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A PHENOMENOLOGICAL EXPLORATION OF CLIENT EXPERIENCES OF TRAUMA DEBRIEFING BY LAY COUNSELLORS

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KEYWORDS

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ABSTRACT

A PHENOMENOLOGICAL EXPLORATION OF CLIENT EXPERIENCES OF TRAUMA DEBRIEFING BY LAY COUNSELLORS

South Africa is a country with one of the highest crime rates in the world, resulting in much violence and trauma. Trauma debriefing models are used with groups and individuals in an attempt to facilitate the trauma recovery process and prevent the development of post-traumatic stress disorder (PTSD). There has been much debate on the efficacy of trauma debriefing over the past two decades with few qualitative studies exploring the utility of debriefing. A phenomenological methodology was used in this study, with the aim of understanding how participants experienced the process of trauma debriefing and what aspects were perceived as helpful or unhelpful. Semi-structured in-depth interviews were conducted with six adults who received debriefing following a single traumatic event, by volunteer lay counsellors from the Community Intervention Centre (CIC) based at the Milnerton Medi-Clinic. The overall experience of the majority of participants was that they found the debriefing beneficial. This was largely due to their perception of the counsellor values and the nature of the therapeutic relationship formed. Other beneficial aspects included psycho-education, counsellor availability and follow-up, and participants' recommended the continuation of the service. Unhelpful aspects included not forming a therapeutic relationship, a lack of follow-up and not being referred to a counsellor immediately after the traumatic event. These findings suggest trauma debriefing is beneficial for those it intends to assist. Limitations of the study

include the issue of counsellor variables and the fact that the participants varied between receiving a debriefing on a group or individual basis. The experience of the trauma debriefings were explored but more specific information relating to debriefing could have been elicited. Therefore, these findings cannot be generalised and further research could explore the utility and efficacy of trauma debriefing.

DECLARATION

I declare that *A Phenomenological Exploration of Client Experiences of Trauma Debriefing by Lay Counsellors* is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Full name: Fiona Mary Chandler Date:

Signed: _____

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CONTENTS

CHAPTER 1: INTRODUCTION

1.1 Introduction

South Africa is a country with one of the highest trauma incident rates in the world (Van Houten, 2002). Van Houten (2002) discusses how traumatic events challenge us and cut through our usual coping skills. Traumatic events affect all South Africans, either personally or vicariously and repressing such experiences may only serve to evoke them at a later stage (Keel & Naidu, 1998).

Given the high incidence of trauma in South Africa, it is important to explore what may be of value in the trauma recovery process within the South African context. Trauma debriefing models are used internationally and in South Africa to facilitate the normal recovery process after the experience of a traumatic event. South African non-government organisations such as the Community Intervention Centre (CIC) (based in Milnerton, Cape Town) train volunteers to enable them to offer trauma debriefing as a free service to the community. This study will focus on one service offered to the community; namely trauma debriefing.

1.2 Rationale for the study

The study hopes to contribute towards the gap that exists in the literature specifically on client experiences of trauma debriefing, and what was perceived as helpful or unhelpful. Whilst the efficacy of debriefing is often debated, qualitative feedback from clients themselves may reveal aspects to consider when developing best practice models of trauma debriefing. Specifically, it can inform best practice models for the CIC.

In reviewing the literature, there appears to be a paradigm shift in terms of valuing the client's 'voice' in perceptions of therapy in general (Singer, 2005) and in trauma debriefing specifically (Williams & Collins, 2006). Phenomenology, as a qualitative methodology, is an appropriate framework for understanding such phenomena (Singer, 2005). However, this study differs in terms of exploring trauma debriefing as an intervention offered by trained volunteers (para-professionals) as opposed to professionals in other studies cited (Williams & Collins, 2006). The study therefore also hopes to illustrate what value trained volunteers may have in offering this intervention as perceived by the clients themselves. However, the main focus of the study is on client experiences of trauma debriefing and it does not compare the efficacy of lay counselling to professional counselling.

1.3 Overview of the manuscript

This manuscript is divided into six chapters, namely; Literature review (3 chapters) on trauma, Research design and methodology, Results and discussion, and Conclusions and recommendations. Chapter 2 provides an overview of trauma, Chapter 3 includes intervening with trauma, and Chapter 4 presents a debate on trauma debriefing as well as perceptions of therapy and trauma debriefing. Chapter 5, the Research design and methodology chapter discusses phenomenology as the theoretical framework used and applied in the data analysis. A description of the procedures, participants and ethics is included. Chapter 6, the Results and discussion chapter presents a discussion of the emergent themes found in the analysis with reference to the literature. Finally, Chapter 7, the Conclusions and recommendations chapter provides an overview of the study, including its limitations and recommendations for further research.

LITERATURE REVIEW

CHAPTER 2: AN OVERVIEW OF TRAUMA

2.1 Introduction

In order to understand trauma, this section will deal with the historical development of post traumatic stress disorder (PTSD) followed by definitions of trauma and related terms and then trauma in the South African context.

2.2 Historical perspectives

With similar symptoms to that of PTSD, the disorder had different historical names prior to the current diagnosis. Kaplan and Sadock (2003) trace PTSD back to the U.S. Civil War where it was named 'soldier's heart' due to the autonomic cardiac symptoms experienced. Thereafter, during the 1900s the condition was named 'traumatic neurosis' largely due to the psychoanalytic movement in the U.S. It was named 'shell shock' during World War I due to the possibility of brain trauma being caused by exploding shells. Following World War II, with survivors of bombings and Nazi concentration camps presenting symptoms such as fatigue, increased nervousness and nightmares, it was called 'combat neurosis' or 'operational fatigue'. Finally, Vietnam War veterans were given the diagnosis of PTSD (discussed under definitions) to account for their condition. PTSD is currently diagnosed following the exposure to a traumatic stressor,

where symptoms involving avoidance, re-experiencing and hyper-arousal occur (American Psychiatric Association, 2000).

2.3 Definitions of trauma

- **Traumatic event**

Arambasic (2001, p. 27) defines a traumatic event as "… an event that occurs outside the range of usual human experience and which is likely to cause distress in anyone." The person's equilibrium is disturbed after experiencing such an event. The actual event, however, may be less significant than the person's subjective experience thereof (Van Wyk, 2004). The DSM-IV-TR describes how a traumatic event may be experienced directly, witnessed or experienced by a person with whom the individual shares a close relationship (American Psychiatric Association, 2000). Traumatic events include violent personal assault, torture, natural or man-made disasters, severe motor vehicle accidents and being diagnosed with a life-threatening illness (American Psychiatric Association, 2000).

- **Multiple trauma**

There is no current diagnosis for repeated, prolonged trauma and Herman (1997) proposes the term 'complex post-traumatic stress disorder'. For purposes of this study, multiple traumas involve more than one trauma or ongoing trauma.

- **Situational crises**

These involve unpredictable circumstances such as loss of property due to fire, or the sudden loss of a job (Ajdukovic, 2001).

- **Post Traumatic Stress Disorder (PTSD)**

According to the DSM-IV-TR (American Psychiatric Association, 2000) classification for PTSD:

A person experiences or witnesses an event involving actual or threatened death or serious injury, responding with intense fear, helplessness or horror. The three symptom clusters include re-experiencing, avoidance and hyper-arousal, which need to occur for at least one month to qualify for a diagnosis.

Re-experiencing the event may occur in intrusive recollections, distressing dreams, and psychological or physiological distress at exposure to cues that resemble an aspect of the event. Avoidance may include efforts to avoid thoughts, conversations, people or places associated with the event, an inability to recall an important aspect of the event, restricted range of affect, diminished interest in significant activities, feelings of detachment from others, and a sense of foreshortened future. Increased arousal includes sleeping difficulties, irritability or outbursts of anger, decreased concentration, hyper-vigilance and exaggerated startle response.

- **Debriefing / trauma counselling**

Trauma debriefing will be defined as counselling or trauma support offered to clients (who have witnessed or experienced a traumatic event) with the aim of processing the trauma and facilitating the prevention of post-traumatic stress disorder (PTSD) (Arambasic & Ajdukovic, 2001). For purposes of this study the terms "debriefing" and "trauma counselling" will be used interchangeably. This will be discussed fully later.

2.4 Trauma in the South African context

South Africa has a history of violence during the apartheid regime. Violence was used in maintaining the system in areas such as forced removals, restrictions on travel and the establishment of a third force in black communities (Skinner, 1998). Resistance against the system was reacted to by different means, such as detention, torture, assassinations and imprisonment (Skinner, 1998). Criminal violence existed in conjunction with trauma enforced by the state (Eagle, 2000). In addition, inadequate access to health, welfare and education amplified the oppression of the majority of South Africans (Skinner, 1998).

Although South Africa's transition from apartheid to a new democracy has been described as 'miraculous', the long-term effects of trauma under apartheid remain (Skinner, 1998). Keel and Naidu (1998) discuss how the nature of trauma has shifted to criminal violence, such as hijacking, robbery and murder. They maintain that because most criminals are armed, this increases the level of trauma experienced.

Tables of statistics from the CIC are included in the following pages to illustrate how traumatic events are experienced in the post-apartheid S.A. context, and confer the shift to criminal violence discussed above.

COMMUNITY INTERVENTION CENTRE - STATISTICS 2006													
EVENTS	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Armed robbery / robbery	7	3	3	6	3	12	8	5	6	8	9	14	**84**
Assault - common / GBH	1	2	0	3	3	2	2	6	4	4	6	2	**35**
Assessment	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Bereavement support	0	3	2	0	2	1	1	1	0	1	0	0	**11**
Child abuse & neglect	3	3	6	2	0	3	0	3	3	2	0	1	**26**
Child crisis / medical	0	1	0	0	0	2	2	0	2	1	0	0	**8**
Child trauma de-briefing	0	0	0	0	2	1	0	0	0	0	0	0	**3**
CISD	4	4	3	14	4	6	1	7	4	2	4	6	**59**
Counselling	4	7	1	1	6	0	2	0	2	2	0	2	**27**
Death / resus	2	1	1	2	2	4	2	2	2	1	4	2	**25**
Death of child	0	0	1	0	0	0	1	0	1	3	0	2	**8**
Disabled & elderly	0	2	1	0	0	0	0	0	0	0	0	0	**3**
Disaster Management	0	0	0	0	0	2	0	0	1	1	1	0	**5**
Domestic violence	12	6	12	1	2	14	5	7	9	5	7	6	**86**
Drowning / resus	0	0	0	0	0	0	0	0	0	1	0	0	**1**
Family crisis	0	2	0	0	2	1	3	0	0	0	0	0	**8**
Follow-up - calls	38	22	17	18	64	37	41	59	48	45	77	58	**524**
Follow-up appointments	3	5	12	14	14	12	14	13	16	3	6	8	**120**
Highjacking/Attempted Hijacking / Cash in Transit Heist	0	1	3	0	0	3	7	1	2	1	3	1	**22**
HIV counselling	0	0	0	0	0	1	0	0	0	1	0	0	**2**
Hospital visit	8	2	3	2	0	3	3	3	1	0	2	15	**42**
Mental disorder	1	0	0	0	0	1	0	0	0	0	2	0	**4**
Missing / runaway / lost	3	0	1	1	0	0	0	1	0	2	1	1	**10**
MVA	1	0	1	3	1	0	5	4	1	3	2	5	**26**
Murder	0	0	2	1	0	0	0	0	1	0	0	1	**5**
Prison	0	0	0	0	0	0	0	0	0	0	1	0	**1**
Rape / indecent assault	2	7	5	6	10	4	2	2	4	2	7	6	**57**
Rape - minor	1	3	0	0	0	1	3	0	2	1	0	0	**11**
Referrals - direct	21	19	28	25	13	14	23	23	17	28	24	20	**255**
Referrals - CLS - pro bono	0	0	0	0	0	0	1	1	0	0	0	0	**2**
Safehouse needed	1	0	0	2	0	2	3	0	4	2	0	0	**14**
Social welfare	6	0	0	2	4	1	1	3	2	5	0	1	**25**
Special Child Play Therapy	0	0	0	0	0	1	5	9	7	3	18	4	**47**
Staff support	0	0	0	0	4	3	2	2	0	1	2	0	**14**
Street children	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Substance abuse	0	3	3	0	6	4	3	0	0	7	7	2	**35**
Suicidal / depression	1	2	4	7	5	5	3	7	4	2	8	5	**53**
Suicide	0	4	0	1	3	3	0	1	0	1	0	1	**14**
Supervision	0	0	1	0	0	0	0	0	1	0	0	0	**2**
Trauma support	4	1	5	6	6	6	4	8	6	9	10	10	**75**
Youth at risk	0	1	2	1	1	0	0	3	1	3	0	3	**15**
TOTAL	**123**	**104**	**117**	**118**	**157**	**149**	**147**	**171**	**151**	**150**	**201**	**176**	**1764**

COMMUNITY INTERVENTION CENTRE - STATISTICS 2007													
EVENTS	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Armed robbery / robbery	8	4	5	3	9	13							**42**
Assault - common / GBH	2	2	2	2	1	2							**11**
Assessment													**0**
Bereavement support		1	2			1							**4**
Child abuse & neglect	2	2		1	2	3							**10**
Child crisis / medical		1				1							**2**
Child trauma de-briefing		1				1							**2**
CISD	7	4	3	2	8	7							**31**
Counselling	4		3	2	5	6							**20**
Death	2	4	2	2		1							**11**
Death of child	1	3		1	1	3							**9**
Disabled & elderly													**0**
Disaster Management													**0**
Domestic violence	12	9	11	8	2	6							**48**
Drowning / resus	1												**1**
Family crisis		1			1								**2**
Follow-up - calls	49	77	51	55	64	42							**338**
Follow-up appointments	8	13	5	6	6	3							**41**
Highjacking/Attempted Hijacking / Cash in Transit Heist		2	2	1	3	2							**10**
HIV counselling			1		1								**2**
Hospital visit	14	2				3							**19**
Indecent Assault		2	4		2								**8**
Indecent Assault of Minor				3	2	3							**8**
Kidnapping/Abduction		1											**1**
Mental disorder		5											**5**
Missing / runaway / lost		2				1							**3**
MVA	5	2	2	6	5	5							**25**
Murder					3								**3**
Prison													**0**
Rape	7	5	1	2	1	1							**17**
Rape - minor													**0**
Referrals - direct	27	28	14	32	22	21							**144**
Referrals - CLS - pro bono													**0**
Resus			1										**1**
Safehouse needed	3				1	1							**5**
Social welfare	3	1			1	6							**11**
Special Child Play Therapy	9	17	3		8	16							**53**
Staff support	2	4		3	2	1							**12**
Street children						1							**1**
Substance abuse	1			3	5	2							**11**
Suicidal / depression	3	7	2		3	1							**16**
Suicide	2	2	2		1	1							**8**
Trauma support	21	7	9	4	5	5							**51**
Youth at risk	3	4	5	2	4	2							**20**
TOTAL	**196**	**213**	**130**	**138**	**168**	**161**	**0**	**0**	**0**	**0**	**0**	**0**	**1006**

When comparing the same period (January to June) from 2006 to 2007 there has been an increase in the number of clients seen by the CIC for armed robberies and hijacking. Interestingly, the sample of clients seen in this study had experienced one of these crimes. The amount of motor-vehicle accident clients seen by June 2007 have equaled the total amount seen during 2006. This indicates that there has been an increase in crime due to the increase in people helped by the CIC.

Although traumas include non-criminal acts such as motor-vehicle accidents and natural disasters, the current emphasis appears to be on criminal acts due to the very high statistics of crime in South Africa. A detailed report was issued by the South African Chamber of Business (SACOB) on crime statistics for the financial years 2006 / 2007 (email correspondence on 4 July 2007). A few statistics are highlighted in the following table. Interestingly, the Western Cape had the highest murder rate in South Africa when compared to other provinces. When comparing the Western Cape and CIC statistics, it is apparent that the CIC has dealt with more cases involving robbery, rape and hijacking as opposed to murder.

CRIME STATISTICS FOR FINANCIAL YEARS 2006/2007

TYPE OF CRIME	WESTERN CAPE 2006/7	S.A. 2006/2007
Murders	2881	19202
Rape	5722	52617
Robbery with aggravating circumstances	15226	126558
Carjacking	911	13599

The above-mentioned tables illustrate the incidence of crime in the given areas. The high incidence and increase in criminal violence confirms the shift from trauma under apartheid to criminal violence as mentioned by Keel and Naidu (1998). As many crimes involve the use of a weapon this may be experienced as more life-threatening and thus exacerbate the trauma (Keel & Naidu, 1998). As the crime rates remain high, there is therefore a growing need for trauma support.

CHAPTER 3: INTERVENING WITH TRAUMA

3.1 Introduction

Trauma debriefing / support may be given to people following a traumatic event. This is often offered in South Africa as a free service or nominal charge by trained volunteers from various organizations (described in section 3.4) with the aim of facilitating normal recovery and referral for professional treatment when indicated. Private counselling is unaffordable for many South Africans and therefore many organisations counsel people who would otherwise receive no treatment. Trauma debriefing is offered as a preventative measure, whereas psychotherapy involves professional treatment once PTSD has been diagnosed (Arambasic & Ajdukovic, 2001). Although stressors causing PTSD / ASD can affect most people, the average lifetime prevalence is estimated at 8%. Therefore, most people do not develop PTSD following a traumatic event (Kaplan & Sadock, 2003).

Kaplan and Sadock (2003) discuss how PTSD develops through psychodynamic, cognitive-behavioural and biological explanations as well as predisposing factors in the development of PTSD. These are briefly discussed as this area is not the focus of the study. Psychodynamic explanations include the possibility that the trauma resonates with a previous childhood trauma or unresolved psychological conflict. The person may not be able to regulate the affect, resulting in the use of defense mechanisms such as dissociation and guilt. Cognitive-behavioural explanations include the trauma

(unconditioned stimulus) being paired with a conditioned stimulus (physical or mental reminders of the trauma) through classical conditioning. The person then learns to avoid reminders of the unconditioned stimulus or conditioned stimulus which produces the feared response. Biological factors suggest increased activity and responsiveness of the autonomic nervous system as well as hyperactivity in the HPA axis, noradrenergic and opioid system with patients who develop PTSD. Predisposing factors in the development of PTSD include the presence of a childhood trauma, certain personality disorders, inadequate support systems, stressful life changes, being female, having an external locus of control, excessive alcohol intake and the genetic predisposition to a psychiatric illness (Kaplan & Sadock, 2003).

Treatment models are based on the understanding of how trauma develops as discussed in the previous paragraph. Treatment can include trauma debriefing (discussed in 3.2), psychotherapy for PTSD (discussed in 3.3) as well as pharmacotherapy. Many forms of medication have been used in the treatment for PTSD. However, selective serotonin reuptake inhibitors (SSRIs) such as sertraline (Zoloft) and Paroxetine (Paxil) are popular choices due to their efficacy, safety and tolerability. They have been effective in reducing PTSD symptoms from the various clusters (Kaplan & Sadock, 2003). The focus of this study, however, will be on trauma debriefing discussed in the following section.

3.2 Trauma debriefing

Critical incident stress debriefing (CISD) is a form of crisis intervention developed in 1983 by Jeffrey Mitchell (Everly, 1995). Originally the procedure was applied to reduce stress symptoms of groups of rescue workers who were exposed to traumatic experiences. The general aims of debriefing are to reduce the impact of the trauma, accelerate the recovery process and to prevent long-term psychological problems such as post-traumatic stress disorder (Arambasic & Ajdukovic, 2001). Psychiatric 'labeling' is avoided, with the emphasis being on normalizing current reactions. The recipients of debriefing are perceived to be normal people who have experienced an abnormal event (Foa, Keane & Friedman, 2000). It is important to note that trauma debriefing was designed as a preventative measure and does not claim to cure psychological problems or to take the place of psychotherapy (Arambasic, 2001; Keel & Naidu, 1998).

Although trauma debriefing was initially developed for groups, it can be applied to individuals and is argued to be as effective with individuals as with groups (Arambasic & Ajdukovic, 2001). With group factors missing, the focus is on individual experiences and reactions. The facilitator normalizes individual reactions by sharing information from the literature and other people's experiences as opposed to highlighting common reactions in a group debriefing (Foa et al., 2000). However, the process remains the same in terms of the seven steps outlined below (Ajdukovic, 2001).

Since its inception, Mitchell's model (and modified versions) has been widely used for individuals, couples and families in various settings. Mitchell's CISD model consists of seven phases (Foa et al., 2000) namely:

1) Introduction.

2) Fact phase.

3) Thought phase.

4) Reaction phase.

5) Symptom phase.

6) Teaching phase.

7) Re-entry phase.

The seven phases offer structure following the chaos experienced during a trauma (Everly, 1995). The **introduction phase,** which is cognitively oriented, gives the participants an overview of the process (Everly, 1995). The **fact phase** remains within the cognitive domain and involves re-telling the event. Emotions are acknowledged, however the focus remains on the factual description of the event (Foa et al., 2000). The **thought phase** elicits the person's current thoughts and thoughts at the time of the incident, which involves a shift from the cognitive to the emotional domain (Everly, 1995). The **reaction phase** elicits emotions associated with the event, such as the worst aspect experienced, which remains in the emotional / affective domain (Everly, 1995). The **symptoms phase** involves the discussion and normalization of symptoms reverting from the emotional back to the cognitive orientation (Foa et al., 2000). The **teaching phase** looks at coping strategies and what symptoms may emerge, remaining in the

cognitive domain (Foa et al., 2000). The final **re-entry phase** provides an opportunity for the clarification of issues and questions, as well as a summary of the debriefing and closure within the cognitive domain (Foa et al., 2000). Practical information (such as handouts) may be given, and an assessment for further debriefing or referral to a professional may be done where appropriate (Everly, 1995).

Debriefing typically involves a single session set up within 48 to 72 hours of the traumatic event (Everly, 1995). Aspects of CISD's effectiveness include: early prevention, the opportunity to verbalize the trauma, catharsis, structured phases which include cognitive and affective domains, the benefits of group/peer support (where applicable) and the demonstration of caring by others (Everly, 1995). The therapist is able to contain and tolerate the worst images, leaving the client feeling less afraid and alone (Keel & Naidu, 1998). The later version of CISD, namely, CISM (Critical Incident Stress Management) allows for the inclusion of social support systems and follow-up sessions with referrals given as indicated (Van Wyk, 2004).

The Wits Trauma Counselling Model is a short-term trauma intervention model that was developed out of a case study approach in the South African context by staff of the psychology department at the University of the Witwatersrand (Hajiyiannis & Robertson, 1999). Eagle (2000) discusses how the model has been largely effective (according to research conducted) and is appropriate for persons with acute stress disorder (ASD) or PTSD, whereas complex or continuous traumatic stress should be addressed by traditional long-term therapy. According to Hajiyiannis and Robertson (1999), the model

has been used successfully by both volunteer and professional counsellors and is applicable cross-culturally, therefore suited to the S.A. context.

The model comprises five components which may be used interchangeably according to the client's needs (Eagle, 2000), namely:

1) Telling / retelling the story.
2) Normalising of the presenting symptoms.
3) Addressing survivor guilt or self-blame.
4) Encouraging mastery.
5) Facilitating the creation of meaning should the client raise this issue.

The **telling / retelling the story** component involves a detailed description of the event (including aspects such as facts, feelings and cognitions) whereby the therapist acts as a witness to the event. During the **normalizing of the presenting symptoms** phase, symptoms are empathically elicited and education around PTS symptoms is provided. In **addressing self-blame / survivor guilt**, the therapist may reframe the client's role by looking at strategies that were effective, thus restoring self-esteem. **Encouraging mastery** serves to counteract helplessness, facilitating a return to the previous level of functioning. Anxiety management techniques may be given and the client is encouraged to use available support systems. **Facilitating the creation of meaning** is an optional component, usually part of a longer-term process whereby the therapist engages with the client's belief system, serving to facilitate hope without minimizing the damage done (Eagle, 2000).

Besides being a time-limited and thus cost-effective approach, the model's major strength is that it integrates both psychodynamic and cognitive-behavioural approaches for treating psychological trauma, thus addressing both internal psychological processes and external behaviours (Hajiyiannis & Robertson, 1999; Eagle, 2000). It is also interesting to note how the Mitchell's model and Wits Trauma Counselling Model both share common elements, such as the re-telling of the story, psycho-education and normalizing of symptoms.

In response to much negative feedback over the past decade, the Trauma Clinic in Kenilworth (South Africa) has reconsidered evidence from research as well as their findings to develop an alternative trauma support model for assisting trauma victims. The model focuses less on retelling and re-experiencing the event and more on early identification of risk factors, early treatment interventions when necessary, and on optimizing resources in the victim's environment that may facilitate normal recovery (Van Wyk, 2004). Social support was found to be an important factor in recovery from trauma, whether constructive or destructive (Van Wyk, 2004). In a study by Myller (2000), safety, coping mechanisms and the availability of the therapist were most important. However, as is consistent with Van Wyk (2004), it was recommended that the more confronting parts of the debriefing be discarded from the process.

Recommendations for the use of CBT (cognitive behavioural therapy) have been suggested by Bower (2003) and Sherman (2002). However, this would indicate the need for professional treatment. Replacing debriefing with 'resiliency management' has been

proposed by Blythe and Slawinski (2004). This process would be similar to CISD but does not include details such as re-telling the event, and would focus on enhancing natural resilience with support and follow-up. This proposed model resembles the one mentioned by Van Wyk (2004). The educational component is an important part of any trauma model (Bryant & Harvey, 2000; Deahl, 2000).

It can therefore be argued that there is no clear distinction between trauma counselling models and psychotherapy in South Africa, due to the influence and use of psychotherapy techniques in practice (Eagle, 2000). The Wits trauma model serves as an example of the influence of psychotherapy on trauma models. However, psychotherapy for PTSD is discussed separately in the following section.

3.3 Psychotherapy for PTSD

Once PTSD has developed, clients may seek or be referred for professional treatment. Psychotherapy is normally individualized to suit the client. Psychodynamic psychotherapy and CBT (cognitive behavioral therapy) are two main therapies used, although the boundaries between the two are not always clear. These therapies may be applied to both individuals and groups (Foa et al., 2000).

Psychodynamic psychotherapy aims to enhance the client's understanding of unconscious issues which take place within the context of a strong therapeutic alliance. It aims to improve self-understanding and ego strength. Brief psychodynamic therapies (limited to

12 sessions) are found useful as the build-up towards termination may enhance progress (Foa et al., 2000). Time-limited psychotherapy is often used in treating PTSD as it may reduce the risk of dependence (Kaplan & Sadock, 2003). It is relevant for trauma due to clients' issues of separation and loss (Foa et al., 2000).

Within the CBT framework, exposure therapy may be used, whereby the client re-experiences the traumatic event through in vivo exposure or imagination techniques. Another approach involves teaching the client stress management which includes relaxation techniques (Kaplan & Sadock, 2003). EDMR (eye movement desensitization and reprocessing) is another technique used, which involves the client focusing on the lateral movement of the therapist's finger (during a state of relaxation) whilst having a mental image of the trauma experienced (Kaplan & Sadock, 2003).

Foa et al. (2000) discuss various techniques used in CBT and also how some are used in combination. Exposure therapy (such as flooding, imaginal or in vivo) is a form of exposing the person to the anxiety-provoking stimuli, until the anxiety is reduced. Systematic desensitization involves the person being exposed to anxiety-provoking stimuli on a graded scale and is paired with relaxation techniques. Cognitive processing therapy includes challenging problematic cognitions such as self-blame and cognitive therapy, and aims to modify dysfunctional (automatic) thoughts which are inaccurate or too extreme. Assertiveness training educates people about the connection between thoughts, emotions and behaviours and may be taught through role-plays (Foa et al., 2000).

Group therapy (where appropriate) is often beneficial due to the sharing of traumatic experiences and support received from others (Kaplan & Sadock, 2003). Psychodynamic groups look at understanding the trauma and each individual's reactions to it, as well as issues of concern around the trauma. CBT group therapy aims to reduce PTSD symptoms or enhance the person's control over them via prolonged exposure and relapse prevention planning (Foa et al., 2000).

Similarities between certain psychotherapy approaches and debriefing models include educational aspects and coping mechanisms such as stress management. However, psychotherapy involves more sessions (even if time-limited) than debriefing and uses specific techniques to treat PTSD symptoms. It is important to also note that psychotherapy involves treatment and debriefing is a preventative measure when comparing the two therapies (Arambasic & Ajdukovic, 2001).

3.4 How trauma debriefing is operationalised in Cape Town

Various non-governmental and non-profit organisations in the Western Cape, specifically in Cape Town, are involved with trauma support services. Certain organisations (such as Life Line) have branches throughout South Africa however, for purposes of this study the focus will be on the Cape Town region. Some organisations specialize in trauma and others offer it as one of their services. The Trauma Centre based in Woodstock (with another office in the Manenberg area) offers free trauma counselling to individuals. Counselling is given by professionals, and organisations referring clients or groups are

charged a nominal fee (N. Neethling, personal communication, 8 August 2007). FAMSA (Family and Marriage Society of South Africa) offers trauma debriefing at their office in Observatory and certain satellite offices. This is done by professionals, and clients are charged on a sliding scale according to income (S. Olivier, personal communication, 8 August 2007).

Rape Crisis offers free counselling by trained volunteers for men and women who have been raped or sexually assaulted. They have offices in the Observatory, Khayelitsha and Manenberg areas (T. Pretorius, personal communication, 8 August 2007). Life Line offers trauma debriefing by trained volunteers as a free service to the community in Cape Town at its offices in Khayelitsha and Gugulethu (S. Reed, personal communication, 31 July 2007). The Jewish Community Services offer trauma counselling by professionals as a free service to the Jewish community in Cape Town (A. Marx, personal communication, 27 July 2007). The Catholic Welfare Department offer the same services (not limited to church members) by trained volunteers in Cape Town and surrounding areas (J. Forgiarini, personal communication, 27 July 2007).

The Department of Community and Safety has funded 'trauma rooms' at 129 police stations in the Western Cape. Volunteers have been trained by both NICRO (National Institute for Crime Prevention and Rehabilitation of Offenders) and the Trauma Centre to assist victims at the various police stations. However, the amount of training and volunteer availability varies from one police station to the next (http://www.capegateway.gov.za). The Rondebosch police station is supported by a

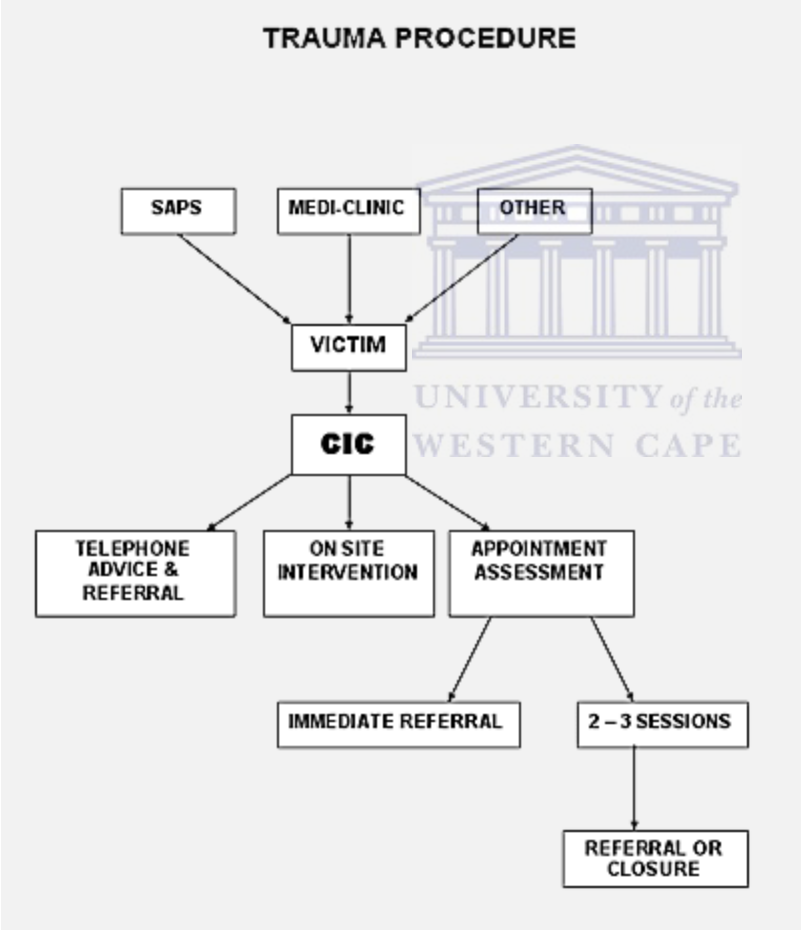
group of trained volunteers called ‘Survivors of Crime’ who offer trauma debriefing in the victim support room at the police station (M. Goldstone, personal communication, 27 July 2007). The Fish Hoek trauma room offers a similar service (D. McLean, personal communication, 1 August 2007).

The Community Intervention Centre (CIC) located at the Milnerton Medi-Clinic, Cape Town is the organisation used in this study. The CIC is a non-profit organisation registered with the Department of Welfare, offering a free 24-hour crisis intervention and trauma service covering the catchment areas serviced by the Milnerton, Table View and Melkbos police stations (http://www.blaauwberg.net/cic). Volunteers are trained in different areas, including trauma debriefing, which is the focus of this study. Referrals for trauma debriefing are received via the hospitals, police stations and the community within the catchment areas previously mentioned.

CIC TRAUMA PROCEDURE

The Trauma procedure copied with permission from the CIC

(http://www.blaauwberg.net/cic):



The CIC trauma debriefing team is initially trained using the Mitchell's model. Thereafter, they receive training using the Wits trauma model as well as ongoing skills development within the field of trauma. This includes the understanding and management of trauma and the latest developments within the field (M. Humby, personal communication, 25 July 2007). There is no charge for trauma debriefing or other services offered and clients are generally seen at a counselling room in the hospital or at one of the police stations in the area. They are able to refer clients to other organisations in the Cape Town region or to private practitioners where appropriate.

CHAPTER 4: IS TRAUMA DEBRIEFING HELPFUL?

4.1 Introduction

There is much debate over the efficacy of trauma debriefing. Research studies show arguments in favour of debriefing and those that reveal no effect or at worst imply harm caused in the natural recovery process. I shall discuss the literature which argues both in favour of and against debriefing with proposed models / ideas for future use. Thereafter, I will look at client experiences of therapy in general and experiences of debriefing.

4.2 The debriefing debate

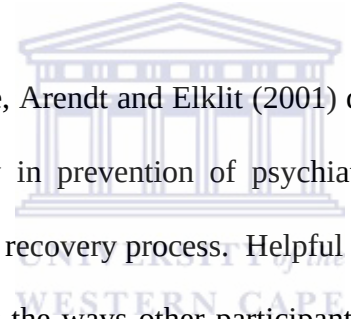
The review of the literature suggests that there is a debate about the efficacy of debriefing. Some argue that there is no evidence of its efficacy and caution that it may be detrimental to recipients by disrupting the natural recovery process (Bower, 2003; Feldner, Monson & Friedman, 2007; Gist & Devilly, 2002; Joseph, Williams & Yule, 1997; Sherman, 2002; Walling, 2003). Rose, Bisson and Wessely (2003) conducted a comprehensive study (The Cochrane Review) to establish whether psychological debriefing prevents PTSD. The results showed no evidence that psychological debriefing is useful for PTSD prevention and they recommended the cessation of compulsory debriefing of trauma victims. A meta-analysis of single session debriefing after psychological trauma (Van Emmerik, Kamphuis, Hulsbosch, Emmelkamp, 2002) concluded that debriefing has no efficacy in reducing symptoms of PTSD (or other

trauma-related symptoms) and does not improve natural recovery from psychological trauma.

Other reviews such as that done by Lewis (2003) suggest that although psychological debriefing lacks empirical support, studies have many methodological shortcomings. This implies that the methodology of studies should be critiqued, instead of the efficacy of debriefing. However, Carlier (2000, p. 384) cited in Shalev, Yehuda and McFarlane (2000) states that methodological flaws are inevitable in field research and that there is still evidence of "…hazards of debriefing from controlled impact evaluation studies". The possibility that debriefing disrupts the natural recovery process of traumatized people is of concern (Van Emmerik et al., 2002; Van Wyk, 2004).

Other research findings suggest that there is value in psychological debriefing. Van Houten (2002) conducted a study at Pollsmoor prison involving three group sessions (workshops). The results revealed that participants benefited from the workshops in terms of understanding their past and present traumas and learning new skills to cope with ongoing trauma. Irving and Long (2001) used a case study approach of three participants to ascertain the effectiveness of debriefing. Six months after the traumatic event, results revealed positive outcomes. The women in the study experienced the debriefing as a safe forum for exploration of their needs; for the processing of their experiences and the creation of constructive narratives. Although the benefits were attributed to the debriefing process by the participants, they did receive counselling from other sources, therefore possibly influencing their perceptions.

Leonard and Alison (1999) studied debriefing and its effects on coping strategies and anger in a sample of Australian police officers involved in shooting incidents. Results revealed a reduction in anger levels and greater use of adaptive coping strategies. However, they cautioned about the contribution of debriefing to their improvement with a discussion of contextual factors in the officer's lives contributing to the outcome. Qualitative feedback regarding how CISD changed the way they coped with the shooting incidents revealed negative factors such as a lack of follow-up and support, and lack of communication between psychologist and police, as well as a positive outcome with participants' increased awareness of emotional responses.



In their review of the literature, Arendt and Elklit (2001) discuss how, despite the lack of evidence for CISD's efficacy in prevention of psychiatric disorders, people find the intervention helpful during the recovery process. Helpful aspects include: learning about stress reactions; hearing about the ways other participants coped with stress; being in a group with others who had similar experiences; hearing others talk about the incident; talking about the incident; learning about coping strategies; and realizing reactions are normal and making it easier to talk to significant others about the experiences. Results showed that talking to others was experienced as most helpful, and that educating or seeking to normalize reactions was not as important. The preference for a group setting versus an individual one was inconclusive. Although there was no correlation between high degrees of perceived helpfulness and preventive effect, the authors argue for its use as a screening procedure.

Broad and unclear descriptions of debriefings researched in terms of contents, techniques, timing and frequency make their effectiveness hard to evaluate (Deahl, 2000; Kenardy, 2000). This is consistent with Everly and Mitchell (2000), who question critics' application of CISD and CISM and the validity of studies suggesting a lack of equivalent groups for comparison. Other factors are known to impact on the recovery process (besides the debriefing), such as personality and coping style, pre-morbid psychiatric state and the presence of ongoing stressors (Kenardy, 2000). Edwards (2003) argues that labeling debriefing as counterproductive is oversimplified and suggests people need to re-process and integrate traumatic events.

Due to the complex etiology of PTSD, Bryant and Harvey (2000) state that it is unrealistic to expect CISD to prevent PTSD. Recipients of debriefing may also report more symptoms than control groups due to their awareness of symptoms via the CISD process (MacDonald, 2003). Deahl (2000) and MacDonald (2003) argue that besides PTSD symptoms, other measures should be taken into account, such as social functioning and substance abuse.

In the South African context it is also economically viable to have short-term psychological interventions. Leonard and Alison (1999) suggested that debriefing should be offered to trauma victims. However, the question remains as to whether para-professionals may be suitably trained to offer trauma debriefing. Carlier (2000) in Shalev et al. (2000), argues that the level of care-giver training and its impact on the process have not been established. Dyregrov (1998) in Everly and Mitchell (2000), states that the

debriefing debate is not just scientific but a political one whereby debriefings (as a technique) represent a threat to the psychiatric elite.

Everly and Mitchell (2000), state that crisis intervention is designed to complement psychotherapeutic services and to assess the need for further care. The need for follow-up after debriefing, where CISD is seen as part of CISM cannot be over-emphasized as a key component for assessment and/or referral (Blythe & Slawinski, 2004; Deahl, 2000; Everly & Mitchell, 2000; Lewis, 2002; Van Wyk, 2004).

The results of outcome studies have been inconclusive and there have been few qualitative studies done in the area of trauma debriefing. However, qualitative studies conducted to date, have been informative with results showing that clients' experience of the process was helpful. This study therefore hopes to complement existing knowledge by exploring client views on the debriefing process. Spinelli (1994) discusses how few studies focus exclusively on clients' experience of therapy. Roberts (2000) suggests continued studies of CISD / CISM including those done through qualitative analysis. When questioning respondents, however, Blythe and Slawinski (2004) caution that the respondents' eagerness to feel better and their desire to comply with expectations may influence their responses. Another aspect to consider is that perceived helpfulness does not correlate or imply efficacy of debriefing (Devilly, Gist & Cotton, 2006). However, benefits of CISD (such as increased feelings of hope and control, opportunity to share experiences with decreased feelings of isolation and coping mechanisms including those that may be used for future events) have often been overlooked as outcomes in empirical

studies (MacDonald, 2003). Irving and Long (2001) suggest that assessments of efficacy of debriefing must take into account the experiences of those it seeks to help.

4.3 Perceptions of trauma counselling

There is a limited amount of literature on client perceptions of trauma counselling. Spinelli (1994) maintains that counselling and therapy are similar. Therefore, this discussion will include related literature to build on existing studies. There is a debate about the efficacy of psychotherapy in general and specifically on the efficacy of different therapeutic approaches. Spinelli (1994) reviews various studies and discusses how the theoretical approach may not play a large part in the effectiveness of therapy. The reviews reflect what the client finds important in therapy. Frank and Frank (1993), state that all therapies have healing components in common. Therefore, qualitative studies can contribute towards the debate about debriefing (Irving & Long, 2001; Roberts, 2000).

Studies reviewed by Spinelli (1994) reveal that the therapeutic relationship is of central importance. Within this relationship, clients want their therapist to enter their world view empathically and non-judgmentally. The mere opportunity to talk has been very helpful to clients. This however, should be balanced by the therapist engaging in talk, albeit around the client issues.

Other studies view the therapeutic relationship as a central component to therapy (Dimcovic, 2001; Glass & Arnkoff, 2000; Henkelman & Paulson, 2006; Kremer & Gesten, 2003; Paulson, Truscott & Stuart, 1999; Singer, 2005). In addition, Singer (2005) found the therapist's expertise important, offering suggestions and options to the client without imposing them. The role of the therapist is mainly to create a space for trust, in order for new ways of perception to be explored.

Rogers (1961) expands on this and discusses how the client is helped through the therapeutic relationship. He maintains the client is empowered through a genuine, accepting and understanding therapist. The genuineness of the therapist involves being transparent in terms of an awareness of one's feelings to become 'real' in the relationship. Acceptance of the client encompasses a warm regard and respect for the client, providing unconditional self-worth and safety within the relationship. Understanding involves a sensitive empathy for the client's thoughts and feelings at that moment.

Egan (2002) discusses genuineness as a professional value. Genuineness is described in terms of the therapist's attitude and behaviours. The therapist needs to feel comfortable enough to be themselves in all situations which include being 'natural' in the counselling role whereby appropriate self-disclosure may be helpful. The genuine therapist is more spontaneous with appropriate verbal responses and is open to explore criticism from the client.

Empathy can be described as a value as well as a communication skill (Egan, 2002). Egan (2002) discusses different definitions of empathy. Firstly, it has been defined as a personality trait whereby the person is inherently empathic. It has been learnt as a useful 'tool' in the counselling process. Thirdly, in Rogerian terms it refers to understanding the client's 'inner world' and relating that back to the client. However, empathy described as a communication skill, is similar to the Rogerian description whereby the counsellor tries to understand the client and checks this understanding by communicating it back to the client. The result is that the client feels understood. Empathic presence involves being with the client even in the absence of conversation (Egan, 2002).

Client perceptions are an important indicator of outcome in therapy (Henkelman & Paulson, 2006; Singer 2005). However, clients are generally reluctant to discuss negative aspects of counselling or may only remember positive aspects if their overall experience was positive (Henkelman & Paulson, 2006). Therefore, the importance of the therapeutic relationship may also serve to elicit helpful feedback which could be uncomfortable yet vital, for client and counsellor alike.

Paulson et al. (1999) divided client perceptions of helpful experiences into 9 clusters, namely: counsellor facilitative interpersonal style, counsellor interventions, generating client resources, new perspectives, emotional relief, client self-disclosure, gaining knowledge, accessibility, and client resolutions. The counsellor facilitative interpersonal style and role of the therapeutic relationship (described as a 'positive' working relationship) were found to be very helpful. In addition, the client's self-disclosure

occurs in the context of such a relationship, which is discussed as the best predictor of therapeutic outcome. Interestingly, the client resolutions category was perceived as achieving what was desired, with the option of more counselling as opposed to specific goals or symptom reduction. Gaining knowledge included learning information and interpersonal skills. Accessibility referred to the availability and affordability of the therapist, of which the affordability was extremely important to clients (Paulson et al., 1999). Kremer & Gesten (2003) found affordability, accessibility, confidentiality and autonomy in decision making to be important.

Ress (2004) investigated the impact of trauma on interpersonal relationships and, using Martin Buber's philosophy and theory explored which components of psychotherapy were found useful in restoring such relationships. Prominent themes that were found useful included the therapist's flexibility and non-prescriptive attitude as well as treating the client holistically. Less prominent themes included the therapist's genuineness and care which were perceived as helpful. However, in some instances understanding of the situation and direction from the therapist took preference over empathy (Ress, 2004).

Williams and Collins (2006) conducted a predominantly qualitative study of 30 participants, to determine clients' perceptions of the counselling they had received from professionals at a trauma centre. The study found that the counsellor's human qualities such as warmth, caring, acceptance and understanding were most helpful. The therapeutic relationship (as is consistent with research) was therefore a fundamental part of the process.

Over fifty percent of the participants preferred a female counsellor, with the perception of women as being more nurturing than men. Others found that it did not matter as they were seeing a professional person. Religious and racial preferences were found to be less important. However, one person mentioned that it would have been uncomfortable had the counsellor been from the same racial group as her assailants. The importance of other support systems, outside of the therapeutic process, was an important factor in their recovery, and eighty percent of participants achieved post-traumatic growth in terms of greater self-awareness, by resolving other issues besides the trauma itself (Williams & Collins, 2006).

Interestingly, all respondents perceived the counselling to be a positive experience, with some participants previously having had a negative counselling experience elsewhere. High fees, lack of concern and psycho-education by the counsellor, lack of expertise in trauma management and a physical environment not conducive to counselling, were found to be negative factors in participants' experience in other settings. Important factors (found to be helpful in this study) included the creation of a safe environment, the perception of the counsellor as an expert in trauma management with the appropriate skills, psycho-education and the resolution of symptoms (Williams & Collins, 2006).

The safe environment included physical security as well as emotional security. Emotional security was achieved by ensuring confidentiality, and the counsellor's ability to not become overwhelmed by the client's distress and offer containment. The counsellors were perceived as being experts in trauma management as the centre

specialized in this area, and counsellors were able to locate the trauma in the context of other traumas. Psycho-education involved educating clients about the symptoms experienced with the normalization of symptoms and advice on coping strategies. Resolution of symptoms meant that clients' symptoms had improved or had been overcome (Williams & Collins, 2006).

In summary, the therapeutic relationship formed plays an integral role in the experience of therapy in general or in trauma debriefing specifically. Counsellor qualities such as warmth, empathy, unconditional acceptance as well as the empowerment of the client fit within the Rogerian approach (Moore, 1997). However, trauma debriefing models also draw on other theories, such as psychodynamic and cognitive-behavioural therapy (Eagle, 2000). Frank and Frank (1993) discuss how all forms of psychotherapy share common therapeutic elements and are therefore not fundamentally different.

Quantitative research has tried to establish the efficacy of trauma debriefing. However, there appears to be a gap in the literature in qualitative studies, whereby clients give their perceptions of the process, specifically where the debriefing is conducted by trained volunteers that have no professional training. Roger's approach is considered phenomenological as the subjective perception of the individual is considered more important than the event itself (Moore, 1997). Phenomenology is particularly useful as it explores 'meaning making' which can contribute to this area and can complement outcome studies.

CHAPTER 5: RESEARCH DESIGN AND METHODOLOGY

5.1 Introduction

This chapter provides a rationale for the use of phenomenology as a qualitative method. It also describes the aims, procedures, participants, data collection and analysis, reflexivity, credibility of the study and ethical considerations. Finally, it discusses the value of the study.

5.2 Assumptions and rationale for Phenomenology

This study is conducted within a qualitative framework. Creswell (1996, p. 15) defines qualitative research as "…an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem." This involves the researcher building a complex, holistic picture using detailed descriptions of participants given in a natural setting. Within the qualitative framework the researcher using a phenomenological approach looks at understanding human experience in context whilst suspending preconceived assumptions (Terre Blanche & Kelly, 1999).

Interpretative Phenomenological Analysis (IPA) is a phenomenological method of analysis used and is concerned with how people perceive an experience. There is no pre-determined hypothesis but the researcher has general questions in mind to explore (Langdridge, 2007). The researcher tries to make sense of the sense-making activities which Smith and Osborn (2003) refer to as a 'double hermeneutic'.

This framework fits the study as a method for understanding the difficult phenomena of human experience (Giorgi, 1997). The researcher is interested in discovering how the participants have experienced trauma debriefing. Each person in the study had gone through the trauma debriefing process first-hand and was therefore in a position to describe their lived experiences. This methodology allowed the researcher to go beyond the conversation of the interview and take cognizance of non-verbal behaviours. Kelly (1999) discusses how people may not verbalise their true feelings due to conscious and unconscious reasons. Therefore, being attuned to subtle changes in verbal and non-verbal communication yields a richer understanding of the experience.

5.3 Aims

The aim of this study is to explore how clients experience the trauma debriefing process offered by the Community Intervention Centre (CIC).

Key questions the study will address are:

1. How clients experienced the trauma debriefing process.
2. Their perceptions of the helpfulness / utility of the trauma debriefing.

5.4 Procedures

Counsellors (who met the criteria discussed in 5.5) explained to clients that the organisation is conducting research and gave then a form (see appendix A) to acknowledge whether they would like to participate in the study, giving their contact details. Only clients who met the criteria (as discussed in 5.5) were asked if they would be willing to participate. The researcher took the recommendation from a study done by Williams (2004) - that it would be preferable to gain consent from the client to be contacted as opposed to obtaining their phone numbers from the organisation and then phoning them. By doing this, the organisation's client names and contact details remained confidential apart from those who gave consent to be contacted. Furthermore, when phoning the participants to set up interviews, they had an idea of who the researcher was and what the study entailed.

Interview appointments were made with each of the participants (as discussed in 5.5) at a date and time that was suitable. Six interviews were conducted in a private counselling room at the Milnerton Medi-Clinic. During the interviews, the researcher introduced herself and explained to participants the nature and objectives of the research. Issues of confidentiality were discussed and participants gave their written consent to participate (see Appendix C). They were reminded that their participation was voluntary and that they were free to withdraw from the study at any stage.

Finally, they were advised of the availability of further counselling from the CIC, should the need arise. The researcher assured each participant that they would receive a letter of

general feedback on the results of the study (see Appendix D). The researcher felt it would be important for participants to receive an overview of results (written in everyday language), given their time and input with regards to the study.

5.5 Participants

Participants were selected using purposive sampling as is used with interpretative phenomenological analysis (Smith & Osborn, 2003). Langdridge (2007) suggests that the sample be fairly homogenous with a sample size of five to six people. This enables the researcher to draw similarities and differences from information obtained but may vary due to the "richness" of the cases as well as constraints within the study.

The researcher did not foresee a problem in obtaining participants for this study, given the above-mentioned criteria. However, most clients seen by the CIC had experienced a previous trauma and were therefore not included in the sample. This may be a reflection of the high trauma rates in South Africa (and the Western Cape) as discussed in the literature review. Should the researcher have needed a larger sample, the above-mentioned criteria would need to include clients that had experienced previous traumas.

To this end, six participants were selected involving adult clients (aged 20 and above) who had experienced a single traumatic event and had not been referred to a psychologist. The motivation for this limitation was to not introduce too many variables through exposure to multiple traumas and treatment by another therapist. The interviews were conducted within one to two months of the traumatic event and subsequent

debriefing. The time-frame was considered to allow the participants some time to recover from the trauma, whilst being able to recall their experiences of the debriefing.

The age range of participants was from 20 to 60 years with an average age of 41 years, consisting of two females and four males. Five participants were 'white' and one participant was 'coloured'. The 'ethnic' groups are distinguished for research purposes only and the researcher does not imply fixed racial differences between people. The traumatic events experienced by participants involved two armed hijackings with assault, three armed robberies and one armed robbery with assault. Three participants were seen on an individual basis and three participants were seen as part of a group. Two of the three participants that were seen in a group, experienced the same traumatic event and group debriefing.

Lay counsellors (who had been selected and trained by CIC) with at least two years' experience conducted the debriefing for this study, to control for certain counsellor variables such as training received and counsellor experience. Participants were therefore seen by different counsellors who met these criteria; however, two participants were seen in a group by the same counsellor. The counsellors were all 'white' females who had been initially trained in the Mitchell's model with continued skills development in the field of trauma (M. Humby, personal communication, 25 July 2007). The debriefing traditionally involves at least one debriefing session and a follow-up session.

5.6 Data collection

Semi-structured interviews are commonly used in phenomenological research to elicit rich descriptions of first-person accounts of concrete experience (Langdridge, 2007). The interview schedule was constructed after having reviewed the literature. Questions were 'funneled' which involves questioning from the general to the specific, so as to allow the participants to express their experience, prior to the interviewer eliciting detailed information which may have influenced their responses (see Appendix B). Semi-structured interviews have advantages of allowing rapport to be built with the interviewee. They maintain consistency through the interview schedule, giving questions and prompts to gain as much information as possible from the interviewee, as well as allowing the flexibility of the interviewer to pursue areas not anticipated that may arise (Langdridge, 2007). Respondents are seen as experts with regard to their own experiences and therefore have the opportunity to discuss an issue not introduced by the researcher (Smith & Osborn, 2003).

Interviews lasted between 25 and 75 minutes with the average duration being 42 minutes. Participants gave consent for the interviews to be recorded. The recordings were done by both tape and digital recorder to prevent any information being lost by changing the tape or any technical problems. The researcher had the digital recordings transcribed verbatim and kept a copy of the tape recordings for safekeeping. All transcriptions were carefully checked by the researcher. Field notes were taken by the researcher at the end of each interview, to reflect on the process.

5.7 Reflexivity

Reflexivity can be described as the researcher's awareness and engagement with aspects of their role or possible influence in the process (Eagle, Hayes & Sibanda, 1999). The research topic was of interest to me after having previously volunteered at the CIC, which included being part of the trauma debriefing team. I was cognizant of the fact that I hoped for a favourable response from the participants, due to my positive experience of the work done by the organisation. Although I endeavoured to stay open to positive and negative feedback, I may have influenced participants' responses unconsciously by verbal or non-verbal means. I was also aware of the power-relation that exists between researcher and participant, which can influence the respondent's answers to questions during the interviews (Egan, 2002; Spinelli, 1994). However, during the research I was pleased to receive some constructive criticism, which may have reflected openness on my part to both positive and negative responses during the interviews. During my reflection after each interview, I surmised that the participant's responses were genuine.

Prior to the study, I worked as a counsellor in a variety of settings (including the CIC) involving trauma. Whilst this was an advantage in understanding the process and being sensitive to what may emerge, I needed to be clear in the role of the interviewer and not that of counsellor. This posed a challenge, as certain participants would like to have discussed counselling-related questions. However, my role as a researcher was made clear at the beginning of the interviews and participants were reminded of the option of seeing a counsellor at the CIC.

5.8 Analysis of the data

Giorgi and Giorgi (2003) discuss the procedure of data analysis as having four steps:

Given that the phenomenological approach is a holistic one, the first step is to read the entire description of the participant in order to obtain a global understanding. The second step involves the researcher carefully rereading the description and assigning 'meaning units' to the text. The third step is to transform what is implicit to the explicit and to seek psychological meaning from the text. The final step is the discussion of the structure of the experience. This is achieved by discerning which 'meaning units' are essential in describing the experiences reported.

Interpretative phenomenological analysis (IPA) as described by Smith and Osborn (2003) was the method of analysis used in this study. IPA is consistent with the phenomenological analysis outlined by Giorgi and Giorgi (2003), as previously discussed and is concerned with how participants experience their world. Specifically, an event (such as trauma debriefing in this study) is explored in terms of the participants' personal perception as opposed to an objective statement of the event (Smith & Osborn, 2003).

The method used as discussed by Smith and Osborn (2003), is outlined in the following paragraph:

After all the interviews (and transcripts) were completed, one transcript was examined in detail prior to engaging with other transcripts. Themes were derived after having read the transcript several times. These 'meaning units' were recorded in the left-hand margin. The transcript was then re-read to ascertain theme titles (recorded in the right-hand margin), which included psychological terminology. Themes were then listed to search for connections between them, first chronologically and then theoretically. Cluster themes and super-ordinate themes were then tabulated with referral to the relevant page and line number in the text. The same process was then repeated for the other transcripts. Once completed, an overall list of themes was tabulated.

The above-mentioned process was followed, as outlined above. However, after the initial analysis was drafted, the transcripts were re-read to enhance the discussion. This was done by refining the themes and drawing on more quotations from the transcripts to illustrate meaning and give credibility to the findings. The literature review was later reviewed and expanded in order to discuss the findings in more detail.

According to Langdridge (2007), participant feedback regarding the findings needs to be carefully considered. Although it can be a valuable part of the process, there are limitations. Firstly, academic reports are not written for people in everyday language, and participants may not give honest feedback so as not to offend the researcher. There

is also the possibility of people not being able to distance themselves from their own experience. Finally, by interpreting the text, it means the participants may not recognize the original description given. In light of the above considerations, the participant feedback was not elicited.

5.9 Credibility of the study

There has been an historical debate between qualitative and quantitative research methods in social science, with quantitative methods claiming superiority over qualitative methods due to statistical (and thus 'scientific') analysis (Neuman, 1997). Quantitative researchers aim to control for effects of individual differences through methods such as randomization of participants into experimental and control groups. However, higher controls correlate with higher reactivity of participants, resulting in artificial results, thus reducing validity (Mouton, 1996).

Quantitative research measures objective facts using statistical analysis, with many cases where the researcher is detached and reliability is crucial. Qualitative research, on the other hand, constructs social reality using thematic analysis, with a few cases where the researcher is involved and authenticity is pivotal (Neuman, 1997). Mouton (1996) discusses how research is a compromise between reducing error and creating reactivity, whilst Neuman (1997) claims that both approaches have strengths and limitations.

Qualitative researchers have argued against judging the quality of their work by measures of validity and reliability that are applied to quantitative studies. They have suggested that their work be assessed by more appropriate criteria (Smith, 2003). Yardley mentions three broad principles for validity in qualitative psychology, namely, sensitivity to context; commitment, rigour, transparency and coherence; and impact and importance (Smith, 2003). The researcher hopes to have demonstrated the credibility of the study by outlining in the following paragraph how these principles have been met.

Sensitivity to context has been explained with the rationale for a phenomenological study, and illustrations of evidence drawn from the data in the results and discussion section as well as reflections on the process. Commitment, rigour, transparency and coherence have been illustrated by documenting the process that was followed, and showing how there is a fit between the research conducted and the approach used. The researcher hopes that the degree of engagement and thoroughness of the study is sufficient given the parameters of the study. However, the data collected during the interviews could have been explored more to give a richer understanding, which is discussed in the section on the limitations of the study. The impact and importance of the study (although modest) has been outlined in the value of the study (section 5.11).

Furthermore, data verification is demonstrated through the trustworthiness and credibility of the researcher. The researcher critically engaged with the findings to ensure they are credible and thus prove to be a believable account of the process (Durrheim & Wassenaar, 1999).

5.10 Ethical considerations

All participants were informed about the study and its aims, and had the opportunity to ask any questions relating to the research. They were asked to give their written consent (see Appendix C) prior to (and on completion of) the interview to affirm that they were satisfied with the process, and all queries were answered. Participants' anonymity was assured as their names were not mentioned on the tape recordings or in the thesis.

Participants were informed that they could withdraw from the study at any stage. No participants chose to withdraw during or after the interviews. Some participants even expressed gratitude for the opportunity to engage with the topic. The researcher was sensitive to the fact that engaging in the topic may evoke painful emotions, with a need for further counselling or referral. Participants were informed that they could see their CIC counsellor (or another counsellor if preferred) should the need arise. This was mentioned at the beginning and end of the interviews. The arrangement was made with the CIC prior to the commencement of interviews. In addition, the researcher also ensured that the interviews ended on a more positive note and ascertained that participants were contained by the end of the interview.

5.11 Value of the study

The literature is starting to acknowledge that it is important to find out what clients think about therapy (Manthei, 2007; Singer, 2005). There is also a limited amount of literature on client experiences of trauma debriefing. Therefore, this phenomenological study hopes to be of value in building on the existing literature within the field of trauma.

This study also specifically aims to be of value to the CIC. The organisation may take cognizance of client perceptions of the trauma debriefing offered, giving them an awareness of what is perceived as helpful/unhelpful by the client. This knowledge may be useful in the future selection of volunteers and the ongoing training of the trauma team.

CHAPTER 6: RESULTS AND DISCUSSION

6.1 Introduction

As discussed in the methodology section (chapter 5), the data has been analyzed and interpreted using different themes that highlight the clients' experiences. The results are discussed with reference to the literature, and quotations are given to illustrate these findings. Quotations in the discussion have been referenced from participant 1 to participant 6.

6.2 Client expectations and needs

With regards to the trauma debriefing, clients differed in having formed and unformed expectations of the session prior to the trauma debriefing received. This was reflected by participant 6 saying, *"… I didn't go there with any expectations…"* which encapsulates some general responses. The expectations clients have of therapy influence their perceived outcomes (Frank & Frank, 1993). Frank and Frank (1993) discuss how a client will not benefit from therapy unless there is a fit between expectations and outcome. The reason for having unformed expectations may be because it was their first traumatic experience and participants had not received debriefing prior to this. Participants with no idea of the process would therefore have had no comparative yardstick and thus would have been unlikely to be disappointed with the debriefing received.

However, participant 3 was initially resistant to receiving counselling, feeling irritated after having reported the event to the police saying, *"…I didn't want to sit and talk to somebody…why must I do it again?"* Another participant had built up expectations of the session after having spoken to a police officer and having been referred to an 'expert' in the field. Expectations of the session involved dealing with his thoughts and feelings and in terms of the outcome participant 5 stated, *"…I actually expected to feel alive, to feel back to normal after seeing this person."* Participant 1 reflected, *"I never expected counselling to be like that; I just thought it was a whole lot of paperwork…ask one or two questions and you walk out and you are still feeling the same as you were when you walked in."*

Participants generally felt that the need to talk to someone was important. This often included being able to express feelings, having someone listen and understand, catharsis, reassurance, comfort and advice. Participant 5 captured his needs by saying, *"So I thought, speak to somebody then I can actually let go of things inside me and get advice on which direction I have to deal with it…am I dealing with it in the correct way…?"* Participant 1 said, *"…I needed to be comforted and I needed that guarantee that there would be someone here for me."* whereas participant 5 felt, *"I needed a shoulder to cry on to be honest…I needed to share things with somebody different that can advise me."* These needs are addressed in trauma debriefing models as discussed in the literature review. For example, by re-telling the story clients have the opportunity to express their feelings whilst the counsellor listens to them. Psycho-education also forms part of educating clients around symptoms and coping strategies.

6.3 What was perceived as helpful/unhelpful

Participants were questioned about the helpfulness/unhelpfulness of the process. Having someone to talk to who was able to listen well, and information gained, were perceived to be important parts of the process. This will be discussed in detail in the following sections.

Interestingly, all participants saw the process in relation to the experience of the counsellor(s) seen. Spinelli (1994) reviews several studies which highlight the quality of the relationship between counsellor and client as a key component of the therapeutic process. In Rogerian person-centred therapy the quality of the therapeutic relationship is vital in creating a therapeutic climate (Moore, 1997). Although the trauma debriefing involved only one formal session, the therapeutic relationship formed seemed to have played an integral part in the process. The relationship formed appeared to have influenced the perceived outcome of participants, with a positive relationship contributing towards a beneficial outcome.

6.3.1 Counsellor values

The perception of the counsellor's values appeared to play a crucial part in how the debriefing was experienced. The different values will be discussed as follows:

Warmth and acceptance

Clients generally appreciated the warmth and acceptance of their counsellors. Participant 4 said, *"I could tell she was a comfortable lady when she walked in."* whilst participant 1 echoed, *"…she was very, very comforting; I could talk to her and I became totally relaxed, and I felt that warmth is like a bond I think…"* Some participants mentioned having appreciated the counsellor being 'soft-spoken' with a relaxing voice as participant 3 stated, *"…she spoke in such a nice way and she's a soft-spoken person in nature…"* The warmth of the counsellor appeared to contain clients' emotions and enabled them to feel safe enough to trust talking to the counsellor. The warmth expressed by the counsellor as well as showing a genuine interest in the clients contributed towards them being approachable. Participant 1 captured this by saying, *"…when a person talks to you with sort of love and affection and brings the warmth out and you calm down, you can feel it happening…I trusted her, and I still trust her today."*

This relates to what Rogers (1961) discusses as unconditional positive regard afforded to the client, involving respect and liking the client for who they are, thus creating a safe space for exploration of thoughts and feelings. Warmth is often discussed in the

literature without any detailed description. However, it is described by Gladding (2000) as an important personal quality of counsellors, which forms part of their personality.

Empathy

Participants identified empathy as an important part of the counselling process. Participant 1 captured this by saying, *"…she sort of puts herself right in the position so that she can guide me and help me."* Empathy can be defined as being able to put oneself in someone else's 'shoes' by feeling 'with' the client and being able to relate this back to them (Gladding, 2000). In Rogerian terms it goes beyond this; to clarifying meaning of which the client is not yet aware (Moore, 1997). It also involves an appreciation for the client's thoughts and feelings at that moment (Rogers, 1961). As discussed by Egan (2002) empathy has been defined as both a value and an acquired communication skill. As a value, it has been described as a personality trait, a situation-specific state used in counselling and in Rogerian terms as intuitively understanding the client's 'inner world' and reflecting this back to the client. Empathy described by Egan (2002) as a communication skill is similar to the Rogerian description given.

McLeod as discussed in Spinelli (1994) highlights factors that may impede the therapeutic process, of which one is problems in the relationship with the therapist. Contrary to the majority of participants, one participant identified empathy as important even though he did not find the counsellor concerned empathic. Although participant 5 stated that she was a *"…nice person"* he did not feel comfortable to disclose his feelings

to her and attributed this to the lack of therapeutic relationship formed, which included a lack of empathy. Participant 5 explained that, *"I just didn't get the vibe that I can let it out…"* and *"I didn't feel that she has experience in the field with emotions and that."*

Conversely, the participant found talking to a policeman helpful due to the perceived qualities he possessed such as concern, listening skills, being feeling-orientated as well as asking appropriate questions, giving advice and making him feel understood. He admitted preferring to discuss emotional issues with a female counsellor but found that, despite being a male, the policeman was more helpful. Participant 5 mentioned that the policeman was, *"…being a real human with feelings…his whole being…you can feel that, you can relate that he's showing interest, he's caring…" and "He cares, you know you can see the way a person looks at you, the way a person's emotions, a person's face, that they are listening to you…he definitely understood where I'm coming from…"* The empathy afforded by this policeman was therefore appreciated. This supports the above-mentioned argument that empathy is crucial.

Genuineness

The counsellor's presence and genuineness was generally perceived as helpful. Participant 4 stated, *"…her presence was good enough* and participant 3 reflected, *"…you know you really speak from the heart…"* Rogers (1961) discusses how genuineness is achieved in the therapeutic relationship by the therapist being aware of their own feelings and having the ability to be 'real' or transparent with the client. Egan (2002) expands on

this by suggesting genuineness refers to the counsellor's attitude and behaviour. The counsellor shows congruence by being themselves in all situations, therefore not putting on a façade in the counselling situation. This therefore allows for more spontaneous responses to clients and may include appropriate self-disclosure as well as being open to explore criticism voiced by the client.

The above-mentioned attributes are consistent with a study by Williams and Collins (2006), who found counsellors' human qualities (such as warmth, caring, acceptance and understanding) most helpful. These qualities have been found to be an important part of the therapeutic process in studies viewed by Spinelli (1994), and resonate with the Rogerian style of unconditional acceptance, empathy and the authenticity of the therapist (Moore, 1997). Rogers (1961) argues how the therapeutic qualities discussed are a necessary and sufficient pre-condition for therapeutic work to take place.

6.3.2 General skills

Listening skills

Counsellors who showed good listening skills were found to be helpful in the debriefing. Specifically, active listening during the retelling of the traumatic event was well received by participants. Participant 2 commented, "*…she was very concerned…"* and *"She was a very good listener, excellent listener, she let me wobble on and talk and talk…"* capture this.

Egan (2002) describes full listening as being able to listen actively, accurately and to search for meaning. The counsellor needs to be totally present with the client psychologically and emotionally. Rogers described listening as 'empathic listening' which is driven by empathy. The counsellor is selfless and is totally 'with' the client, putting their own concerns aside whilst listening and communicating this understanding. Empathic listening precedes understanding, which in turn precedes responding (Egan, 2002).

6.3.3 Counsellor techniques

Counsellor techniques discussed in this section include skills acquired by the counsellor as well as aspects that are specific to trauma debriefing:

Assessment and containment

The way in which the counsellor concerned asked questions was important to most participants in terms of eliciting thoughts and feelings as participant 3 said, *"…the way she asks the question…"* Participant 1 appreciated the timing and flexibility shown in her questioning and explained, *"…she wasn't trying to just stab away at what happened, she came around it and came clean and back again"*. In a study by Ress (2004) it was found that the therapist's flexibility was important. The counsellor style had a calming effect on most participants. Participant 1 stated that, *"…it came from the talk, and she brought out things that made me calm down…"*

On the other hand, one participant felt the session was too report-orientated by not having enough thoughts and feelings elicited via in-depth questioning. Participant 5 felt that he may have been able to give deeper thoughts and feelings had more questions been asked, such as, *"…what goes on in your mind, what are you thinking, open up your worst thoughts, it doesn't matter how it sounds."* These types of questions form part of the Mitchell's model discussed in the literature review.

It was also found to be unhelpful to hear what other people had experienced in terms of their trauma and how they felt and recovered, as participant 5 said, *"…I want it to be about me…"* This is consistent with a study by McLeod in Spinelli (1994), that therapists who said something that 'did not feel right', impeded the therapeutic process. Howe discussed in Spinelli (1994) found that when clients felt misunderstood or had explanations imposed on them, this was detrimental to the process.

Psycho-education

Psycho-education was found to be an important part of the debriefing process. Participant 6 perceived the counsellor's expertise, with information given as being the most beneficial part of the session, as he reiterates, *"…they were informed, they knew what they were talking about."* The perception of the therapists' expertise was considered important in other studies (Paulson et al., 1999; Singer, 2005; Williams & Collins, 2006). Most participants placed a lot of value on psycho-educational aspects, as participant 6 stated, *"…they were just great with the kind of information they gave you."*

This included information such as body functioning, emotional aspects, knowing what to expect and advice on how to cope. Two participants mentioned the value of the pamphlet they had received, as participant 3 emphasized, *"She gave us a pamphlet…and that made good sense…"* The educational component of counselling was found to be important in various studies (Bryant & Harvey, 2000; Deahl, 2000; Williams & Collins, 2006).

Information received by participants appeared to be reassuring and empowering. Participant 1 said, *"What she spoke to me about, we put into practice and when I say we – I did it through her…"* Other participants gave examples of advice given which they had found reassuring and helpful. Participant 2 commented, *"…she did say it will come right, just be patient, it will take time."* and participant 1 found, *"…there were lots of things she told me to do – go for long walks…but if somebody talks to you about it, talk about it…"* This relates to the normalizing of symptoms and coping strategies previously discussed in the trauma models.

One participant found that some humour used towards the end of a group session made the counsellors further relate to the group. Another participant appreciated receiving a hug at the end of the session, which is generally not considered appropriate in traditional psychotherapy. However Howe, discussed in Spinelli (1994), mentions how each therapist's individual personality - with aspects such as humour and 'quirks' - was found to be important to clients.

Another participant was the victim of a second robbery since the initial trauma and debriefing. He found that the knowledge gained from the debriefing had been so helpful that he was empowered to help himself deal with the subsequent incident. Participant 6 emphasized, "*They were just great with the kind of information that they kind of gave you…I actually used some of that information that they gave me with the second one that happened to me."* This relates to the study by Myller (2000) whereby coping mechanisms were found to be important, as well as the resolution of symptoms in a study by Williams and Collins (2006). This directive component of trauma debriefing is important, given the brief time counsellors have with clients, and differs from many long-term therapies. Both the trauma models previously discussed include phases of education and normalization of symptoms, as well as teaching or encouraging mastery.

6.3.4 Perceived outcome

Perceived outcome was not assessed directly in terms of symptom relief but was explored in terms of how participants experienced the process. As discussed in the literature review, outcome studies can be complemented by client perceptions in the debate over the efficacy of debriefing. Five of the six participants found the debriefing to be very helpful in the process of recovery from the trauma. Frank and Frank (1993) discuss how 'success' in therapy is related to the establishment of a therapeutic relationship. The five participants who found the debriefing helpful had formed a 'therapeutic relationship' with their counsellors.

Most participants found talking to be helpful in bringing about catharsis and thus felt more relaxed after the session. Re-telling the story is a key component in trauma debriefing models, as discussed in Chapter 3. Spinelli (1994) mentions that the opportunity to talk was most helpful in a study done by Feifel and Eells. Participants' comments reflect this, such as participant 3 who felt, *"…it's like the mountain is off my shoulders, I gave it to someone else."* and participant 1 who said, *"I was very much more relaxed by the time we had finished than what I was…I am 80 percent better than I was…and that's stunning, it's working."* Participant 3 found, *"…the whole puzzle was for the first time put together"* after having re-told the story, thus facilitating cognitive closure. Participant 1 emphasized, *"When I left here I was a totally different person."*

Other factors mentioned were reduced anger, being informed, as well as the prevention of psychological damage. This relates to the educational aspect of trauma debriefing with its aim of preventing PTSD and facilitating recovery, as outlined in the literature review. Participant 2 admitted to needing a further session and had intentions of contacting the counsellor concerned as he sometimes, *"…can't concentrate too well at work…"* Another participant commented that despite the helpfulness of the session, she felt it should be noted that a person still needs to 'do the work' themselves, meaning that the counsellor is only a facilitator in the process.

Participant 5 found the session to be unhelpful as nothing was achieved and the feeling was one of disappointment and confusion, as he said, *"…if I'm going to see somebody and I'm mentally now prepared to let everything out and it doesn't happen, it's almost*

like you know everything is there, ready to explode and now it just stays there because it's not coming out and it leaves you sort of semi-confused." He therefore did not have cathartic relief as mentioned with other above-mentioned participants. The participant appeared to feel guilt at being seemingly ungrateful, as he was impressed with the service offered and *"…knowing there are people who care."* It is possible that the high expectations of what would be achieved in the session were not met and resulted in his later disappointment. This may have been exacerbated by the trauma of bringing up past difficulties in his life, for which a referral to a professional may have been warranted.

Most participants found comfort in the fact that they could contact their counsellor should the need arise. This made an impact on participants with comments such as participant 1, *"…I know in the back of my mind that she's there…if I do need to talk I can pick up the phone…"* and participant 2, *"With dedicated people like that, you don't always get and I can call her at any time…"* Participant 1 felt that having his counsellor's phone number, *"…gave me a lot more confidence in myself; that I knew there was somebody there if I wasn't too sure."* Myller (2000) found that the availability of the therapist was one of the most important factors. This is also consistent with Paulson et al. (1999) finding that availability (which includes affordability) is important.

Follow-up calls with the opportunity for further sessions were well received by participants as participant 3 reflected, *"It wasn't just a once off…she followed up…"* The need to follow up clients, as previously discussed, is a key component of CISM.

Participant 5 indicated that there was no follow-up and felt, *"…we just disappeared from one another in life…"*

All participants recommended that the organisation continue with its trauma counselling. Participant 1, who captured the general feedback said, *"Well I could recommend anybody that goes through a traumatic experience…it's fantastic what that lady did for me"* with participant 2 emphasizing *"…and this was for free as well, unbelievable."* The accessibility and affordability of the therapist were found to be important factors in a study done by Kremer and Gesten (2003) and Paulson et al. (1999). Participant 4 advised that clients go for debriefing as she said, *"They are patient, they will listen and they will give you advice on how to handle it."*

Some participants recommended that timing was of essence and suggested seeing clients as soon after the event as possible, thus urging the organisation to emphasize to police stations the importance of immediate referrals to the CIC. Participant 5 captured this by saying, "*If somebody can be there at that moment or closest to that time, I think it probably would be much greater."* This is consistent with the CISD model, whereby debriefing normally occurs within 72 hours of the event.

Another suggestion was for the organisation to be more visible in the area via the distributing of cards or posters (for example) in offices. A follow-up call from the counsellor concerned was deemed important as well as the possibility of including the family in a session as an option. It was also recommended that counsellors make a

judgment as to when they need to refer a client to a colleague in terms of counsellor/ client fit, or to a professional, where more expertise is required. Participant 5 commented, *"Do you feel that you would need to see somebody else, or do you feel that you can speak to me?"* and *"I think they serve a good purpose…but then put them onto people that can really help them, that specializes in whatever field…"* The inclusion of follow up and/or referral is part of the CISM process outlined in the literature review.

6.4 Critical reflection of the general findings

In the literature review, the debate regarding the efficacy of debriefing suggests that outcome measures are too narrow. However, it is important to address why the majority of participants in this study did not give negative feedback. Five of the six participants could not mention anything about the debriefing that was perceived as unhelpful. Comments such as that of participant 2, *"No, not that I can think of, definitely not."* and participant 4, *"Nothing, she was helpful all the way."* capture this. Although it is important to take cognizance of the responses as experienced, a critical engagement with the findings can give a more holistic understanding. This includes understanding silence on negative feedback. Spinelli (1994) recommends that therapists consider alternative possibilities, thus reconsidering our assumptions.

There are two possibilities why participants were not critical of the process. Firstly, they had no negative feedback. Secondly, negative feedback was not shared. Reasons for not sharing negative feedback could be that clients are not aware of the debriefing process

itself and have no comparative yardstick. Another possibility is that the person may feel disempowered and is grateful for receiving free help, and this may override any criticism. Finally, the participant may not want to upset the researcher or organisation in any way. This is due to the unavoidable imbalance of 'power' between researcher or therapist and the client (Spinelli, 1994). Frank and Frank (1993) maintain that therapists bias client responses by both verbal and non-verbal means. This is not done intentionally but may occur, for example, by means of encouragement (verbally or non-verbally) of certain responses.

Having said this, one participant, although appreciative of the service offered found the debriefing unhelpful. He offered a rich description as to why this was the case. Obtaining critical feedback regarding the session is valuable as there is generally reluctance in people to discuss negative aspects (Henkelman & Paulson, 2006). This relates to the relationship of power discussed above.

CHAPTER 7: CONCLUSIONS AND RECOMMENDATIONS

7.1 Limitations of the study

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Counsellor variables in terms of their experience in the area of trauma debriefing and the consistency of treatment may influence client experiences. However, lay counsellors whose clients participated in the study were limited to those who had the same training and a minimum of two years' experience at the organisation to minimize this limitation.

Half the participants in this study were seen as part of a group and the other half on an individual basis. This is seen as a limitation in terms of generalizing findings. However, although debriefing was initially developed for groups, it is applied to individuals exposed to traumatic incidents (Ajdukovic, 2001). Furthermore, group and individual treatments share common elements, even though groups offer unique healing components, such as universality, altruism, vicarious learning and cohesion (Frank & Frank, 1993).

What strongly emerged in terms of the themes were counsellor qualities or values. This information is useful and is confirmed by previous studies mentioned in the literature review. Some of the more specific information relating to debriefing did not emerge. Explanations for this could be that this is less helpful or that it wasn't explored more fully. The researcher did not want to influence participants' responses and therefore did

not directly obtain as much specific information. Further literature therefore needs to distinguish between the two.

From a quantitative perspective, the study was limited to a sample of participants from one organisation, thus findings will therefore not be generalisable. However, findings provide rich in-depth explanations that are sensitive to context, giving a coherent picture of the research question (Neuman, 1997).

7.2 Conclusions

Five of the six participants perceived the debriefing process to be very helpful. Their experience of the process itself was synonymous with their experience of the counsellor seen. This is consistent with the literature which states that the therapeutic relationship formed in counselling is central to the process. This is significant, given the nature of trauma debriefing as having limited therapeutic contact when compared with psychotherapy.

Counsellor qualities (such as empathy, warmth, concern and the ability to listen) are found to be important in all types of therapy (Spinelli, 1994). However, more directive aspects of the debriefing such as psycho-education and advice – which differ from long-term therapy - are valued by clients. Counsellor availability and follow-up were considered as important and containing parts of the process, even if not utilized. The willingness of the counsellor to be contacted telephonically or to meet with clients should

the need arise appears to be more flexible and comforting to the client than a more rigid appointment system of many long-term therapies.

It appears from this study that the trauma debriefing offered by the CIC is of great value to the community it serves and may serve as an example of what could be achieved in other areas around the country. Although trauma debriefing is not a substitute for psychotherapy, it is an intervention that has been found to be helpful, and made accessible to the public as a free service. With limited access to professional therapy, largely due to affordability in South Africa combined with high crime/trauma statistics previously discussed, it can be argued that there is a need for trauma debriefing services to be continued by the CIC and started in other areas.

7.3 Recommendations for further research

It is evident from this study and the literature available that more research is needed to elicit client views of therapy, and in this case trauma debriefing. However, given the perceived helpfulness of trauma debriefing found in this study (and other studies mentioned in the literature review), contrasted with the largely negative findings of outcome studies, it would be fruitful to explore a similar study whereby both methodologies are employed. In addition to this, it would be fruitful to study individual and group debriefings separately as well as different trauma models.

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APPENDICES

Appendix A

Dear Client

The community intervention centre (CIC) is involved in research so that we can ensure that we are meeting the needs of our clients in the best possible way. Your participation may assist us in improving our understanding of trauma and you would be helping us in our attempt to address the impact it has in our community.

We may need to telephone you during your attendance here or after you have completed your counselling to establish whether you would be willing to participate in the research study. Could you please complete the following section which indicates your willingness to be contacted to participate in the research? **As a participant, you are free to withdraw from the research at any stage and this will not adversely affect you in any way. Your identity will be kept confidential at all times and should the research affect you in any way, you will have the opportunity to speak to a counsellor at the organisation.**

I_____WOULD/WOULD NOT

like to be contacted to participate in research.

Signature_____ Date_____

Thank you.

Appendix B: INTERVIEW GUIDE

Introduction: Nature of interview and purposes. Confidentiality. Counsellor availability and feedback.

1) Explain briefly what your traumatic event was and how many sessions you had.
2) What did you expect from the debriefing process?
3) How did you experience the trauma debriefing?
4) What meaning did the process hold for you?
5) What were your needs at the time of the trauma debriefing? Describe how these were/were not met.
6) Describe any specific part of the process that impacted on you in any way.
7) Was this process helpful? What was helpful? How did the counsellor facilitate this?
8) How did you experience the counsellor? Which attributes were most and least helpful?
9) What was not helpful about this process?
10) How have you integrated this experience into your life?
11) Would you recommend trauma counselling/support offered by the CIC? Why?
12) Do you have any recommendations you wish to make for the organisation?
13) Is there anything else you would like to mention?

Notes to self:

Reflection on interview. Availability of counsellor should the interview have evoked anything you wish to discuss. Containment.

Contact details for feedback.

Appendix C: PARTICIPANT INFORMATION SHEET / CONSENT FORM

This study hopes to inform our understanding of how trauma counselling is experienced from clients' perspectives. The research will also be used towards the obtention of a master's degree. As a participant, you are free to withdraw from the research at any stage and this will not adversely affect you in any way. Your identity will be kept confidential at all times and should the research affect you in any way, you will have the opportunity to speak to a counsellor at the organisation.

Instructions to participant: Please print and then sign your name in the space provided in Section A before you participate in this study. Once the study is over and you have been debriefed, you will be asked to initial the three statements listed in Section B to indicate your agreement.

Section A

I, _____, voluntarily give my consent to participate in this project. I have been informed about, and feel that I understand the basic nature of the project.

I understand that I may leave at any time and that my anonymity will be protected.

_____ _____

Signature of Research Participant Date

Section B

Please initial each of the following statements once the study has been completed and you have been debriefed:

_____ I have been debriefed.

_____ I was not forced to stay to complete the study.

_____ All my questions have been answered satisfactorily.

(Rosnow & Rosenthal, 1999)

Appendix D: Copy of feedback letter

Date

Dear _____

Thank you once again for participating in the research study which I conducted during April and May this year. I am pleased to be able to share some of the general findings with you, as previously discussed. Here are some of the key results of the research:

- **Five out of the six participants interviewed generally found the trauma counselling that they had received helpful.**

- **The helpfulness of the counselling was perceived to be largely due to the counsellor's qualities, such as warmth, understanding, calmness, concern and the ability to listen well.**

- **Other helpful aspects included information on post-trauma symptoms (including the pamphlet received), advice on ways of coping, retelling the event, flexible questioning, the counsellor's availability and personal contact details as well as follow-up calls.**

- **Some recommendations were made regarding the trauma counselling service, such as the importance of being referred for counselling as soon as possible after the traumatic event, referral to a colleague or professional where appropriate, and the importance of follow-up calls.**

- **All participants felt that the Community Intervention Centre (CIC) should continue with trauma counselling and were appreciative of the service offered.**

If you would like more information regarding the above results or have any queries, please feel free to contact me. As discussed during the interview, if this research evoked any feelings you wish to discuss, you are welcome to contact your counsellor or any other counsellor at the CIC for a follow-up session or referral. Thank you for your time and contribution, which have been a valuable part of this project.

Yours sincerely

Fiona Chandler
Researcher: Contact tel. 0833759787