)	p-level
Intercpt			24.594	1.188	20.703	.000
EDU	-.271	.156	-1.064	.612	-1.739	.092
THERAPY	-.236	.154	-1.728	1.128	-1.532	.136
MONTHS	-.348	.179	-.057	.029	-1.932	.063
SUPERVIS	-.177	.152	-1.171	1.006	-1.164	.253
HRS	.180	.177	.023	.023	1.018	.317

Regression Summary for Dependent Variable: **SELF-INTIMACY**
R= .65156419 R^2= .42453589 Adjusted R^2= .32862521
F(5,30)=4.4264 p<.00388 Std.Error of estimate: 4.3853

	BETA	St. Err. of BETA	B	St. Err. of B	t(30)	p-level
Intercpt			9.949	3.984	2.497	.018
AGE	.296	.158	.159	.085	1.877	.070
HRS*	**.546**	**.175**	**.114**	**.036**	**3.115**	**.004**
SURVIVOR*	**-.510**	**.175**	**-.062**	**.021**	**-2.902**	**.006**
MARITAL	.224	.144	1.114	.714	1.559	.129
EDU	-.153	.151	-.968	.958	-1.010	.320

Regression Summary for Dependent Variable: **OTHER-INTIMACY**
R= .47042359 R^2= .22129836 Adjusted R^2= .17410432
F(2,33)=4.6891 p<.01613 Std.Error of estimate: 4.2021

	BETA	St. Err. of BETA	B	St. Err. of B	t(33)	p-level
Intercpt			9.245	3.471	2.663	.012
SUPERVIS*	**.451**	**.164**	**4.141**	**1.511**	**2.738**	**.009**
AGE*	**.373**	**.164**	**.173**	**.076**	**2.268**	**.029**

Regression Summary for Dependent Variable: **SELF-CONTROL**
R= .44312579 R^2= .19636046 Adjusted R^2= .09266504
F(4,31)=1.8936 p<.13653 Std.Error of estimate: 5.4503

	BETA	St. Err. of BETA	B	St. Err. of B	t(31)	p-level
Intercpt			15.130	3.874	3.905	.001
MARITAL	.185	.168	.981	.895	1.095	.281
AGE	.245	.167	.140	.096	1.463	.153
THERAPY	.246	.167	3.10	2.107	1.475	.150
MONTHS	-.177	.168	-.049	.047	-1.056	.299

Regression Summary for Dependent Variable: **OTHER-CONTROL**
R= .37795308 R^2= .14284853 Adjusted R^2= .09089996
F(2,33)=2.7498 p<.07860 Std.Error of estimate: 4.3252

	BETA	St. Err. of BETA	B	St. Err. of B	t(33)	p-level
Intercpt			10.228	2.973	3.440	.002
AGE	.298	.166	.135	.075	1.795	.081
MARITAL	.170	.166	.716	.698	1.024	.312

Regression Summary for Dependent Variable: **TSI Total Scale**
R= .58243451 R^2= .33922996 Adjusted R^2= .27728276
F(3,32)=5.4761 p<.00375 Std.Error of estimate: 31.593

	BETA	St. Err. of BETA	B	St. Err. of B	t(32)	p-level
Intercpt			201.159	28.133	7.150	.000
EDU	-.375	.1570	-16.417	6.875	-2.387	.023
MARITAL	.229	.148	7.889	5.130	1.537	.133
AGE	.228	.161	.852	.603	1.412	.167

*NOTE: Potential variables for inclusion were: age, education, marital status, trauma history, therapy, supervision, months, hours and survivors/caseload.

**Note*=p<.05

The following hypotheses (set out in chapter 3) were accepted when applied to the TSI Belief Scale (i.e., when looking at disrupted beliefs):

- *Counsellors with a high school education are more vulnerable to vicarious traumatization than those in the post-school education group.*

The above conclusion is supported by the data in Table 7 which showed a negative correlation between education and the TSI Total (r = -0.47), as well as between education and some of the sub-scales (other-safety: r = -0.62; other-trust: r = -0.55; other-esteem: r = -0.39). In addition, Table 9 also showed that education was significantly inversely related to other-safety and other-trust. Therefore it appears that education acts as a protective factor against disrupted beliefs, particularly beliefs related to other.

- *Counsellors with a personal trauma history would have a higher level of symptoms than the counsellors who do not have a personal trauma history.*

The above conclusion is supported by the data in Table 7, which showed a positive correlation between trauma history and self-trust (r = 0.44). Table 9 also showed that trauma history was a significant predictor of self-trust, with the relation in the positive

direction. Therefore it appears that the presence of a personal trauma history increases the risk of disrupted beliefs pertaining to self-trust.

- *Counsellors who were receiving supervision from their organizations regarding their casework would have fewer symptoms than counsellors who were not receiving supervision from their organization.*

The above conclusion is supported by the data in Table 7, which showed a negative correlation between supervision and other-trust (r = -0.42). Table 9 also showed that supervision was a significant predictor of other-trust and other-intimacy, with the relation in the negative direction. Therefore it appears that the provision of organizational supervision would act as a protective factor against increased risk of disrupted beliefs or schemas.

- *Higher symptom levels experienced by the counsellors would be positively correlated with greater number of hours counselling survivors.*

The above conclusion is supported by the data in Table 9, which showed that number of hours spent counselling per month was positively related to self-intimacy. Therefore it appears that more time spent counselling per month increases the risk of disrupted beliefs or schemas related to self-intimacy.

- *Personal therapy addressing the nature of their work would act as a protective factor.*

The above conclusion is supported by the data in Table 7, which showed a negative correlation between therapy and other-esteem (r = -0.36).

The following hypotheses were rejected when applied to the TSI Belief Scale because they were not supported by the results:

- *Younger counsellors would experience more symptoms than their older counterparts.*

The above conclusion was not supported by the data in Table 7, which showed a positive correlation between age and self-safety ($r = 0.38$); age and other-trust ($r = 0.57$); age and self-intimacy ($r = 0.38$); age and other-control ($r = 0.34$); age and TSI Total ($r = 0.43$). Table 9 also showed that age was positively related to other-trust and other-intimacy. Therefore it appears that being older is more of a risk factor for this population.

- *The larger the caseload of the counsellors, the higher the level of symptoms experienced by the counsellors.*

The above conclusion was not supported by the data in Table 9, which showed a significant inverse relationship between the number of survivors counselled per month and self-safety as well as self-intimacy.

- *Newer counsellors would have more symptoms than counsellors who have worked in the field for a longer period of time.*

No significant data (all $p > 0.05$) were obtained for the relationship between symptoms and length of time spent counselling (calculated as months).

Table 10 summarises the above findings by indicating whether or not hypotheses were supported by the IES and TSI scales.

TABLE 10
Hypotheses summary

Hypotheses	Supported by IES	Supported by TSI
Younger counsellors would experience more symptoms than their older counterparts.	No	No
Counsellors with a high school education are more vulnerable to vicarious traumatization than those in the post-school education group.	Yes	Yes
Counsellors with a personal trauma history would have a higher level of symptoms than counsellors who do not have a personal trauma history.	No	Yes
Personal therapy addressing the nature of their work would act as a protective factor.	No	Yes
Newer counsellors would have more symptoms than counsellors who have worked in the field for a longer period of time.	No	No
The larger the caseload of the counsellors, the higher the level of symptoms experienced by the counsellors.	Yes	No
Higher symptom levels experienced by the counsellors would be positively correlated with greater number of hours spent counselling survivors.	No	Yes
Counsellors who were receiving supervision from their organisations regarding their casework would have fewer symptoms than counsellors who were not receiving supervision from their organisation.	Yes	Yes

4.2 Qualitative data

Qualitative data were gathered regarding the most difficult and enjoyable aspects of trauma work as well as any coping strategies utilised by the counsellors by means of three open-ended questions. The responses allowed for a fuller understanding of potential effects of trauma work as the questions were tapping into their own perceptions of the effects of counselling survivors. Several central themes emerged concerning what they found difficult about their work, what aspects of their work made it worthwhile and how they coped.

Table 11 includes the number and percentage of references to identified themes. The themes are then presented in more detail with the inclusion of direct quotations where these are thought to be relevant.

TABLE 11
Themes identified by counsellors

No	Theme	N	%
A	*Difficult Aspects*		
1	Broader systemic issues	21	58%
2	Clients' emotional reactions	17	47%
3	Own emotional reactions	17	47%
4	Therapy management	17	47%
5	Severe forms of victimization	6	17%
6	Miscellaneous category	4	11%
7	Changes in own beliefs	3	8%
B	*Enjoyable aspects*		
1	Being part of the healing process	27	75%
2	Importance of their work	22	61%
3	Clients' ability to change	13	36%
4	Resilience of clients	8	22%
5	Establishing a trusting relationship	7	19%
6	Own growth and change	4	11%
C	*Coping strategies*		
1	Leisure activities	33	92%
2	Instrumental and emotional support	27	75%
3	Spiritually oriented activities	23	64%

4	Physical health	10	28%
5	Negative coping strategies	8	22%
6	Balance	2	5%
7	Cognitive restructuring	1	3%

4.2.1. Negative aspects

The most commonly (by 58% of the sample) reported difficult aspect of working with trauma survivors were factors related to broader systemic issues, such as the way in which other professionals worked with the survivors (the police, doctors, and various professionals within the courts as well as the legal system); the level of violence in our society; having no support structures for survivors in place; and a lack of resources concerning making counselling available to all survivors or to be able to provide long-term counselling. Therefore counsellors have most difficulty with general systemic issues as well as systemic issues that lead to the further victimization of survivors.

The following three categories of difficult aspects of working with trauma survivors were mentioned with the same frequency (47% each). Counsellors reported that dealing with their clients' emotional reactions to the traumatic experience was a difficult aspect of the work, such as working with their client's fear, anger, denial, detachment, hurt, pain and shame. In addition to dealing with the client's emotional reactions the counsellors also reported that having to deal with their own emotional reactions to hearing the client's material was a difficult aspect of doing trauma counselling. The majority of the counsellors reported feelings of helplessness or powerlessness as well as difficulty in bearing others' pain. For example, one participant said, "there are times I think my words are empty".

Another stated, "seeing how helpless they are to change certain things triggers my own frustration at things I can't change" and another said "feelings of helplessness- I can't fix it, only they can heal themselves with time and understanding". A few of the counsellors mentioned how in having to deal with extreme emotions they have learnt to rely on emotional detachment, which makes them feel uncomfortable about themselves, for example the response that " it is just another rape". Counsellors further reported difficulty with issues regarding therapy management, such as language and cultural differences; resistant clients or difficulty in establishing trust; working with clients who are not ready to help themselves; dealing with premature termination; working with young clients still at school as the counsellors have not had special training in this regard; setting and maintaining boundaries and limits; and dealing with care-givers' reactions.

Other difficult aspects of trauma work mentioned by fewer participants (8%) related to resultant changes in beliefs about the world after hearing traumatic material. For example, " that people can do things so hurtful to the next" and "... the senselessness of the hurts that people inflict on others". In addition, counsellors found it difficult to witness material related to severe forms of victimization (17%), such as hearing stories of multiple traumas and brutal traumas (e.g., rapes where bottles and sticks are used). Finally, other difficult aspects were coded into a miscellaneous category (11%) that included the work set-up such as anxiety around 24-hour telephone counselling as well as having to deal with extreme client behaviour such as suicidal clients.

4.2.2. Positive aspects

The most enjoyable aspect of working with trauma survivors related to being part of the healing process (reported by 75% of the sample). For example, knowing that they have helped clients, feeling needed and being available to clients on their road to recovery. Closely related to this some commented on how being able to break through the client's shattered sense of trust and being able to work in a sharing and trusting relationship has been a positive experience (19%). Secondly, counsellors noted that the importance of their work is a positive aspect (61%). Where they feel uplifted about knowing that they are doing something both good and important, knowing that they are helping to change society, and that they are appreciated by their clients. For example one counsellor related how "seeing how love changes people and makes a difference" is a positive aspect of her work. In addition, two participants mentioned that sharing knowledge with colleagues was a positive aspect, which relates to the work environment as opposed to the nature of their work. Thirdly, being able to watch clients grow and change was extremely rewarding (reported by 36% of the counsellors). For example, one counsellor reported, "I love to see the change in body language and facial expressions after a number of sessions, the lifting of a cloud sometimes". Fourthly, witnessing the client's creativity, strength, hope and resilience was reported (22%) to be a positive aspect of doing trauma work. Lastly, counsellors noted that their own growth and change is a positive aspect of working with survivors (reported by 11%). For example, some mentioned how important this work is for self-growth and they found it very fulfilling, leaving them with a strong sense of self worth.

4.2.3. Coping strategies

Counsellors were also asked to list any coping strategies they used to help them with their work-related stress. The most common coping strategy (reported by 92% of the sample) was to engage in some kind of leisure activity, such as listening to music, taking long walks, reading or going to the movies. Secondly, counsellors reported (75%) that by seeking both instrumental and emotional support, which includes talking to colleagues as well as support from family and friends, they are able to reduce stress. The third most common (64%) strategy was to engage in more spiritually oriented activities such as meditating, aromatherapy massage and prayer. Fourthly, engaging in activities related to physical health and well-being, such as exercising, interacting with pets and getting enough rest were listed as beneficial (by 28% of the sample). Two less frequently reported coping strategies were actively seeking balance (5%) between their personal and professional life and cognitive restructuring (3%), for example, one counsellor listed "thinking of pleasant, positive things". Lastly, negative coping strategies, such as smoking, crying more often, excessive eating and distancing themselves from others were listed (by 22% of the sample).

4.3 Chapter summary

The results revealed that counsellors experienced a moderate level of distress symptoms but still at a sub-clinical level, as well as showing some disruptions in cognitions. Analyses of the demographic data revealed that age, level of education, personal trauma history, therapy, supervision, caseload and hours significantly influenced specific responses. Qualitative findings not only supported quantitative findings but also expanded on them to include broader considerations of factors involved in trauma work. The discussion of these findings is presented in the next chapter.

CHAPTER 5

DISCUSSION, RECOMMENDATIONS AND CONCLUSIONS

5.0 Introduction

This chapter discusses all the major findings reported in the previous chapter. It will further comment on the limitations of the present study as well as provide some suggestions for future research within the field of vicarious traumatization. Finally, it concludes with recommendations for intervention regarding the well being of the counsellor working within the field of trauma.

5.1 Explanation of main findings

The present study assessed the levels of vicarious traumatization (avoidance and intrusion symptoms as well as disrupted cognitive schemas) amongst lay- counsellors working with adult survivors of sexual violence. Consistent with research within the field and constructivist self-development theory, whereby trauma counsellors are considered to experience similar reactions to their clients but at sub-clinical levels, the IES and TSI Belief Scale results indicated that counsellors were experiencing moderate symptoms of distress reactions as well as disruptions in their cognitive schemas. Therefore the effects of empathic engagement with trauma clients' material does appear to manifest as disturbances in counsellors' basic schemas about the world, as well as symptoms of post-traumatic stress disorder. The fact that a moderate level of symptoms were reported, necessitates the need for intervention on both an organizational and individual level, which will be discussed later. However, the above-mentioned moderate level of symptoms was higher than expected given the low means obtained for the proposed hypothesis put

forward by Pearlman and Mc Ian (1995) that current (caseload and hours) and accumulative (years) factors are linked to an increased risk of stress responses in counsellors. The present study was only designed to measure levels of symptoms and not to tease out alternative explanations, therefore it is possible that these counsellors are experiencing symptoms tapped by the IES and TSI scales for reasons other than vicarious traumatization. For example, the counsellors may have developed distress responses and disrupted beliefs (particularly about others) due to the fact that South Africa is a society in which crime and trauma is endemic. In addition, the present research does not account for pre-existing levels of psychological functioning and as Steed and Downing (1998) found in their qualitative study of trauma therapists, it is often difficult to separate unresolved personal issues and the vicarious effects of trauma therapy.

Comparison of the TSI sub-scales revealed that counsellors were experiencing the least disruption in the area of self-esteem, which replicates the finding of Pearlman and Mc Ian's (1995) research of 188 self-identified trauma therapists. The counsellors therefore appear to be functioning well with regard to the need to feel valuable and worthy of respect. A constructivist perspective requires that the participant and not the researcher define what constitutes trauma work experiences and therefore the present study included qualitative data. The qualitative data support the above quantitative finding in that being part of the healing process and believing their work to be important were the two most commonly reported positive aspects of doing trauma work. Therefore it appears as if the rewards inherent in this work act as protective factors in that the counsellors' perceptions of having helped clients may have enabled them to achieve better self-functioning. The studies of Schauben and Frazier (1995) and Steed and Downing (1998) found the same

association between increased self-esteem and perceived rewards of trauma work. Pearlman and Saakvitne (1995) believe that impairments in self-capacities imply difficulty in self-soothing and that external sources of comfort of a negative nature, such as alcohol consumption, may then be sought out. The fact that only 22% of the sample reported using negative coping strategies could be seen as support for the quantitative finding of better levels of self-functioning.

Counsellors were experiencing the most disruption in the area of other-safety, which implies that counsellors are functioning the least effectively when it comes to the need to believe that others are reasonably protected from harm (inflicted by oneself or others). According to McCann and Pearlman (1990) cognitive schemas are sensitive to disruption when a discrepancy between the client's traumatic memories and the counsellor's existing schemas emerges and any alterations are reflected in the perspectives they may develop. It is understandable that rape counsellors would lose trust in the ability of others to protect as they are exposed to traumatic material related to the capacity of one to inflict horrific harm on another. Hendricks (undated) also found that Rape Crisis counsellors found their personal sense of safety in the world had been threatened. Therefore it appears as if the counsellors have developed the perspective that there is no safe place in the world. Qualitative data from the present study add to the above finding in that the most commonly reported negative aspect of doing trauma work was related to broader systemic issues. Counsellors mentioned their frustration at how other professionals worked with the survivors and how these professionals had added to secondary traumatization experiences for the survivors as well as general high levels of violence within our society. The literature on vicarious traumatization states that exposure to trauma material may effect the

inner world and relationships one holds with others (McCann & Pearlman, 1990) and therefore these counsellors may need to guard against restricting their activities and possible withdrawal from significant others in order to protect themselves. Qualitative data revealed that a few of the participants engage in negative coping strategies (22%), which included "distancing oneself from others". According to Pearlman (2001), disruptions in beliefs about safety arise from chronic exposure to danger, death or abuse and because 75% of the present sample did not report a personal trauma history it is possible that their disruptions in this area are vicarious. Pearlman further states that individuals with high scores in the area of safety are likely to be hyper vigilant and have a chronically high level of physiological arousal. It is therefore unfortunate that the present study did not use the Impact of Events Scale – Revised, which includes a hyperarousal sub-scale to investigate the above statement (it was not used due to reported mixed results in reliability studies).

The present study revealed relationships between some personal and work- related factors and vicarious traumatization of lay-counsellors working with sexual trauma survivors:

With regard to personal characteristics education was a protective factor for the counsellors for both distress responses (IES) and cognitive disruptions (TSI), which replicated the findings of Green (undated) and Aylward and Green (undated). A personal trauma history was a risk factor for disrupted beliefs (TSI). These findings are supportive of the research undertaken by Cunningham (1996), Cornille and Meyers (1999), Kassam-Adams (1995), Moran and Britton (1994) and Pearlman and Mc Ian (1995). Not all research has duplicated these findings, however, as seen in the studies by Follette et al. (1994), Munroe (1998), Green (undated) and Schauben and Frazier (1995). For this sample a personal trauma history was not related to distress responses (IES). With regard to age,

older counsellors were more at risk than younger counsellors. These findings do not support the burnout literature (Ackerley et el., 1988; Deutsch, 1984), however research has shown that vicarious traumatization and burnout are distinct constructs (Munroe, 1991; Schauben & Frazier, 1995). In addition, the above findings are inconsistent with other studies working specifically with trauma populations where age was not found to predict distress responses (Pearlman & Mc Ian, 1995; Schauben & Frazier, 1995; & Steed & Downing, 1998).

With regard to the nature of the work, supervision was found to be a protective factor against distress responses (IES) and disrupted beliefs (TSI), which replicates the findings of Pearlman and Mc Ian (1995). Only 56 % of the counsellors were receiving supervision and if this variable is consistently found to be helpful then the implications and practical implementation of such a support for counsellors working with trauma needs to be addressed by organizations. Linked to ideas around possible support for the counsellors, personal therapy was also found to be a protective factor for cognitive disruptions. Seventy-two percent of the sample were not receiving personal therapy, therefore the need to look at other means of support for these counsellors is important. Qualitative data revealed that counsellors found "sharing knowledge with colleagues" to be a positive aspect of their work. Therefore, given the moderate levels of symptoms as well as the difficult demands of rape trauma counselling organizations could help to counter the negative affects by ensuring that lay-counsellors receive supervision as well as by encouraging them to attend their own therapy and set up peer supervision groups.

The hypothesis proposed by Pearlman and Mc Ian (1995) that current (large caseload and hours) and accumulative (years) factors are linked to increased risk of stress responses in helpers was not supported by the present study. Number of hours was a risk factor for disrupted beliefs, however, the number of months spent counselling did not produce significant results. In addition the results for caseload were contradictory in that a higher caseload was a protective factor against disrupted beliefs (TSI) but a risk factor for PTSD symptoms (IES). The contradictory findings from the present study as well as from the literature highlights the need for a more sophisticated way to research independent variables (particularly the nature of the work). The fact that caseload was predictive of self-safety, and self-intimacy for the TSI scale and predictive of introversion for the IES scale could mean that the counsellors have little disruption when it comes to self-functioning but because of their lack of other-trust have tended to isolate themselves from others. This possibility would need to be investigated further.

From the present study and the literature it appears that consistent with constructivist self-development theory the personal characteristics of the counsellor and the nature of the work do appear to influence vicarious traumatization, however research to date has not been able to isolate many variables that act exclusively as either risk or protective factors. Steed and Downing's (1998) study raised a question regarding the adequacy of vicarious traumatization as a conceptual framework and suggested the need for investigations into the positive aspects of trauma work in order to reach a more comprehensive approach. In addition it appears as if the research tools are inadequate to investigate the full range of effects of trauma work, particularly when linking the effects to constructivist self-development theory. For example, looking at other aspects of constructivist self-

development theory (McCann & Pearlman, 1990, detailed in table 1) the area of self-capacities could be impacted on by psychological trauma. It appears that counsellors are more able to maintain a positive sense of self (lower means on TSI were mostly associated with self sub-scales) and could possibly find difficulty in maintaining an inner sense of connection with others (most disruptions found in other sub-scales of TSI). Qualitative data highlighted the difficulty some of the counsellors have in tolerating strong affect, where they had difficulty in working with their client's strong negative emotional reactions as well as their own feelings of inadequacy and helplessness, which supports McCann and Pearlman's (1990) assertion that cognitive shifts resulting from vicarious exposure to trauma may create emotional distress. This replicates the findings of Pearlman and Saakvitne (1998), whose qualitative study found that counsellors' responses to traumatic material were predominantly affective and Moosa's (1992) study of South African therapists' reactions to survivors of political violence. In addition, this supports Koss and Harvey's (1991) conclusion that rape counselling is challenging and emotionally intense due to the strong emotions experienced by the survivors. Within the area of frame of reference, aspects of spirituality were gleaned through the use of demographic (high percentage) and qualitative data (used as a coping mechanism), however the TSI Belief Scale only investigates the area of psychological needs and does not investigate frame of reference, self-capacities, ego resources, and memory system, which are all purported by McCann and Pearlman (1995) to be impacted on by trauma experiences. Besides the TSI Belief Scale other scales tap trauma symptoms but there are no quantitative measures to tap the positive aspects of doing trauma work. Future research could focus on constructing additional scales that could deepen our understanding of trauma work and its effects.

Due to the lack of a full understanding of the effects of trauma work qualitative data were obtained from counsellors regarding their own perceptions of the effects of working with trauma survivors. The negative and positive aspects of doing trauma work have been discussed above, however counsellors also mentioned various coping strategies that they utilize in order to ameliorate the effects of their work. Mostly positive strategies were mentioned which included leisure activities, seeking instrumental and emotional support, spiritually oriented activities and activities related to physical health. Very few counsellors mentioned balance and cognitive restructuring which could be focused on in terms of organizational programmes or interventions. Due to the fact that spiritually oriented activities were reported by counsellors to be a coping mechanism and the fact that 86 % of the sample identified themselves as religious, it would be interesting to quantitatively investigate if religiosity acts as a protective factor.

5.2 Limitations and generalisability of the present study

The findings of the present study need to be interpreted with caution for the following reasons: Firstly, the study was severely underpowered. A sample size of thirty-six was insufficient given the number of variables included in some of the analyses, however due to a lack of research within the South African context an exploratory approach was taken with the present study. Secondly, this study surveyed rape counsellors from the Western Cape, with some branches of rape crisis and the comfort room project opting not to participate and therefore from the sample used it is unlikely that the findings hold much ecological validity. Although there is no reason to suspect significant regional differences, some caution should also be used in generalizing these findings to counsellors from other regions. Future studies should use a larger and more representative sample of rape trauma

counsellors throughout the province or the entire country, which would produce more generalisable results and make comparisons to the original study more meaningful. Thirdly, in line with the above-mentioned exploratory stance of the present study a 0.05 significance level was used, which hopefully invites future research within the South African context, however more conservative significance levels in testing the hypotheses could have yielded more rigorous results. Fourthly, the applicability of the scales used needs consideration, given that they were not standardised for the South African population. In addition, the scales were administered in English, which raises concern, as just under half (46%) of the sample's first language was Afrikaans. Although it was assumed that all the counsellors were proficient in English (the counselling coordinators who elected to participate in the study did not feel that English questionnaires would be problematic) the level of bi- or multi-lingualism among the counsellors was not known. Thus although the obtained alpha coeffiecient scores were strong, the applicability of the instruments used in a cross-cultural, cross-linguistic context should be considered, especially taking the small sample size into account. To further the generalisability of the results, future research should explore the standardisation of the IES and TSI Belief Scale for the South African population, as both scales were standardised on an American population. In addition, looking at back-translating the scales into the relevant first languages of the populations used in a study could also ensure findings that are more generalisable. Fifthly, the present study only assessed the effects of working with survivors of sexual trauma and to ensure broader investigations into vicarious traumatization future research could compare the effects of working with survivors of different types of traumas (e.g., hijackings or abused children). Finally, the present study only investigated the dependent variables in lay-counsellors but did not compare them

with non-counsellors therefore it is not known if findings are not more general than just relating to trauma counsellors. Future research could investigate whether obtained means differ statistically from other populations, such as the general population (to investigate if levels are higher among lay-counsellors), out- or in – patient populations seeking treatment for trauma experiences (to investigate if levels for lay-counsellors are at a sub-clinical level) or counsellors providing services to clients that do not relate specifically to trauma counselling.

5.4 Implications and recommendations

Despite the above limitations, the findings have important implications for counsellors who work with trauma survivors. The moderate levels of symptoms among the lay-counsellors, though not compared with non-counsellors, suggest that they are vulnerable and therefore active intervention strategies need to be put into place. Firstly, the fact that some of these counsellors appear to be in distress needs to be fed back to the relevant organizations. On a more general level, organizations could acknowledge the possibility that their counsellors are distressed and work through symptoms within the organization. To this end, awareness is an important first step, where counsellors should be made cognisant of the fact that their experiences are normal reactions to doing trauma work. Awareness of vicarious traumatization needs to be addressed in a supportive environment to counter possible feelings of stigmatisation. Once an open discourse around possible distress responses has been achieved, the use of scales could be utilised in order to measure and monitor the distress levels of counsellors. Secondly, organizations would need to provide support for their counsellors. This could take the form of providing professional supervision linked to a trauma-specific theoretical framework, where

counsellors could receive input regarding case material and be helped to understand their own experiences of vicarious traumatization as well as begin to develop ways of managing it. Education around management could include input relating to the need for counsellors to strive for balance between their personal and professional lives as well as teaching cognitive restructuring skills (very few counsellors mentioned these coping strategies). In addition, counsellors could be educated about important self-care issues. Organizations could also help counsellors set up peer supervision groups and suggest the need for personal therapy if indicated. Lastly, consistent with Schauben and Frazier's (1995) study, the qualitative data suggest the need for broader systemic societal changes, given that some of the most difficult aspects of working with rape survivors are dealing with the injustices in the related professional (police, legal and medical systems) systems, the levels of violence in our society and a lack of resources. Therefore, in addition to counsellor oranizational support (organizational supervision, peer supervision, personal therapy), and education around effective personal coping techniques that appear to act as protective factors, there is also a need to address and change broader systemic issues that are contributing to added distress amongst both survivors and counsellors.

Organizations could also use the traumatology literature to help guide them with selection criteria. Looking at the literature as well as the present study, education (a higher level) appears to be the only variable that has been able to show consistent findings. Therefore it appears as if one selection criterion could be that counsellors need to have a matric education, and preferably a post-matric education to counsel survivors of sexual trauma. This selection criterion however, would probably not be feasible within a South African context as limited resources call for organizations to rely on a limited pool of volunteer

counsellors. One suggestion could be for organizations to look into the possibility of becoming accredited with the Health Professions Board in order to offer a community placement to psychology students.

5.5 Conclusions

The present study will hopefully be regarded as a pilot study to initiate further research that intends to investigate the effects of vicarious traumatization on lay-counsellors working within the field of sexual violence within the South African context. This preliminary study suggests that lay-counsellors working with sexual violence survivors are experiencing symptoms consistent with vicarious traumatization. Factors that appear to be able to predict vicarious traumatization were found via quantitative and qualitative analyses, however further research is needed in this area, as the literature has produced contradictory findings. The lay-counsellors who have participated in this study have provided invaluable information regarding the positive and negative experiences of their work.

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APPENDIX A

QUESTIONNAIRE PACKAGE

RESEARCH OUTLINE

Vicarious traumatization amongst lay-counsellors, working with adult survivors of sexual abuse

I am currently in the process of completing my Masters Degree in Psychology and currently engaged in research, in partial fulfillment of my degree requirements, at UWC. The purpose of this research is to explore how lay-counsellors, working with adult survivors of sexual violence, are effected by and cope with the nature of their work.

Your help in this regard is greatly appreciated and confidentiality of information and anonymity of participants will be upheld.
Thank you.

DEMOGRAPHIC DATA

(Please circle the appropriate answer / Use block letters)

1) SEX: M / F

2) AGE: _____

3) FIRST LANGUAGE: _____

4) HIGHEST LEVEL OF EDUCATION: _____

5) RELIGION (please specify if not religious): _____

6) MARITAL STATUS: Single Married Co-habiting

7) Do you have a personal trauma history? (have you experienced any of the traumatic events listed below?)

YES / NO
If YES please circle one:

Rape Attempted rape

Sexual assault Other: (Please specify): _____

8) Do you have personal therapy to deal with the negative effects of doing trauma work?
YES / NO

9) Are you receiving work related supervision within your organization? YES / NO
If YES please specify: _____
_____

10) Number of years/months working with sexual violence survivors: _____

11) Number of hours per month spent counselling survivors: _____

12) Number of survivors worked with over the past 6 months: _____

Please turn over the page for the questionnaires

These questionnaires ask you to indicate what **you** generally do and feel when **you** experience traumatic events. Please refer to these traumatic events as the trauma material that you hear from your clients' while counseling. I.e., the stressful events relate to other peoples stories and how you personally react to what survivors tell you. Furthermore, please treat each item separately. There are no right or wrong answers.

Below is a list of comments made by people after stressful life events (please focus on client's trauma stories as the event). **Please circle each item,** indicating how frequently these comments were true during the past 7 days.

	Not At All	Rarely	Some-times	Often
1. I thought about it when I didn't mean to.	0	1	3	5
2. I avoided letting myself get upset when I thought about it or was reminded of it.	0	1	3	5
3. I tried to remove it from my memory.	0	1	3	5
4. I had trouble falling or staying asleep, because of pictures or thoughts about it that came into my mind.	0	1	3	5
5. I had waves of strong feelings about it.	0	1	3	5
6. I had dreams about it.	0	1	3	5
7. I stayed away from reminders of it.	0	1	3	5
8. I felt as if it hadn't happened or it wasn't real.	0	1	3	5
9. I tried not to talk about it.	0	1	3	5
10. Pictures about it popped into my mind.	0	1	3	5
11. Other things kept making me think about it.	0	1	3	5
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.	0	1	3	5
13. I tried not to think about it.	0	1	3	5
14. Any reminder brought back feelings about it.	0	1	3	5
15. My feelings about it were kind of numb.	0	1	3	5

Please turn over ...

This questionnaire is used to learn how individuals view themselves and others. As people differ from one another in many ways, there are no right or wrong answers. **Please place next to each item the number from the scale below** which you feel most closely matches your own beliefs about yourself and your world. Try to complete every item.

1	2	3	4	5	6
Disagree strongly	**Disagree**	**Disagree Somewhat**	**Agree Somewhat**	**Agree**	**Agree Strongly**

_____ 1. I generally feel safe from danger.*

_____ 2. People are wonderful.*

_____ 3. I can comfort myself when I'm in pain.*

_____ 4. I find myself worrying a lot about my safety.

_____ 5. I don't feel like I deserve much.

_____ 6. I can usually trust my own judgment.*

_____ 7. I feel empty when I am alone.

_____ 8. I have a lot of bad feelings about myself.

_____ 9. I'm reasonably comfortable about the safety of those I care about.*

_____ 10. Most people destroy what they build.

_____ 11. I have a difficult time being myself around other people.

_____ 12. I enjoy my own company.*

_____ 13. I don't trust my own instincts.

_____ 14. I often think the worst of others.

_____ 15. I believe I can protect myself if my thoughts become self-destructive.*

_____ 16. You can't trust anyone.

_____ 17. I'm uncomfortable when someone else is leading the group.

_____ 18. I feel good about myself most days.*

_____ 19. Sometimes I think I'm more concerned about the safety of others than they are.

_____ 20. Other people are no good.

_____ 21. Sometimes when I'm with people, I feel disconnected.

_____ 22. People shouldn't place too much trust in their friends.

_____ 23. Mostly, I don't feel like I'm worth much.

Please turn over ...

1 Disagree strongly	2 Disagree	3 Disagree Somewhat	4 Agree Somewhat	5 Agree	6 Agree Strongly

_____ 24. I don't have much control in my relationships.

_____ 25. My capacity to harm myself scares me sometimes.

_____ 26. For the most part, I like other people.*

_____ 27. I deserve to have good things happen to me.*

_____ 28. I usually feel safe when I'm alone.*

_____ 29. If I really need them, people will come through for me.*

_____ 30. I can't stand to be alone.

_____ 31. This world is filled with emotionally disturbed people.

_____ 32. I am basically a good person.*

_____ 33. For the most part, I can protect myself from harm.*

_____ 34. Bad things happen to me because I'm bad.

_____ 35. Some of my happiest experiences involve other people.*

_____ 36. There are many people to whom I feel close and connected.*

_____ 37. Sometimes I'm afraid of what I might do to myself.

_____ 38. I am often involved in conflicts with other people.

_____ 39. I often feel cut off and distant from other people.

_____ 40. I worry a lot about the safety of loved ones.

_____ 41. I don't experience much love from anyone.

_____ 42. Even when I'm with other people, I feel alone.

_____ 43. There is an evil force inside of me.

_____ 44. I feel uncertain about my ability to make decisions.

_____ 45. When I'm alone, I don't feel safe.

_____ 46. When I'm alone, it's like there's no one there.

_____ 47. I can depend on my friends to be there when I need them.*

_____ 48. Sometimes I feel like I can't control myself.

_____ 49. I feel out of touch with people.

_____ 50. Most people are basically good at heart.*

_____ 51. I sometimes wish I didn't have any feelings.

_____ 52. I'm often afraid I will harm myself.

Please turn over ...

1 Disagree strongly	2 Disagree	3 Disagree Somewhat	4 Agree Somewhat	5 Agree	6 Agree Strongly

_____ 53. I am my own best friend.*

_____ 54. I feel able to control whether I harm others.*

_____ 55. I often feel helpless in my relationships with others.

_____ 56. I don't have a lot of respect for the people closest to me.

_____ 57. I enjoy feeling like part of my community.*

_____ 58. I look forward to time I spend alone.*

_____ 59. I often feel others are trying to control me.

_____ 60. I envy people who are always in control.

_____ 61. The important people in my life are relatively safe from danger.*

_____ 62. The most uncomfortable feeling for me is losing control over myself.

_____ 63. If people really knew me, they wouldn't like me.

_____ 64. Most people don't keep the promises they make.

_____ 65. Strong people don't need to ask for others' help.

_____ 66. Trusting other people is generally not very smart.

_____ 67. I fear my capacity to harm others.

_____ 68. I feel bad about myself when I need others' help.

_____ 69. To feel at ease, I need to be in charge.

_____ 70. I have sound judgment.*

_____ 71. People who trust too much are foolish.

_____ 72. When my loved ones aren't with me, I fear they may be in danger.

_____ 73. At times my actions pose a danger to others.

_____ 74. I feel confident in my decision-making ability.*

_____ 75. I can't work effectively unless I'm the leader.

_____ 76. I often doubt myself.

_____ 77. I can usually size up situations pretty well.*

_____ 78. I generally don't believe the things people tell me.

_____ 79. Sometimes I really want to hurt someone.

_____ 80. When someone suggests I relax, I feel anxious.

TSI Belief Scale

Please turn over …

QUALITATIVE DATA

The following questions relate to how **you** experience working with trauma survivors and how **you** cope with the nature of this work:

A) Please list the 3 most enjoyable / positive aspects of working with survivors of trauma:

1) _____

_____

2) _____

_____

3) _____

_____

B) Please list the 3 most difficult / negative aspects of working with survivors of trauma:

1) _____

_____

2) _____

_____

3) _____

_____

C) Please list any ways or plans **you** use to cope with work-related stress or any suggestions you may have (e.g., *taking long walks).*

_____

_____

_____

_____

Thank you for your help.

APPENDIX B

Belief Scale Interscale Correlations

	SS	OS	ST	OT	SE	OE	SI	OI	SC	OC
Self-Safety	.--									
Other-Safety	.55	--								
Self-Trust	.54	.25	--							
Other-Trust	.57	.48	.40	--						
Self-Esteem	.65	.38	.53	.51	--					
Other-Esteem	.59	.52	.29	.80	.53	--				
Self-Intimacy	.43	.21	.39	.20	.40	.18	--			
Other-Intimacy	.61	.38	.41	.68	.63	.68	.29	--		
Self-Control	.69	.38	.57	.61	.66	.56	.49	.65	--	
Other-Control	.53	.49	.36	.61	.44	.53	.29	.54	.62	--
Belief Scale Total	.85	.63	.63	.80	.78	.78	.51	.81	.84	.73

Presented at the International Society for Traumatic Stress Studies
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For further information, contact Dr. Pearlman at tsicaap2@snet.net

APPENDIX C

Belief Scale Means and Standard Deviations for Clinical Groups on Form L

	All Clinical Cases 2,463			No History of Trauma 481			Any Trauma History 279			History of Child Abuse 144		
	Mean	s.d.	Average Item Response Value	Mean	s.d.	Average Item Response Value	Mean	s.d.	Average Item Response Value	Mean	s.d.	Average Item Response Value
Age	30.5	14.1		30.44	13.5		41.97	12.2		38.1	10.7	
Belief Scale Total	202.2	55.0	2.53 (.69)	198.7	47.5	2.48 (.59)	225.8	73.0	2.82 (.92)	267.9	62.8	3.35 (.79)
Self-Safety	21.2	8.1	2.35 (.90)	20.6	6.8	2.29 (.75)	25.1	10.9	2.78 (1.21)	30.4	10.9	3.38 (1.21)
Other-Safety	22.5	6.3	2.50 (.70)	22.2	5.9	2.46 (.65)	23.5	7.7	2.65 (.86)	26.7	7.9	2.97 (.88)
Self-Trust	17.7	6.4	2.53 (.92)	17.7	6.2	2.52 (.88)	19.7	7.7	2.81 (1.09)	23.4	7.2	3.34 (1.03)
Other-Trust	21.4	7.2	2.68 (.91)	20.9	6.8	2.62 (.85)	23.9	8.8	2.98 (1.10)	28.3	8.1	3.53 (1.01)
Self-Esteem	19.7	8.5	2.19 (.95)	18.7	7.4	2.08 (.82)	22.9	10.7	2.55 (1.19)	28.4	10.5	3.16 (1.17)
Other-Esteem	19.7	5.5	2.46 (.68)	19.6	5.2	2.46 (.65)	21.1	6.7	2.63 (.83)	24.2	6.3	3.03 (.78)
Self-Intimacy	18.6	6.2	2.66 (.88)	18.3	5.6	2.62 (.79)	19.6	8.3	2.79 (1.18)	23.6	7.5	3.37 (1.08)
Other-Intimacy	20.4	7.7	2.55 (.97)	20.2	7.0	2.53 (.87)	23.8	8.9	2.98 (1.11)	28.7	7.6	3.58 (.96)
Self-Control	22.7	8.0	2.84 (.99)	22.2	7.1	2.78 (.89)	26.3	9.8	3.28 (1.22)	31.7	8.2	3.96 (1.03)
Other-Control	18.4	5.4	2.63 (.77)	18.1	5.1	2.59 (.73)	20.1	6.0	2.88 (.85)	22.6	5.3	3.23 (.76)

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