



UNIVERSITY *of the*  
WESTERN CAPE

The Faculty of Community and Health Sciences

**A Qualitative Study Exploring the Experience of Vicarious  
Trauma among Female Psychologists Working with Survivors of  
Sexual Violence in the Western Cape**

Nondumiso Gqomfa  
9552475



Mini-thesis presented to the Department of Psychology, University of  
the Western Cape, in partial fulfilment of the requirements for the  
Masters degree in Clinical Psychology

Supervisor: Prof Anita Padmanabhanunni

30 October 2019

*The financial assistance of the National Research Foundation (NRF) towards this research is hereby acknowledged. Opinions expressed and conclusions arrived at, are those of the author and are not necessarily to be attributed to the NRF.*

**UNIVERSITY OF THE WESTERN CAPE**  
**DEPARTMENT OF PSYCHOLOGY**

**Declaration**

1. I know that plagiarism is wrong. Plagiarism is to use another's work and pretend that it is your own.
2. I have used the APA convention for citation and referencing. Each significant contribution and quotation from the works of other people has been attributed, cited and referenced where appropriate.
3. I certify that this submission is all my own work.
4. I have not allowed and will not allow anyone to copy this assignment with the intention of passing it off as his or her own work.

Signed:



Date: 30/10/2019

## Abstract

South Africa experiences one of the highest rates of sexual violence in the world. It is well-documented that therapists who work with trauma survivors are negatively affected by the trauma stories they hear from their clients. The negative consequence of being exposed to traumatic material on the therapists is known as Vicarious Trauma (VT). VT refers to clinicians' negative emotional, cognitive and behavioural changes due to hearing stories of trauma from their clients. This study aimed to explore the experience of VT among female clinical/counselling psychologists who treat survivors of sexual violence in the Western Cape province of South Africa and the coping strategies they employ to counter VT symptoms. The interpretive phenomenological analytic (IPA) qualitative research method was used in this study with semi-structured interviews being scheduled for 15 female clinical/counselling psychologists. IPA was also employed as a means of data analysis. The results are consistent with existing research, with all participants in this study attesting to being negatively impacted by hearing trauma stories. A majority of psychologists reported negative emotional and psychological reactions from the work. PTSD symptoms were present in some of the participants, however, all felt that in the context of South Africa, hypervigilance should not be understood as maladaptive but rather a very adaptive and necessary tendency. Only one participant reported developing VT as a result of the work. All used different strategies for coping with the negative effects of their work with supervision being used the most by all participants. A majority of psychologists also attested to having gained renewed hope and positive growth through engaging with survivors of sexual violence.

**KEYWORDS:** *vicarious trauma, compassion fatigue, secondary traumatic stress, burnout, trauma, posttraumatic stress disorder, sexual violence, coping strategies, psychologists, South Africa*

## Acknowledgement

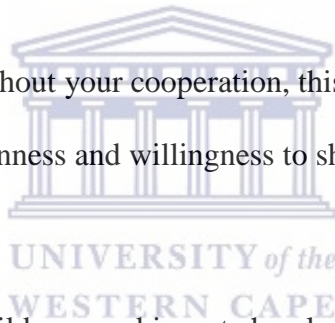
If it had not been for the support and encouragement of so many people, this thesis would never have seen the light of day.

Firstly, my heavenly Father, my God, my Saviour, You are faithful in all Your ways. Thank you for the fresh supply of grace and mercy every time I needed them.

My supervisor, Prof Anita Padmanabhanunni, you stuck through when I had given up on my ability to complete this study. Thank you so much for your perseverance, support, encouragement and grace when I needed it most.

Prof Mwaba, my mentor, you came at just the right time. Thank you for reminding me of my priority to complete what I had started.

The participants in this study, without your cooperation, this study would never have been possible. Thank you for your openness and willingness to share your experiences to a novice researcher.



My husband, Mxolisi, and our children, my biggest cheerleading team, knowing all there is to know about me, yet you accept me. Thank you so much for your love, encouragement and support throughout this process.

My mother and siblings for always demanding that I do not settle for less and reminding me that I had not yet achieved the goals I had set out to achieve.

To the University of the Western Cape's department of psychology for financial assistance towards completing the MPsych degree.

## Dedication

I dedicate this work to my amazing children, Lulibo, Lima, Luvuno, OweNkosi and Luyana. You are made a strong stuff, I'm really privileged to witness your incredible resilience in the face of so many challenges. I look at you and I know there is hope for our country, South Africa.

To all the survivors of sexual violence, you are my inspiration! Thank you for having the courage to share your stories.



## **Glossary of Abbreviations**

---

VT – Vicarious Trauma

ST S – Secondary Trauma Syndrome

CF – Compassion Fatigue

PTSD – Post traumatic Stress Disorder

CSDT - Constructivist Self-development Theory

## **List of Tables**

---

Table 1: Prevalence of rape..... 18

Table 2: Participants’ Demographic Details .....27



UNIVERSITY *of the*  
WESTERN CAPE

## **List of Figures**

---

Figure 1: Themes .....35

## Table of Contents

<b>Declaration.....</b>	<b>i</b>
<b>Abstract.....</b>	<b>ii</b>
<b>Acknowledgement .....</b>	<b>iii</b>
<b>Dedication .....</b>	<b>iv</b>
Glossary of Abbreviations .....	v
List of Tables .....	v
List of Figures .....	v
<b>Chapter 1: Introduction .....</b>	<b>1</b>
1.1 Background .....	1
1.2 Rationale .....	5
1.3 Problem Statement .....	7
1.4 Aim .....	7
<b>Chapter 2: Literature Review.....</b>	<b>8</b>
2.1 The Prevalence Sexual Violence in South Africa.....	8
2.2 Psychological Consequences of Sexual Violence for Survivors .....	10
2.2.1 Post Traumatic Stress Disorder.....	10
2.3 The Impact of Treating Survivors of Sexual Trauma on Clinicians.....	12
2.3.1 Vicarious Trauma: the Burden of Caring.....	12
2.3.2 Vulnerability to VT.....	14
2.3.2.1 Personal Trauma History .....	14
2.3.2.2 Gender.....	15
2.3.2.3 Experience in Trauma Work .....	16
2.3.2.4 Trauma Training .....	17
2.3.3 Coping with Vicarious Trauma.....	18
2.3.3.1 Social Support.....	18
2.3.3.2 Spiritual Renewal.....	18
2.3.3.3 Supervision .....	19
2.3.3.4 Self-Care .....	19
<b>Chapter 3: Theoretical Framework .....</b>	<b>21</b>
<b>Chapter 4: Methodology.....</b>	<b>23</b>
4.1 Research Design.....	23
4.2 Participants.....	25
4.3 Data Collection .....	26

4.4 Data Analysis .....	27
4.5 Ethical Considerations .....	28
4.6 Trustworthiness .....	29
4.7 Reflection of the Research Process .....	29
<b>Chapter 5: Findings .....</b>	<b>33</b>
5.1 Participants' lived experiences of vicarious trauma .....	33
5.1.1 Hearing Sexual Trauma Stories: Feelings Beyond Empathy.....	33
5.1.1.1 "I lost my faith": Feelings of hopelessness and helplessness.....	35
5.1.1.2 "I could never get used to it": Shock and Horror .....	36
5.1.1.3 Feelings of Anger: "I do not want to work with this [case], it is going to make me angry .....	38
5.1.1.4 Sadness and Despair: "these cases just keep me stuck in a place of despair".....	38
5.1.1.5 Feelings of Guilt: "It felt like I was doing nothing" .....	39
5.1.1.6 "There's a part of me that wants to run for the hills": Avoidance of traumatic material.....	40
5.1.1.7 Hypervigilance: "I no longer look at it as being overly cautious or hypervigilance – it's just the smart thing to do.".....	41
5.1.1.8 Intrusive thoughts and images: "I tend to visualise the story as they tell me, so that is quite traumatising for me." .....	42
5.1.1.9 Broken Sleep and Nightmares: "I'm being raped or abused or whatever, I think that's how sometimes it comes out." .....	42
5.1.2 Changes in Beliefs: Threatened Sense of Self .....	43
5.1.2.1 Being a woman: "you always feel vulnerable, always" .....	44
5.1.2.2 Increased Mistrust of Men: "we don't hear about good men" .....	45
5.1.2.3 Increased vigilance around significant others: "even people so close to you like a brother, father and uncle can inflict harm on you.".....	46
5.1.2.4 "Sex causes so much s--t in the world": Sex and Intimacy.....	47
5.2 Coping with sexual trauma: participants' self-identified coping strategies.....	49
5.2.1 Supervision: "No, it (the work) can't be done without a supervisor" .....	50
5.2.2 Peer Supervision: "Yoh! This is a heavy case, I am stuck, what do I do?" .....	51
5.2.3 "Things... that are about filling you": Social interactions.....	53
5.2.4 "Not trying to be a hero": Recognising personal limitations .....	53
5.2. Spirituality "I would never be able to do this work if I didn't have my faith." .....	55
5.2.6 Making trauma work bearable: "For me it's almost bolstered a sense of hope" .....	55
<b>Chapter 6: Discussion .....</b>	<b>58</b>
6.1 Participants' Lived Experiences of VT .....	58
6.2 Participants' Self-Identified Coping Strategies .....	63
<b>Chapter 7: Conclusion.....</b>	<b>65</b>
7.1 Recommendations.....	66



7.2 Limitations ..... 67

**References..... 69**

**Appendix A: Information Sheet ..... 78**

**Appendix B: Consent Form ..... 80**

**Appendix C: Semi-structured interview questions..... 81**

**Appendix D: Ethical Clearance ..... 83**



## Chapter 1: Introduction

### 1.1 Background

*“Very few South Africans live lives completely untouched by trauma and, for many, exposure to potentially traumatic experiences is an inescapable part of daily life.”* (Kaminer & Eagle, 2010, p.8-9)

The South African history of racial oppression with its consequential prolonged political violence under the apartheid regime was not only degrading to the oppressed but it also served to dehumanise certain groups of people and led to the break-down of societal moral fibre (Finchilescu & Tredoux, 2010; Snodgrass & Bodisch, 2015). The advent of a democratically-elected government in 1994 promised a better life for all, however the country’s violence-ridden apartheid past has been carried into the present. Presently South Africa holds the status of being an extremely violent country (Kaminer & Eagle, 2010) such that it “could be described as a country ‘at war with itself’” (Snodgrass & Bodisch, 2015, p.67). There is evidence that South Africa is counted among a few countries that boasts high levels of criminal, domestic and sexual violence along with accidental injury and death (Kaminer & Eagle, 2010). The latest statistics from the South African Police Services reveal high levels of contact crime, such as murder, femicide and sexual offences for the period 2017/2018.

In keeping with international trends, gender represents a risk factor in vulnerability to specific types of victimisation, with men and boys, by and large, being affected by different types of violence compared to women and girls (Burton & Leoschut, 2013; Kaminer & Eagle, 2010). For example, South African men and boys commonly face criminal violence, such as physical assault while women and girls are mostly victims of intimate partner abuse and

sexual violence or coercion (Burton & Leoschut, 2013; Kaminer & Eagle, 2010). In trying to draw similarities and differences with statistics from the rest of the world, technicalities, such as varying legal definitions of rape in different contexts may pose a challenge (Vetten, 2014; Dartnall & Jewkes, 2013), nevertheless, it is evident that women and girls in South Africa are particularly vulnerable to sexual violence compared to other countries in the world (Vetten, 2014; Kaminer & Eagle, 2010).

This study focuses on the impact of working with survivors of sexual violence for clinical/counselling psychologists. For the purposes of this study I have relied on the understanding of sexual violence in its broad sense that involves actual or attempted unwanted sexual acts. These include rape, sexual assault, sexual abuse, levelled at an individual through force or other means of intimidation by any person, taking place in any environment, including the home (Jewkes & Garcia-Moreno, 2002). Although it is difficult to obtain statistics that reflect true rates of sexual violence, largely due to under-reporting by victims, with estimates running at only 1 in 25 cases being reported to the police (Dartnall & Jewkes, 2013), there is enough data to suggest that gender-based violence is extremely high in South Africa (Vetten, 2014; Kaminer & Eagle, 2010). This picture goes in some way to supporting the prevalent view that South Africans are exposed to more traumatic material compared to other nations (Kaminer & Eagle, 2010).

Literature is in agreement that clinical and counselling psychologists as well as other workers in the helping field who treat trauma survivors are not left untouched by the disturbing and often jarring accounts of people's trauma they are called to listen to, though they may be experienced and highly competent (Barrington & Shakespeare-Finch, 2013). The negative effects of working with trauma on psychologists are well documented in literature (Pearlman & Caringi, 2009; Adams & Riggs, 2008; Sprang, Clark, & Whitt-Woosley, 2007). These include Post Traumatic Stress Disorder (PTSD)-like symptoms, seen in intrusive and

avoidant behaviour, heightened sense of alertness, and feelings of powerlessness and isolation (Deighton, Gurriss & Traue, 2007). Prevalent terms in literature that are associated with clinicians' responses to client trauma include vicarious trauma (VT), secondary traumatic stress (STS), compassion fatigue (CF) and burnout. Although they are oftentimes used interchangeably, each term provides a unique point from which we can understand the exchange that occurs when psychotherapists engage meaningfully with trauma survivors (Tosone et al., 2012). A brief discussion of each term follows:

**VT** refers to adverse changes that take place in a psychologist that are directly linked to working with survivors of trauma in the therapeutic space, especially when connected with the obligation to care (Pearlman & Caringi, 2009; Cohen & Collens, 2013). According to McCann and Pearlman (1990, p. 145), VT is “the transformation in the inner experience of the therapist that comes about as a result of empathic engagement with clients’ trauma material.” They see VT as universal (impacting life in its entirety), cumulative (having a snowballing effect where each client narrative strengthens beliefs of, for example, an unsafe world), and coming from recurring therapeutic relationships with survivors of traumatic events (Barrington & Shakespeare-Finch, 2013). The experience of VT can impact on the therapist’s self-concept, beliefs about self, others and the world in a negative way and is linked to experiences of posttraumatic stress disorder (PTSD) and feelings of anger, sorrow and fear in addition to having detrimental effects on empathic alliance (Michalopoulos & Aparicio, 2012).

**STS** occurs when clinicians who work with trauma survivors exhibit PTSD-like symptoms due to their engagement with their clients (Cohen & Collens, 2013). The primary symptoms of STS include intrusion, avoidance, disturbances in affect and behavioural distress (Shoji et al., 2015; Hensel, et al., 2015). STS may impact

clinicians' personal and working lives and may affect the quality of treatment she or he is able to offer clients.

**(CF)**, similarly stems from empathic engagement with trauma survivors who are going through pain and distress. Certain authors have conceptualised CF as comprising both STS and burnout through therapeutic engagement with trauma survivors (Deighton, Gurriss & Traue, 2007; Sabo, 2006).

**Burnout** points to a condition of being emotionally drained, detached from others and decreased feelings of achievement or fulfillment in one's work (Deighton, Gurriss & Traue, 2007). The development of burnout is not necessarily linked to therapeutic engagement that occurs in the counselling room during counselling sessions, but with organisational issues, for example the number of cases a clinician is seeing and organisational pressures (Sprang et. al., 2007).

What is clear from the constructs above is that trauma has the potential of negatively impacting core beliefs or cognitive schemas people hold about the world, which help them navigate life (Jirek, 2015; Devilly, Wright and Varker, 2009). These cognitive frameworks include beliefs that we have control over our lives, and that the world is relatively safe (Barrington & Shakespeare-Finch, 2013). According to Janoff-Bulman (1992), people commonly hold beliefs that the world is benevolent, the world is meaningful and self is worthy. One of the effects of trauma is that it impacts on those beliefs. Beliefs are disrupted or result in what is known as 'shattered assumptions' (Barrington & Shakespeare-Finch, 2013, Janoff-Bulman, 1992). The current study aims to explore the experience of VT among psychologists working with sexual violence. This is because psychologists who are constantly exposed to trauma-filled narratives are at risk of developing VT (Barrington & Shakespeare-Finch, 2013).

A contemporary understanding of VT suggests that it is a natural outcome of working in the helping field (Chouliara et al., 2009), as such there are calls to ‘depathologise and normalise’ clinicians’ affective reactions to trauma work (Deighton, Gurriss & Traue, 2007). VT points to ‘natural’ ramifications of working with traumatised clients (Sabo, 2006), as such it does not point to an abnormality in the therapist nor is it a deliberate behaviour on the part of the client (Barrington & Shakespeare-Finch, 2013). The use of ‘natural’ above cannot be taken in its literal sense but rather is used in reference to those psychologists who are prone to the development of VT. Pearlman and Caringi (2009) acknowledge that current knowledge base does not allow researchers to make emphatic statements that VT is consequential to trauma work. However, what cannot be overlooked is that a majority of helpers who work with trauma survivors undergo negative changes in the way they view themselves, the world and others due to their work (Pearlman & Caringi, 2009).

Psychologists who experience VT symptomology may experience feelings of guilt, shame, incompetence and may further fail to share these feelings with supervisors or fail to seek organisational support (Adams & Riggs, 2008). However, untreated, VT has a potential of causing clinicians to be emotionally detached and empathically unresponsive to their clients. This could lead to burnout and consequently to therapists opting to leave the profession altogether (Adams & Riggs, 2008; Pearlman & Caringi, 2009).

## **1.2 Rationale**

Though statistics that reflect true rates of sexual violence are not easy to come by, there is enough data to suggest that gender-based violence is extremely high in South Africa (Dartnall & Jewkes, 2013; Kaminer & Eagle, 2010; Vetten, 2014). International studies are in agreement that psychologists working with survivors of sexual violence are more prone to developing vicarious trauma symptoms compared to those who do not work with survivors (Michalopoulos & Aparicio, 2012).

According to statistics from the Health Profession Council of South Africa ([www.hpcs.co.za](http://www.hpcs.co.za)) there are 5679 women and 2254 men registered as clinical or counselling psychologists in South Africa. This means that there are a lot more women working in the field compared to men. As a result, it is probable that survivors of sexual violence are more likely to be seen by women psychologists. Women survivors of rape are more likely to seek out a female therapist (Landes et al., 2013).

Given the prevalence of rape in South Africa and the likelihood that female survivors will seek out the help of a woman psychologist, it is important to explore the impact on clinicians of engaging in trauma work with survivors. International literature suggests that in general, female psychotherapists are more prone to reporting higher levels of symptoms related to burnout and compassion fatigue (Cieslak et al. 2013; Michalopoulos & Aparicio, 2012). Though current research is unclear about specific gender factors that increase women psychologists' vulnerability to VT, hypothesis include female vulnerability to PTSD, the role of socialisation and cultural influences of women as 'caretakers' and pressures brought to bear by attempts to balance work and home life (Baum, 2015; Sprang et.al., 2007).

Therefore, psychologists need to understand the detrimental effects of working in the trauma environment so as to adopt coping strategies to deal with the psychological consequences of their work. The training of psychologists also needs to take into account the role that trauma plays on psychologists so as to inform supervision and training. In addressing these concerns, this study looks at the experience of VT on female clinical/counselling psychologists who work with sexual violence survivors as well as the coping mechanisms they use to deal with negative ramifications of working with trauma survivors.

### **1.3 Problem Statement**

South Africa experiences one of the highest rates of sexual violence in the world. In light of the violent nature of the South African society and the resultant traumatic environment most people are living in, research on experiences of vicarious trauma among female psychologists working with trauma survivors is needed. It is therefore important that we explore the experiences of female clinical/counselling psychologists so as to understand the impact of working with sexual violence survivors on them.

### **1.4 Aim**

- To explore the experience of vicarious trauma on female clinical/counselling psychologists who work with sexual violence survivors in the Western Cape Province of South Africa.
- To explore coping strategies employed by mental health workers to cope with VT.





## Chapter 2: Literature Review

In this section I will look at both national and international literature posit on the phenomenon of VT with particular focus on psychologists treating sexual violence survivors. As a start, this chapter will therefore address the prevalence and nature of sexual violence in South Africa. I will also look at psychological consequences of rape as well as PTSD. This will be followed by an examination of VT along with factors that make psychologists vulnerable to VT. I will then end off with a brief discussion on coping strategies employed by psychologists to deal with the negative effects of trauma work.

### 2.1 The Prevalence Sexual Violence in South Africa

Local research has consistently pointed to high levels of sexual violence in South Africa Centre for Study of Violence and Reconciliation, 2008; (Dartnall & Jewkes, 2013; Statistics South Africa, 2000), with prevalence rates for all categories of sexual violence being estimated to be between 12% and 28% (Dartnall & Jewkes, 2013). The latest SAPS statistics also confirm these claims as South Africa has seen an increase of reported sexual violence cases from 49 660 in the 2016/2017 financial year to 50 108 in 2017/2018. The table below shows the prevalence of rape over a period of 5 years.

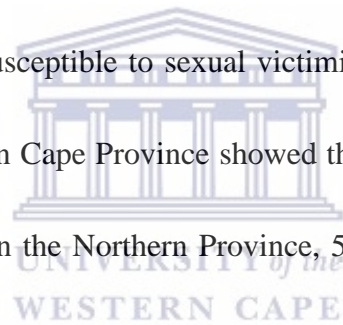
2013/14	45,349
2014/15	43,195
2015/16	41,503
2016/17	39,828
2017/18	40,035

Table 1: Prevalence of Rape

(Source: South African Police Service 2017/18 crime statistics)

Some research indicates that women and girls in particular areas in South Africa are at greater risk of being victims of sexual violence compared to the rest of the country, although there is consensus that in general, rape statistics are not an entirely true reflection of the state of sexual violence in any country due to complications of reporting (Dartnall & Jewkes, 2013; Kaminer, 2013; Stats SA, 2015; Vetten, 2014). In addition, being young seems to put females at greater risk of rape. A disturbing trend in South Africa is the high prevalence of child sexual abuse, which is estimated to be 1 in 3 children experiencing some form of sexual abuse in their lifetime (Dartnall & Jewkes, 2013; Optimus Study, 2016; Weber & Bower-Du-Toit, 2018).

Teenage girls are found to be susceptible to sexual victimization as well. A survey of three secondary schools in the Western Cape Province showed that 17% of teenage girls had been victims of sexual violence and in the Northern Province, 50% of teenage girls in secondary school had been molested sexually without their consent. 28% of young women from Khayelitsha and Soweto reported having been forced into sexual acts by a dating partner (Kaminer & Eagle, 2010). It is commonly reported that sexual violence perpetrators are usually known to the victim (Dartnall & Jewkes, 2013) and could be a relative, a neighbour or a school teacher and with many of these cases never making it to the police, a lot of sexual violence survivors bear an added trauma of engaging with their offenders on a daily basis (Kaminer & Eagle, 2010). Results from the Victims of Crime Survey, 2012/14 indicate that 25,1% of sexual violence acts (on 16 year-olds and older) were perpetrated by family



members, 24% by an acquaintance in the community and 16,8% by intimate partners (Statistics SA, 2015).

The phenomenon of ‘corrective rape’ is also receiving much public attention and very little research emphasis (Vetten, 2014). This happens when men decide to rape lesbians and gender non-conforming women as a way of punishing and/or ‘correcting’ their sexuality (Swarr, 2012). Researchers are reporting the rise of cases of homophobic attacks on lesbians in the townships of South Africa due to the phenomenon being seen, among other things, as un-African (Lake, 2014; Swarr, 2012).

## **2.2 Psychological Consequences of Sexual Violence for Survivors**

Human beings are known to possess great capacity for resilience in the face of excessive pressure they are brought to bear from their environment (Kaminer & Eagle, 2010). However, the common experience of a majority of people is to undergo certain levels of anxiety while processing the trauma they had been subjected to (Kaminer & Eagle, 2010). Such is the case with survivors of sexual violence. Fear, helplessness and powerlessness, self-blame and feelings of guilt and shame, anger, disgust and contamination, betrayal and loss of trust, loss of identity as a virgin, loss of meaning, isolation and alienation, have been cited as some of the consequences of rape for survivors (Padmanabhannuni, 2015).

### **2.2.1 Post Traumatic Stress Disorder**

For some people, exposure to sexual violence leads to the development of symptoms of PTSD. It is understood that normal reactions to trauma include anxiety, sadness, insomnia, flashbacks, constant thoughts about it and hyper vigilance (Mason & Lodrick, 2013; Kaminer & Eagle, 2010). As a way of coming to terms with such feelings, a lot of survivors tend to avoid talking about the event, remove themselves from social contacts, and may go into

shock. It is expected that for most survivors these experiences will diminish after 3 to 4 months (Mason & Lodrick, 2013), however for some, symptoms may lead to marked disturbances in social and occupational life and subsequently to a PTSD diagnosis (Mason & Lodrick, 2013; Kaminer & Eagle, 2010).

Symptoms of PTSD include both direct and indirect exposure to trauma, incessant re-experiencing of the trauma; determined evasion of reminders of the trauma, negative thoughts and feelings associated with the trauma and trauma related reactivity and arousal (DSM-5, 2015). A South African study of 250 rape survivors found moderate degrees of flashbacks, evasions and hypersensitivity symptomology, with hypersensitivity being the highest of the lot. International literature recognises that rape is the greater predictor of PTSD among women, which is seconded only by intimate partner violence (Kaminer & Eagle, 2010). Local literature concurs that females are more vulnerable to posttraumatic stress symptomology than males (Kaminer et.al., 2013). In a study among school learners from Langa, a township in Cape Town, South Africa, Kaminer et al. (2013) found that sexual abuse tended to predict greater severity of PTSD symptoms in girls, regardless of added contact with other types of violence.

In order to deal with these distressing emotions, as much as 30% of sexual violence survivors will employ substances such as alcohol and/or marijuana as a means of ‘self-medicating’ (Mason & Lodrick, 2013). Other effects of sexual violence trauma include generalised anxiety, depression, challenges in social and sex life (Mason & Lodrick, 2013). Some survivors of sexual violence will seek out psychological counseling in order to work through the trauma they were exposed to (Sommer & Cox, 2005).

An interesting development in the study of PTSD has been the expansion of the criteria of PTSD in DSM-5 from being directly impacted by trauma through first-hand experience to

include “repeated or extreme exposure to aversive details of the traumatic event(s)” as a possible precipitant that can lead to PTSD symptoms (DSM-5, 2015). Therefore, according to this definition, clinicians who suffer from VT could also potentially be diagnosed with PTSD.

## **2.3 The Impact of Treating Survivors of Sexual Trauma on Clinicians**

### **2.3.1 Vicarious Trauma: the Burden of Caring**

VT refers to the deleterious alterations that occur in the psychologist as a direct consequence of compassionately interacting with trauma survivors and their trauma stories (Pearlman & Caringi, 2009). Its development is traced to excessive empathic involvement on the part of the clinician with survivors of trauma (Pearlman & Mac Ian, 1995). VT involves disturbances in particular domains of functioning, including alterations in cognitions and spirituality similar to those experienced by trauma survivors, which are often characterised by loss of meaning and hopelessness (Pearlman & Caringi, 2009). Disruptions in cognitive schemas, PTSD symptomology, interpersonal adjustments as seen in aggressive behaviour, re-experiencing, and challenges maintaining professional boundaries, along with generalised anxiety have also been found in clinicians working with trauma (Pearlman & Caringi, 2009).

VT results in changes in psychologists’ internal world, a state of affairs brought about by the therapeutic relationship that therapists contract with clients who share trauma stories (Adams & Riggs, 2008). It would seem empathic engagement that is the bedrock of all successful therapeutic relationship is a double-edged sword when it comes to VT. It is the very condition that makes clinicians vulnerable to developing VT symptoms. This is because when the clinician enters into the world of the client, his or her response might be one of personally feeling the pain of the traumatic material the client is sharing.

Psychologists are vulnerable to VT when they do not process the trauma presented to them by their client through their pre-existing resources of making meaning of the world (Michalopoulos & Aparicio, 2012). Prolonged engagement with traumatic stories has a disruptive effect on core beliefs or cognitive schemas that are needed for adjusting and making meaning of the trauma (Michalopoulos & Aparicio, 2012).

It has also been shown that certain types of trauma elicit greater distress than others, for example traumas that are deliberately inflicted by another person, such as rape, have a disturbing effect on psychologists' cognitive frameworks as opposed to natural disasters or accidents (Jirek, 2015). In a systematic review of studies focusing on VT in practitioners who work with adult survivors of sexual violence, it was established that the work had definite harmful consequences on practitioners (Chouliara, Hutchison & Karatzias, 2009). In some instances the studies that were reviewed also found certain levels of mental strain on clinicians, beyond what would be considered standard for practitioners (Chouliara et. al., 2009). Similarly, Brady et al., (1999) and Bartoskova (2017) asserted that clinicians who treat sexual abuse survivors were at greater risk of developing VT.

Various studies reported symptoms of PTSD, VT and alterations in cognitions in those who treat survivors of sexual violence (Chouliara et. al., 2009) with avoidance and intrusion being the main PTSD symptoms that were reported on (Chouliara et. al., 2009). Altered schemas involved worldview, interpersonal relations, loss of trust (Clemans, 2004; Iliffe & Steed, 2000; Merriman & Joseph, 2018; Shauben & Frazier, 1995; Sui & Padmanabhannuni, 2016), intimacy and security, (Chouliara et. al., 2009). Participants also reported elevated vigilance for potential environmental threats (Merriman & Joseph, 2018; Clemans, 2004; Iliffe & Steed, 2000), and beliefs about lack of personal safety, which led to emotional disturbances

(Devilly, et. al., 2009). Cohen and Collens (2013) found that mistrust of others was linked to men and was reported mainly by those participants who work with sexual violence survivors. Way, VanDeusen and Cottrell (2007) acknowledged the difficulties of sustaining a positive self-regard particularly for female therapists who work with sexual violence survivors in their study mainly because they also experience the agony and outcomes of violent acts that are usually perpetrated by men.

### **2.3.2 Vulnerability to VT**

The impact of VT differs widely and is dependent on such factors as the psychologists' training and level of experience (Adams & Riggs, 2008). Existing literature indicates that some of the factors that increase vulnerability to VT include personal trauma history (Adams & Riggs, 2008; Deighton, Gurriss & Traue, 2007), gender (with female clinicians reporting increased symptomology than male counterparts), experience in trauma work and trauma training. Negative coping strategies and personal stress may also precipitate the development of VT symptoms in psychologists (Deighton et.al., 2007). Prior experience of personal trauma tended to make the psychologist vulnerable to negative effects of working with trauma stories than psychologists with no history of trauma (Adams & Riggs, 2008; Deighton et. al., 2007). Organisational factors, such as high levels of trauma cases a psychologist is exposed to have all been cited as factors that influence the development of VT in psychologists (Cohen & Collens, 2013; Deighton et. al., 2007).

#### **2.3.2.1 Personal Trauma History**

Since VT is associated with altered cognitive schemas, it is believed that a personal history of trauma makes psychologists susceptible to the development of VT (Michalopoulos & Aparicio, 2012). This is because the cognitive schemas that are needed for dealing with trauma would already have undergone changes due to their personal trauma (Michalopoulos & Aparicio, 2012). Thus, hearing client narratives of trauma could elicit intense emotional

reactions that could be triggered by their own unresolved traumatic experiences (Jordan, 2010). Research findings have been varied in relation to personal trauma history of therapists, with some studies reporting a positive link between personal trauma history and VT (Adams & Riggs, 2008; Pearlman & Mac Ian, 1995; VanDeusen & Way, 2006) while others found no relationship between the two constructs (Kadambi & Truscott, 2004; Michalopoulos & Aparicio, 2012; Schauben & Frazier, 1995). In a study that investigated the impact of conducting therapy specifically in cognitions related to trust and intimacy on clinicians working with survivors of sexual abuse, high levels of disturbances in cognitions about intimacy were found in those clinicians with ‘maltreatment history’ (VanDeusen & Way, 2006). The same study found that therapists with less traumatic backgrounds manifested less disturbances (VanDeusen & Way, 2006).

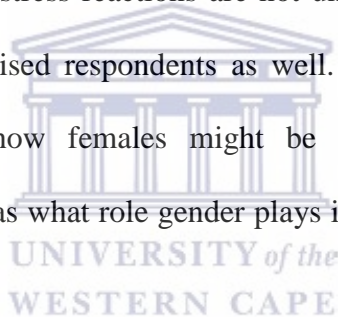
### **2.3.2.2 Gender**

Reactions to trauma by different genders add an interesting dynamic to the investigation of factors that play a role in the development of VT symptomology in trauma therapists because research results are mixed, with some finding higher ratios of elements of burnout in women clinicians, such as dwindling emotional reserves (Watts & Robertson, 2011) or increased CF (Kassam-Adams 1999; Sprang et. al., 2007). Though Sprang et al.’s (2007) study did not focus on VT but on levels of CF, compassion satisfaction and burnout in mental health providers, they found that “female gender enhanced the risk of suffering from CF and burnout.” (p.272). A systematic review of studies on STS in mental health workers has found a particularly salient gender link between professionals working with victims of sexual abuse and female therapists reporting greater rates of STS than male practitioners (Baum, 2015). Some of the explanations that have been put forward for this female therapists’ susceptibility to STS may be an indication of the general female population’s higher prevalence of PTSD than males and not necessarily STS (Baum, 2015).



In trying to understand inconsistencies in findings relating to gender vulnerability to VT, Baum (2015) found that 6 of the 10 studies in their literature review that viewed STS from PTSD criteria as set out in DSM V reveal a relatively steady picture. What the researchers in this systematic review found was that gender links were pervasive across different work places (rape crisis centres etc) that were under investigation and types of trauma therapists dealt with (child abuse, spousal violence, disasters). Even when taking into consideration the clientele and type of trauma, the results pointed to a clear link between gender and STS with females showing greater vulnerability to STS than males (Baum, 2015).

Admittedly prior research findings have been unclear on this issue and this could be put down to differences in samples and sampling techniques (Sprang et. al., 2007). The results of a specifically female proclivity to stress reactions are not unique to this study and have been found in research using traumatised respondents as well. This calls for more research on gender-role socialisation and how females might be susceptible to certain types of organizational pressures as well as what role gender plays in facilitating disclosure of certain symptoms (Sprang et. al., 2007).

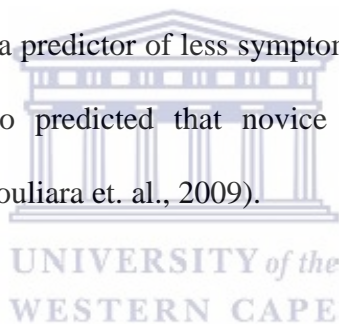


The importance of ascertaining gender differences in response to trauma can never be overstated. Answering the question of: “who is most vulnerable, in what type of work setting and under what type of conditions,” (Figley, 2002, p.6 in Baum, 2015, p.3) has implication for future research (Baum, 2015). Results from such an investigation could inform the design and implementation of preventative or therapeutic gender-specific programmes for therapists (Baum, 2015).

### **2.3.2.3 Experience in Trauma Work**

Another factor that has been cited as influencing the development of VT in psychologists is the amount of time therapists have been engaged in trauma work (Adams & Riggs, 2008,

Michalopoulos & Aparicio, 2012). Research points to a positive correlation between brief encounter with trauma work at an experiential level and challenges in relation to trauma work (Adams & Riggs, 2008, p.27, Chouliara et. al., 2009). According to Adams and Riggs (2008) inexperienced therapists are at risk of developing VT symptoms, a notion that is supported by systematic review results of sexual violence workers and their experience of vicarious trauma, who found that less mature personnel reported increased affective depletion (Chouliara et. al., 2009). Symptoms may involve evasions, disconnection, agitation, intrusive images or thoughts and other trauma-specific reactions (Adams & Riggs, 2008). It was also found that clinicians that had just entered the discipline reported higher levels of cognitive disturbances especially related to trust and intimacy (VanDeusen & Way, 2006). Consistent with this hypothesis, Michalopoulos and Aparicio (2012) found that increased number of years in social work service was a predictor of less symptoms of VT in their studies of VT in social workers. This study also predicted that novice clinicians were more prone to developing symptoms of VT (Chouliara et. al., 2009).



#### **2.3.2.4 Trauma Training**

Formal trauma-specific training was found to be a protective factor against the harmful effects of being exposed to trauma (Sprang et al., 2007). This could be because training increases therapists' beliefs in their abilities as it promotes the use of contemporary evaluation and management tools (Sprang et al., 2007). As such, trained therapists could be meeting relative success in their treatment as compared to those with less training or skill in trauma (Sprang et al., 2007). It is also possible that training opportunities widen the sphere of peer support for clinicians. Pearlman and Saakvitne (1995) maintained that clinicians with no prior recognised training in trauma are more prone to panic and working with trauma material might prove harmful to them.

### **2.3.3 Coping with Vicarious Trauma**

Both international and local literature emphasise the importance of adopting coping strategies as a way of buffering oneself against the negative impact of trauma.

#### **2.3.3.1 Social Support**

Social support is seen as a protective factor against the negative effects of trauma work (Michalopoulos & Aparicio, 2012) and a strong associate of wellness. It can also serve as a predictor for resilience from the pressures of working with traumatic material (Pearlman & Caringi, 2009). Some research goes so far as to link it to robust attachment style (Pearlman & Caringi, 2009). Clinicians who do not isolate themselves but pursue healthy social and peer support are more likely to find satisfaction in themselves and in their occupation (Jordan, 2010; Pearlman & Caringi, 2009). Interpersonal relationships with friends, family and colleagues could work to avert alterations of beliefs that are consequential to working with trauma material (Michalopoulos & Aparicio, 2012).

#### **2.3.3.2 Spiritual Renewal**

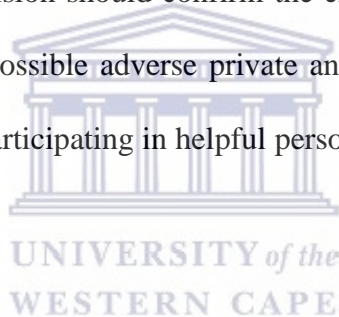
Spirituality is one area that often suffers due to exposure to trauma stories by a therapist (Pearlman & Caringi, 2009). This goes hand in hand with loss of meaning and hope. It is thus vital that clinicians give priority to practices that promote their well-being (Pearlman & Caringi, 2009). Some activities that are suggested in literature include reading spiritual material, joining spiritual services, introspection, prayer or any activity that aids the clinician in discovering meaning apart from themselves (Dombo & Gray, 2013).

An exciting development in trauma research is the recognition of the potential for growth that is present in trauma work, a process known as vicarious post-traumatic growth (Barrington & Shakespeare-Finch, 2013) or vicarious transformation (Pearlman & Caringi, 2009). It is understood that once clinicians are able to process their VT in a meaningful way, gained

knowledge is then incorporated into existing cognitive schemas. Therapists who work with trauma survivors have reported gains in many areas of their lives, such as in better interpersonal skills, improved admiration of resilience in others and shared gains in the therapeutic progression of clients (Barrington & Shakespeare-Finch, 2013).

### **2.3.3.3 Supervision**

Trauma-sensitive supervision has been put forward as one of the ways of assisting psychologists deal with VT (Pearlman, 1995; Sommer & Cox, 2005). Effective supervision includes four main components: a trauma therapy theoretical basis, cognisance of both conscious and unconscious facets of therapy, a reciprocally respectful interpersonal supervision environment, as well as educational components that directly address VT (Sommer & Cox, 2005). Supervision should confirm the challenging environment of giving sexual violence therapy, allow possible adverse private and work-related consequences and teach about the significance of participating in helpful personal coping strategies (VanDeusen & Way, 2006).



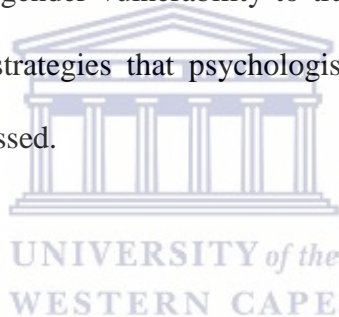
### **2.3.3.4 Self-Care**

For clinicians working with trauma, self-care is not a luxury or an activity to be done when everything else is finished, but a necessary part of providing quality therapeutic work to clients. Pearlman and Caringi (2009) propose that therapists be occupied in what they see as ‘committed’ or ‘radical self-care’, which is “an ethical imperative for all therapists, but especially for those working with complex trauma,” (Pearlman & Caringi, 2009, p.216). Included in self-care practices is taking part in undertakings that are entertaining or offer opportunities for the development of the clinician such as regular workouts, enjoying oneself, going on recreational activities, unwinding (Pearlman & Caringi, 2009). Literature also concurs that a healthy lifestyle, comprising enough sleep, a balanced nutritional intake with

consistent mealtimes and reading goes in some way to ameliorating VT symptomology (Jordan, 2010).

### **Summary**

Both local and internal literature recognises the negative effects of trauma work on psychologists who work specifically with survivors of sexual violence. Literature is overwhelmingly in support of the notion of VT as a reality for many psychologists. This is compounded by the high levels of sexual violence in South Africa, which make it a certainty that psychologists will have to deal with this type of trauma in their span of practice. In this section I discussed some of the factors that have been posited as responsible for making psychologists vulnerable to developing symptoms of VT. Factors that have been discussed are: personal history of trauma, gender vulnerability to trauma, experience in trauma work and trauma education. Coping strategies that psychologists use to deal with the negative effects of trauma were also discussed.



### Chapter 3: Theoretical Framework

In this chapter I will look at the theoretical framework that helps us understand the phenomenon of VT, how and why it is likely to develop in some individuals.

The concept of VT is rooted in the Constructivist Self-development Theory (CSDT). The necessity for a theory of self to explain the effect of trauma on personal growth led to the development of CSDT (Saakvitne, Tennen & Affleck, 1998). As an integrative personality theory that explains the effects of trauma on the development of personality, CSDT borrows heavily from the foundations of both psychoanalytic and social cognition theories so as to describe the experiences of survivors of trauma (Versola-Russo, 2005; Saakvitne, 1998). CSDT sees self-development as the interplay between core self-capacities (related to early relationships, secure attachments and ego resources) and constructed beliefs and schemas (related to cumulative experiences and the attribution of meaning to those experiences) that shape insight and practice (Saakvitne, 1998). Though the theory was developed to understand college students' reactions to trauma, it has since been applied to understand vicarious traumatisation. This theory posits that a psychologist's transformation due to engaging with traumatic stories is not an isolated incident. Rather, changes are seen as stemming from the interaction of multiple factors, such as one's identity, prior history, the incident that caused trauma and its relation to the immediate and wider environment (Cohen & Collens, 2013; Pearlman & Caringi, 2010). The principal hypothesis of CSDT is that people are affected differently by their experience of trauma, thus "the meaning of the traumatic event is in the survivor's experience of it" (Pearlman & Saakvitne, 1995, p.57).

The CSDT theoretical framework's approach to symptoms is to view them as normal adaptations to unusual occurrences instead of pathologising reactions to trauma (Pearlman & Caringi, 2010). One of the theory's contributions to the understanding of trauma is that it

isolates the parts of the self that are altered by personal or secondary trauma. As such it affords a base for grasping different symptoms that individuals present with, such as social withdrawal, dissociation, self-injury, which could be stemming from one area of the self being impacted negatively by the trauma.

According to CSDT the experience of trauma on individuals is said to impact the following five areas: 1. Frame of reference – a person’s normal means of relating to the environment and to self, this incorporates spirituality. 2. Self-capacities: competence to identify, withstand and combine emotions while sustaining a positive equilibrium within as well as with other people. 3. Ego resources- needed to deal with psychological competence in self-reflective behaviour 4. Central psychological needs – reflected in disrupted cognitive schemas in five domains : safety, trust, control, esteem, and intimacy 5. Perceptual and memory system: inclusive of biological adaptation and sensory experience. These five areas include both experiential and cognitive means of shaping experience.

CSDT further posits that people construct their realities through the development of cognitive framework or schemas, which are understood to be the basis through which individuals makes sense of the world. External stimuli are usually incorporated into current schemas and a process of constructing happens over and over again as therapists add new knowledge and skills into their knowledge base or cognitive schemas (Deville et. al., 2009). A crisis in the schema, however, arises when external stimuli is not in harmony with long-standing schemas, for then it cannot be incorporated. This leads to a process of accommodation where schemas have to be altered so as to allow the new material to be assimilated into core beliefs. Traumatic experiences as well as VT undermine existing schemas. In vicarious traumatisation, schemas are negatively altered, a state which is anxiety-provoking and leads to high sensitivity to any material corroborating with the recently adversely modified schemas (Cohens & Collens, 2013).

## Chapter 4: Methodology

In this chapter I will be covering the methodology underlying the study. I will specifically look at the research design, participants, data collection, ethical considerations as well as reflections on the research process.

### 4.1 Research Design

In order to gain an in-depth understanding of the experiences of VT among female psychologists operating in the Western Cape who treat sexual violence survivors, this study uses a qualitative approach. The research design is Interpretive Phenomenological Approach (IPA), a qualitative approach that originates in psychology that is dedicated to exploring the individual's lived experience (Smith, Flowers & Larkin, 2009). IPA as a method of enquiry was developed by Jonathan Smith (Smith, 1996) to allow for the exploration of people's particular view of health in health psychology. Although, originally applied in health psychology, its use has extended beyond psychology to other disciplines (Smith et al., 2009). IPA focuses mainly on examining phenomenon from its own point of view. It concerns itself with a thorough investigation of a specific phenomenon, seeking to find out what meaning an individual gives to an experience (Smith et. al., 2009). Smith et al (2009) maintains that: "IPA researchers are especially interested in what happens when the everyday flow of lived experience takes on a particular significance for people." (p.1)

IPA has its basis in phenomenology, a strongly philosophical qualitative approach developed by the German philosopher, Edmund Husserl (1859 – 1938) that seeks to depict the meaning people attach to their experiences of a phenomenon or event. Phenomenologists then draw themes of similarities in experience from the account of individual participants (Creswell, 2007). Husserl's main tenet in developing a phenomenological approach stemmed from his rejection of experimental scientific research as the only means of arriving at an understanding



of human phenomena and his belief that such scientific endeavours had grown distant and disconnected from people's everyday lives to such an extent that it served to hamper insight into our lives (Crotty, 1996). He, however, felt that it was important to maintain objectivity and scientific vigour in the search for lived experiences (LoBiondo-Wood & Haber, 2002). The method he proposed to achieve such scientific objectivity is known as bracketing, which is the ability of researchers to put aside their bias and presumptions to prevent them from marring their ability to decode material from the participants. Other prominent phenomenologists who expanded on Husserl's theory include Martin Heidegger (Husserl's mentee), who introduced a phenomenological approach that is called hermeneutics (interpretation). In this approach enquirers' perceptions and experiences are not bracketed but they form part of and enrich the research process. This is where the roots of IPA spring from in that the method acknowledges the centrality of the researcher's analysis in elucidating meaning that experiences hold for each research participant (Smith, 2004). In this way, it is not only the research subject that provides meaning of an experience but the enquirer is also actively involved in clarifying the meaning for the participant, a process depicted as "double hermeneutics" by Smith (2004) or "sense making by both participant and researcher." Aisbett (2006, p.53) describes the process as "while the participant is trying to make sense of the world around them, the researcher is trying to make sense of the participant trying to make sense of the world around them." IPA goes further to incorporate both interpretative and descriptive phenomenology in that it provides research subjects a platform to detail a subjective and reliable narrative of an experience. Through IPA, one is then able to not only arrive at a narrative but also at a depiction of an experience (Quinn & Clare, 2008).

In particular, the study of VT is well suited for IPA because the principal hypothesis of CSDT, the theory VT is built on, is that 'meaning of the traumatic event is in the survivor's experience of it' (Pearlman & Saakvitne, 1995, p.57). This assumes that survivors of the

same traumatic event may attach different meanings to the same event. IPA studies commonly commit to few participants as the goal is to show the significance of the experience for each person, focusing on parallels and dissimilarities (Smith, et. al., 2009).

## **4.2 Participants**

In keeping with sampling principles of IPA, a purposive homogenous sample was used to ensure that themes could be drawn from individuals with similar experiences. Inclusion criteria for participating in the study were: (i) female clinical/counselling psychologists (ii) working with survivors of sexual trauma (iii) in the Western Cape area.

To recruit participants for the study, I drew up a pool of prospective participants by reviewing information on a website that hosted psychologists based on the inclusion criteria. The website that I used to identify prospective participants was [www.psychotherapy.co.za](http://www.psychotherapy.co.za).

Initially 28 female clinical or counselling psychologists were drawn who had indicated in their description of their specialty, work with sexual trauma. Invitation letters were then sent to their email addresses as provided in their profiles. These were followed with telephone calls to ensure that they had received the emails and to determine what their responses were to the invitation. The response rate was low with only 9 respondents electing to participate in the study. An additional 6 participants were obtained through referrals by other participants and colleagues, resulting in a total of 15 participants. Such a small number is in keeping with IPA's recommendation to maintain small enough samples to allow for individual experiences to clearly come through as large sample sizes are seen to have a potential of overloading the researcher (Smith et al., 2009).

With regard to participant characteristics, the 15 participants' mean ages were 38. With reference to race, 5 participants identified as White while 10 identified as Black South Africans. Their average number of years in the profession was 6.5 years.

Names	Race	Age	Years in service	Sexual Trauma Cases	History of trauma	History of Sexual Trauma
Eva	White	20s	3	50%	Yes	No
Natalie	White	40s	9	100%	Yes	Yes
Sybil	Black	50s	21	25%	Yes	No
Mavis	White	30s	5	85%	Yes	No
Lee	White	30s	4	25%	No	No
Andrea	White	20s	3	85%	No	No
Fiki	Black	30s	4	35%	Yes	No
Taylor	Black	40s	4	85%	Yes	Yes
Kareena	Black	34	3	25%	Yes	Yes
Phozisa	Black	40	13	20%	Yes	No
Faith	Black	50s	14	50%	Yes	No
Paula	Black	50s	2	30%	Yes	No
Bela	Black	38	9	10%	No	No
Emma	Black	30	1	50%	Yes	No
Cathy	White	50s	16	25%	Yes	No

Table 2: Participants' demographic details

### 4.3 Data Collection

Semi-structured interviews were conducted individually with each clinician as a means of data gathering. Appointments were made telephonically with each participant and were scheduled for a time that suited the participant. All interviews took place in the participants' place of work during the allotted time, an hour, which seemed to be all the participants could spare from their busy schedules. Consent was sought from the participants to conduct the interviews on tape prior to the interview. Prior to the interview, the interviewer had prepared an interview schedule (Appendix C) to facilitate discussion and open-ended questions were employed to ascertain the experience of VT on each interviewee and to explore coping strategies used by therapists to deal with VT. For most of the participants, interviews took between 45minutes and 1 hour. A careful transcription of the audio material was then captured following the interviews. This ensured precision and served acted as a means of quality control. After transcription, data obtained was coded and evaluated using the IPA.

#### 4.4 Data Analysis

A four-stage IPA data analysis framework followed the transcription process. The first stage of analysis involved reading and re-reading data. This, the researcher accomplished through ‘immersing’ herself in the original transcripts (Smith, Flowers & Larkin, 2009). In this study, this was achieved through going back to the original audio tapes to listen to the interview as it took place. The most important purpose of this first stage is to raise the participant as the centre of the study.

The second stage in the analysis of the study was the initial noting. In this step, the elements of the text that make it meaningful as well as the language used were examined (Smith, et. al., 2009). Notes on feelings, interpretations or thoughts that occur during the process were taken, while the researcher sought to maintain a non-judgmental attitude. At this stage the researcher was concerned with gaining more understanding of each individual transcript, as it served to be a vehicle for understanding how a participant narrates, comprehends and reasons about issues relating to the subject of inquiry.

The third stage involved developing emergent themes. In this stage, notes gathered in the second stage were used to draw out preliminary themes that capture the essence of the interview (Smith et. al., 2009). Work here mostly involved working with notes that were taken during the earlier phase, however, in order to clarify or fill-in any missing data, transcripts were also revisited.

The final stage of the analysis involved establishing connections across emergent themes. This was done by drawing out themes that were connected into a list (Smith et. al., 2009). The researcher then typed out all the themes that were drawn from the notes by chronology. Related themes were moved to the same ‘cluster’ making use of a computer-assisted qualitative data analysis software programme (Atlas.ti version 7). Interview quotes that best

represent the feelings of the participant were put along themes. After coding and classifying the data according to themes, the resulting data were interpreted using theoretical and analytical concepts drawn from the IPA conceptual framework.

#### **4.5 Ethical Considerations**

This research was conducted with due regard for ethical considerations that guide psychological research in the University of the Western Cape. All processes that the university prescribes for approving research were followed, starting with submission of a research proposal of the study to the Faculty Higher Degrees of UWC for quality evaluation and suitability. From there, it successfully passed through the Senate Higher Degrees Committee for endorsement and an authorization letter was issued to allow the researcher to proceed with the study.

Given that the subject matter is potentially distressing, the research adhered to the principles of ensuring that subjects of the research were exposed to no harm. All participants were assured of anonymity and confidentiality at all times and informed of their right to terminate the interview at any time should they feel emotionally distressed by the material discussed. All 15 participants' participation was on voluntary basis and they each signed a consent form prior to the interviews. They were informed about what the intended purpose of the information gained from the study. Participation or non-participation in the study did not lead to any negative consequences. As this study involves clinical and/or counselling psychologists, the researcher was supported and guided by the expertise of the project supervisor, a registered counselling psychologist who specialises in the areas of trauma, PTSD and CBT.

#### **4.6 Trustworthiness**

This study made use of Lincoln and Guba's principle of reputable qualitative inquiry, which is trustworthiness. Trustworthiness in the qualitative research realm refers to objectivity or impartiality of the results of the study (Babbie & Mouton, 2009). Lincoln and Guba propose that this objectivity is achieved through their four criteria: Credibility (internal validity) referring to how accurate/believable study results are; Transferability (generalizability), which speaks to whether findings of a study can be employed in other settings; Dependability (reliability), which is the extent to which study results could be consistently reproduced in similar samples with similar settings and Confirmability (objectivity), which refers to findings being directly gained from the study (Babbie & Mouton, 2009).

For this study, 'thick descriptions' and direct quotes from participants have been used in order to attain to the quality of credibility. Furthermore, participants were provided with transcripts of their interviews to allow them to validate the accuracy of the information contained in their transcripts, known as 'member check'. Dependability was achieved by ensuring that each step in undertaking the study will be thoroughly documented so as to allow external researchers to come up with similar results. An audit trail of each decision made in the study was stored in order to allow external researchers to see whether any part of findings of the study could be a consequence of researcher bias.

#### **4.7 Reflection of the Research Process**

Reflexivity refers to "critical reflection of how the researcher constructs knowledge from the research process" (Guillemin & Gillam, 2004, p.261). Recognising that the researcher is a subjective being who is influenced by her environment, reflexivity was used in the entire research process of this study. The researcher sought to reflect upon her own experience as a

researcher as well as the participants' experience of the research. To this end a reflective journal was kept.

I am a 43-year-old Black South African female. My research was conducted with clinical psychologists from the Western Cape area of South Africa who provided psychotherapy services to survivors of sexual trauma.

When I started out on this journey, I was obviously curious and a little naive. It had been my mission to change the world for the better for most of my life and I felt that I could finally begin that process through this study. In the Gospel of John 7:21 the Bible records words spoken by Jesus that say: "Most assuredly, I say to you, unless a grain of wheat falls into the ground and dies, it remains alone; but if it dies, it produces much grain." My ambitions, however, did not include dying in any form whatsoever and though I was familiar with these words, I did not think that they applied to me specifically. That is, until I started the process of dying to self that I am still undergoing.

It all started with a very personal experience of having my heart completely broken just as I was starting data collection for this study. From then on, in my mind, pain and this research became synonymous. As painful as that period was, I learnt the reality of depression and the mind-body unity. I could not will myself to not feel the emotions that could not be silenced no matter how much I reasoned with myself. Though unwanted, the pain was also a gift because my brokenness allowed me access to abilities in my being that I never knew existed. And for the first time, I could empathise with those who I had thought were weak because I too had become weak. The wall had come down, I could feel others' pain and instead of wanting to run, it made me want to listen. As a result, my little research project that I just needed to complete in order to get a degree was no longer such a simple exercise. The pain in my life had made me vulnerable to the cries of others. And so, I was traumatised. I was

traumatised by the stories that the participants shared with me. I was scared of going to the places where these things took place. The nightmares that the participants in the study experienced that were experienced by their clients were now transferred to me. The shattered beliefs about trust and safety that were the source of my participants' clients were my reality. Life was uncertain for me and I was not sure whether the rules that had always protected me would still hold.

Transcribing became impossible for me. This is because I was not only taking information from the participants of the study but I was hearing the women who had shared their experiences with the participants and I was emotionally distressed as a result. I felt just as helpless, if not more because whereas the participants were doing something to alleviate the pain of their clients, I was just using their experiences to pursue my own interests. And so, I felt guilty. The worst part was knowing that this work, which is in partial fulfillment of a bigger dream would never change anyone's life in any significant way. No policy decisions at any level would be taken because of what we learn from it. It is destined to lie undisturbed, with many others like it, in some university library database, there to witness, not to the horrific stories that others have to listen to every day or even the silenced voices that can only speak of their pain in some dingy unwelcoming hospital room turned therapy space but to the fact that I had completed a requirement as specified by my university.

Yet it had to be completed! I found ways to avoid it. I could not even think of working on it the following year. When I finally had enough resources to undertake it again, I learnt that I had to get additional participants to make my study representative. And just when I was finally ready to work on the study, I learnt that I too, had not been spared the pain of sexual violence, for right in my family, someone very dear to me was a survivor but had not shared it with me.



Like most South Africans, I am no stranger to trauma. I grew up in one of the first informal settlements in Cape Town, the Old Crossroads, where I too frequently witnessed police brutality, domestic violence and gang fights that often ended up with a dead person. Having escaped Old Crossroads, I was robbed at gunpoint by a group of young men on my way back from work when I was 24 years old. I never took the train again after that experience. With that history of trauma, I felt that nothing would ever be able to shake me. And maybe that was the problem. I may have been 38 years at the time of undertaking this study, however, I had mastered the art of protecting myself from anything that could potentially touch me. I understood very well that South Africa was a violent place to live in but I knew how to protect myself, that is, until I found out about a family member having gone through the experience of sexual trauma.

As painful as this discovery has been, it has also been a source of my liberation. I now know what I want to spend the rest of my life doing. It is not to hide in fear of what might happen if I decide to truly live. It is not to avoid feeling painful emotions for fear of annihilation. Like the seed of wheat, which can only multiply once it dies, I have been broken by my experiences so that I could proliferate. This study, which started out as a small project to determine whether I am allowed to graduate or not has been a means of my redemption. I want to use my experiences to positively affect the lives of not only my family members who are having to deal with this most painful period in their lives but also of every survivor of sexual violence I am privileged to work therapeutically with.

## Chapter 5: Findings

The aim of this present study was to explore the experience of VT among female clinical/counselling psychologists who treated survivors of sexual violence in the Western Cape province of South Africa. Fifteen female psychologists who work with survivors of sexual violence took part in the study. This section will focus on the common lived experiences as narrated by the participants.

The chapter is divided into two parts, the first part discusses the participants' lived experiences of VT while the second presents their self-identified coping strategies. The first section is further divided into two parts, with the first depicting experiences of hearing trauma stories on the participants while the second highlights some of the changes in beliefs participants identified as stemming from engaging with the work. Very rarely do participants' narratives capture only one theme. Such is the case in this section of the study as well. Themes that have been drawn from the data are explored individually, however, each vignette has a potential of carrying multiple and sometimes overlapping themes.

### 5.1 Participants' lived experiences of vicarious trauma

#### 5.1.1 Hearing Sexual Trauma Stories: Feelings Beyond Empathy

It is worth noting that the participants' experience of VT was quite diverse, however, there were common experiences that were shared. All 15 participants reported that hearing stories of sexual trauma drew from them high levels of empathy beyond what they would normally feel in the course of their work. Loss of hope and helplessness were identified by some participants as representative of their emotional responses to hearing these narratives. Others related feelings of horror, sadness, despair, anger, and guilt. Beyond that avoidance, hypervigilance, intrusive thoughts and nightmares were also experienced by a number of

participants. These responses have been organised into themes for ease of reference and are further explored below (A summary of the themes can be seen in Figure 1).

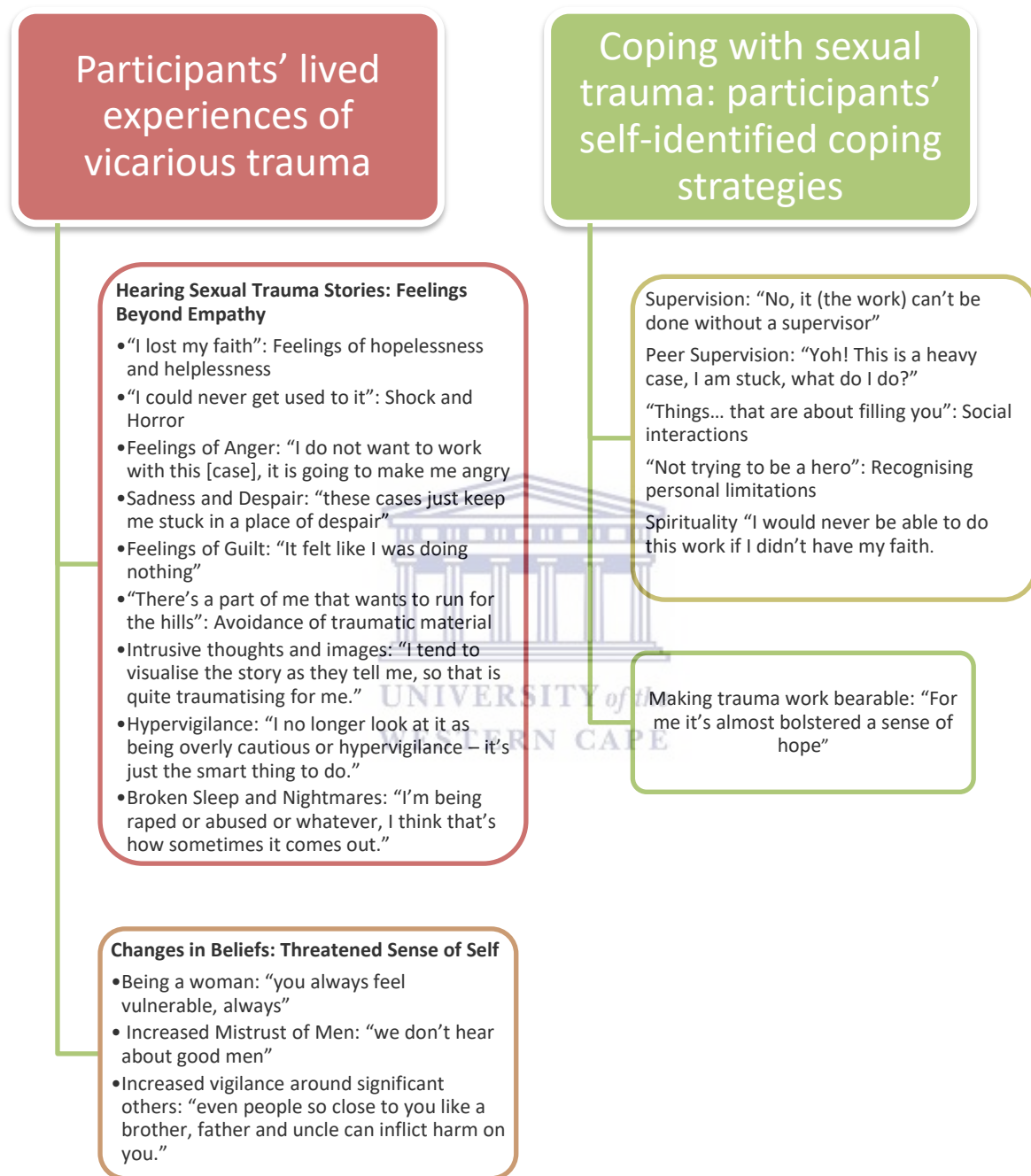


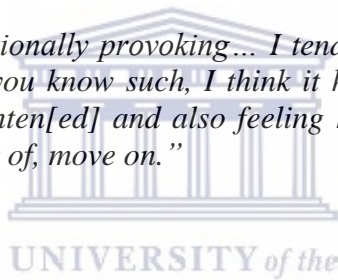
Figure 1: Themes

### **5.1.1.1 “I lost my faith”: Feelings of hopelessness and helplessness**

Feelings of hopelessness, helplessness and “powerlessness” were identified by some participants as representative of their experiences of hearing stories of sexual violence from their clients. Reasons given by participants for feeling helpless were as varied as the participants and were indicative of the empathic relationship each enjoyed with her client.

Emma (38), a clinical psychologist of 2 years, depicted well the various emotions that participants were confronted with in the course of their engagement with survivors of sexual violence. She related that these cases were emotionally provoking for her as she felt a great deal of empathy for her clients. She attributed her feelings of helplessness to her client’s difficulty to move forward or being ‘stuck’.

*“I think it has been emotionally provoking... I tend to feel quite a lot for the client, really feeling empathic, you know such, I think it has been emotionally provoking I tend to feel sad and frighten[ed] and also feeling helpless when a client feels quite stuck and not able to, sort of, move on.”*



Similar to Emma’s experience above, Kareena (38), a clinical psychologist with 4 years’ experience, shared her emotional responses to working with an adult female client who had suffered sexual abuse as a child as well as prolonged rape as an adult from the same family member. This experience elicited feelings of helplessness and hopelessness for Kareena due to the fact that the sexual violence was ongoing and she was not in a position to report it as her client was an adult. This led to her feeling that the work with the client ‘amounted to nothing’ as the situation was not changing. Her helplessness is further depicted by her portrayal of herself as watching the scenes of sexual abuse take place and ‘doing nothing’ to stop them.

*I would feel as though I was watching these scenes unfold and was just standing there and doing nothing. Which was not really the case, I was trying my best. But it amounted*

*to nothing really, in that –It felt like it, because, I mean, nothing was changing and ja, it was hard...I felt scared and hopeless because if it was a child, it would be obvious – I need to report to the authorities, but this was an adult ...”*

Lee’s (30s) description of her work with survivors of sexual violence was that it left her with a sense of hopelessness. Lee, a clinical psychologist of 5 years, reported that her experience stemmed from personally having been diagnosed with VT due to her work early in her career with very difficult cases of sexual trauma. In the excerpt below, she describes not only losing hope and faith but also how she felt personally lost because she had lost a sense of who she was through her work. She found the exercise of believing required ‘a leap of faith’, which she also had lost.

*“I actually lost a whole part of me and I think it’s got to do with hopelessness and feeling lost and being broken. That was such a leap of faith to actually believe in something... So I lost my faith.”*

#### **5.1.1.2 “I could never get used to it”: Shock and Horror**

Paula (50s), a clinical psychologist of 3 years who had previously worked as a registered counsellor, related that listening to her clients’ narratives of sexual violence elicited shock and “absolute horror” for her. She felt that hearing first-hand accounts from survivors was different from being generally aware that ‘these things’ happen and made her believe she could never get used to hearing such stories since each client’s story was unique. In her account, below, she does not designate a word, such as rape or sexual assault, for what she says are ‘things that human beings do to others’ but calls them ‘these things’.

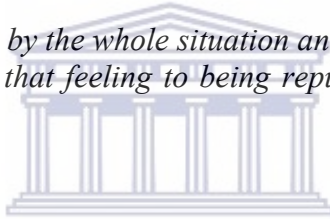
*“I can honestly tell you that I am shocked and horrified when I hear these things but it is not that I am disturbed to the level where it disturbs my functioning... I think just absolute horror that human beings can do that to other human beings and it is not, I mean, we are aware of these things but when you hear them first hand it is very different, uhm ja, a good word to describe it is absolute horror at how human beings can hurt other human beings... In a way I could never get used to it because everybody’s story is different”.*

Emma, below, spoke of being extremely shocked by the stories her clients shared with her detailing what they went through. She also conveyed being greatly frightened by her clients' experiences.

*“[an] unbelievable sense of shock and dismay [that] something to that extent can happen to one person, they have been through that, uhm, it's frightening, incredibly frightening and scary.”*

Kareena's experience of working with one survivor of sexual violence evoked in her what she termed 'revulsion' that was accompanied by a physical reaction. The account of her client's sexual trauma led to her feeling nauseous at the end of almost every session.

*“I felt repulsed you know, by the whole situation and uhm as I say, it's not an emotion as such but it's linked to that feeling to being repulsed. I felt nauseous after almost every session.”*



Similarly, Taylor (40s), a clinical psychologist of 5 years, described a recent encounter with a client that had been referred to her by a doctor for her depressed mood due to witnessing the death of her son in the hands of a vigilante group. The client had gone on to describe graphic details of abuse and sexual violence, which was inflicted to her by her husband. The excerpt below was a result of her attempt to establish whether her client had any familial support she could rely on. She detailed how listening to what she called 'horrific' and graphic account of the client's traumatic experiences in the hands of her husband led to her feeling nauseous.

*“Then she explains fifteen years of absolute trauma, being raped, cut, abused, bottles being stuck up and you know that still – the level of description of that abuse was horrific, I have actually felt physically sick, I felt nauseous, you know.”*

### **5.1.1.3 Feelings of Anger: “I do not want to work with this [case], it is going to make me angry**

For some participants, hearing stories of sexual trauma their clients presented with elicited feelings of anger. The anger was mostly directed at perpetrators who had caused the suffering of the clients. Emma, below, related how, when she started practicing as a psychologist, the work prompted physical sensations as well as feelings of anger in herself. She explained that she had developed ‘sensitivity’ to listening to sexual trauma narratives because significant people in her life had experienced it. As a result of the experience of significant others in her life of sexual trauma, she had negative emotional reactions and anger to listening to them.

*“I think since it had happened to a lot of people close to me, initially, I had a very adverse reaction to working with people that had encountered sexual trauma because it has happened to people very close to me... and because of those experiences that I was exposed to already, I had, um, I would say a sensitivity towards that [and it] caused an adverse reaction within, um, the therapy space...It would be getting a physical sensation in my body, a discomfort in my stomach, heart palpitations, thinking that I do not want to work with this [case], it is going to make me angry. It is obviously that strong reaction that comes from my own experience of people very close to me and the feelings that I felt in those relationships that has been triggered within.”*

Phozisa (40), a counselling psychologist of 14 years, identified anger as her first response to hearing stories of sexual violence from her clients. She felt, however, that as a therapist she is also forced to step out of her own emotions and focus on those of the client while in therapy.

*“My experience has been, it is you get angry ...and at times one feels paralyzed because of whatever dynamics are presenting themselves in the clients’ world if I can put it that way.”*

### **5.1.1.4 Sadness and Despair: “these cases just keep me stuck in a place of despair”**

Feelings of sadness and despair were not uncommon among the participants in connection to hearing their clients’ experiences of sexual trauma. Kareena, for example, shared that her work elicited feelings of despair for her. She saw the work as necessitating her, as a

psychologist, to go into dark places with her clients and she felt that the ‘ugliness’ of what her clients have had to endure often leaks into her, leaving her in despair.

*“This is so – it feels like the – the ugliness of it, seeps into me, you know... and sometimes these cases just keep me stuck in a place of despair.”*

Bela (38), a clinical psychologist who had been practicing for ten years, identified feelings of sadness as stemming from engaging with survivors of sexual violence for her and was not connected to a specific case. The sadness was related to the vulnerability of the survivor and the fact that the perpetrator had power over her at the time of the sexual trauma.

*“Sadness ... because you know this was done to someone when they were in a vulnerable position, you know, they were, the person that was doing it, they had so much power over [them].”*

#### **5.1.1.5 Feelings of Guilt: “It felt like I was doing nothing”**

Feelings of guilt over others’ sufferings reflected some respondents’ responses to listening to stories of sexual trauma as seen in the 2 excerpts below. Natalie (50s), has been a clinical psychologist for 10 years and specialises in working with both survivors and perpetrators of sexual violence. In the excerpt below, she related that there were times when at the end of the day she goes to her house and cries due to her feelings of empathy for her clients’ suffering while feeling guilty at their suffering.

*“Obviously which brings up your own issues of guilt and whatever and why does this person have to live such a hard life? So, there are one or two occasions where at the end of the day I will just walk into my house and start crying.”*

Kareena’s experience of working therapeutically with a client who was suffering from sexual trauma while in therapy left her with feelings of guilt. Her guilt feelings were related to her sense of being complicit to the trauma that was taking place while she was her therapist. She

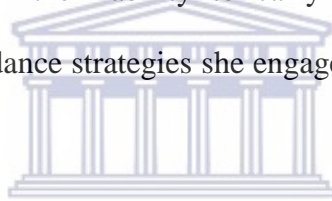


related that she felt she was doing nothing to help the patient even though she was doing her best.

*“I always felt complicit. I remember – I felt complicit in a way...because if you know of something, and you’re not doing anything, even though I was doing something, but it felt like I was doing nothing.”*

#### **5.1.1.6 “There’s a part of me that wants to run for the hills”: Avoidance of traumatic material**

One of the common themes that participants identified due to their engagement with sexual violence was avoidance. Andrea’s (20s) (a clinical psychologist with 4 years’ experience) description below corroborated with the psychologists’ experiences that working with survivors of sexual trauma led to alterations in their affective states and for some such changes impacted negatively on their ability to carry out their work effectively. She continued to describe some avoidance strategies she engaged in, along with feelings of dread associated with her work place.



*“Well the first thing that I noticed was more a behavioural thing, for example I was actually avoiding certain wards in the hospital... I found that one or two instances I would actually turn on my heels and not go into particular wards – so that’s one thing that I noticed. Also I guess just in terms of defending against what you feeling, people would still ask me “How was your day with your work?” and I would be like “Fine, fine everything is fine, I love it” but at the same token realising that some days when I drive into work I feel like a deep sense of dread, like I actually – there’s part of me that wants to run for the hills. So those kind of things I started noticing and also I guess things like cutting interviews short and so those kind of behavioural things.”*

The avoidance described by Andrea above was not only limited to behavioural manifestations but for some psychologists it included an awareness of emotionally withdrawing from engaging with others. Paula’s statement below shows how she had become more emotionally distant from her friends and family members as a result of what she heard in the course of working with sexual trauma survivors.

*“I think the most adverse effect is I distance myself emotionally, I am not distancing myself but I am not emotionally available to friends and family as I used to be, I tend to want to avoid them... it is because of my experience and because of the patients I see and the things I hear.”*

Emma’s response below shows that her emotional reactivity to her work led to her avoidance of listening to trauma news in her personal space.

*“I try to avoid hearing about trauma because I become very angry when I hear about, you know, traumatic things that have happened to people, especially children. I feel like they are totally helpless and innocent.”*

#### **5.1.1.7 Hypervigilance: “I no longer look at it as being overly cautious or hypervigilance – it’s just the smart thing to do.”**

All the participants reported varying levels of hypervigilance as a direct consequence of engaging in the work. Eva (20s), below, a clinical psychologist of 6 years, captured well the experience of others. She had become hypervigilant because of working with survivors of sexual violence and for her this included checking that all the doors are locked, not going out on her own and ensuring her whereabouts are known by significant others in her life.

*“I am very safety conscious. So, I think I often double check certain things, I won’t go anywhere just by myself, [I] make sure all my stuff is locked and if I go somewhere I make sure people know where I am. So I think there's that side of it, but I do think you definitely do become – I would describe myself as probably more hypervigilant due to the work.”*

Some psychologists, however, felt that their behaviours that would be considered hypervigilant were adaptive, though they stemmed from engaging in working with sexual trauma survivors as seen in Phozisa’s comment below.

*“Yes, you do get affected because you – if I have changed somehow my own driving behaviour, I do lock my door, it’s not a – I no longer look at it as being overly cautious or hypervigilance – it’s just the smart thing to do.”*

**5.1.1.8 Intrusive thoughts and images: “I tend to visualise the story as they tell me, so that is quite traumatising for me.”**

A number of psychologists spoke of visual images that they carried long after therapeutically engaging with their clients. Kareena, recalled one such instance, when a story impacted on how she engaged with her children as she struggled with images of sexual abuse related to her by an adult client that happened when she was a 5-year-old girl.

*“Look the only - I mean the closest I have got is, I could not stop thinking about the image of this five year old girl taken into the spare room by her brother and being sodomized. Uhm, I struggled to bath my girls because their naked bodies reminded me of this and what might – I mean, they are so innocent and they are so little and I imagine this girl, this woman at five.... So the process was that I struggled for about a week with these images that wouldn’t stop.”*

Bela’s description of intrusive thoughts as shown below was not unique to herself but a few psychologists recounted their experience of thoughts coming to them involuntarily long after a session had passed. She also captured the feelings of distress she experienced as a result of seeing images in her mind of what her clients share with her.

*“I do experience intrusive thoughts, like, even when I am not with the patient, I would be thinking about [the case] for a long time after the therapy session and I tend to take it home as well... I think also I am a very visual person, like, in my mind I often think about things and have pictures and for me it is quite traumatising as well because I tend to visualise the story as they tell me, so that is quite traumatising for me.”*

**5.1.1.9 Broken Sleep and Nightmares: “I’m being raped or abused or whatever, I think that’s how sometimes it comes out.”**

Some participants reported difficulties with sleep and dreaming about particular cases of sexual violence that they were working on. Andrea, below, recalled a time that lasted for two weeks where she was experiencing insomnia due to her cases of sexual trauma she was involved in.

*“Yes what I noticed most in terms of levels of arousal – I’m definitely- my sleep is affected so I had a period of about two weeks which is now past, where I would have very broken sleep or insomnia basically. So that’s the main thing that I noticed.”*

A few had experienced nightmares, such as Natalie below, who described having nightmares that are linked to a particular case she had worked on and the voice of a client who had told her something that she had never been able to share with anyone else for fear they would be traumatised:

*“But my sleep sometimes gets affected, not often, I mean, very rarely maybe once a year sometimes twice a year I’ll have quite graphic nightmares... They’re quite violent, they’re quite graphic and uhm, and they’re often happening to me, so, something’s happening to me, I’m being raped or abused or whatever, uhm, so you know, I think that’s how sometimes it comes out.”*

Lee was especially highly distressed by the accounts of some of her patients who had survived traumatic experiences, such as repeated abduction and gang rape that she had nightmares about their experiences. Lee was not explicit about the content of the nightmares but described them as ‘horrible’.

*“How it presented in me is nightmares... extreme nightmares about anything that’s horrible that you can think of.”*

### **5.1.2 Changes in Beliefs: Threatened Sense of Self**

The second part of this section highlights some of the changes in the participants’ sense of self they had come to identify due to their engagement with survivors of sexual violence. The respondents had varying experiences of changes that took place in their beliefs about themselves, the world and others due to their engagement with sexual violence survivors. Although some seemed able to hold a positive view of the world and others, several

psychologists reported negative views about the world and others as seen in the depictions below.

#### **5.1.2.1 Being a woman: “you always feel vulnerable, always”**

The psychologists that were part of the study were all female and as such shared the gender of the clients that they were treating for sexual trauma. A majority reported that their work with survivors of sexual violence impacted on their beliefs as it often reminded them of the fact that they were also female and were quite vulnerable to be sexually assaulted. In her attempt to make sense of the phenomenon Kareena revealed feeling vulnerable to experiencing sexual violence due to her being female.

*“It’s such a normal part of the South African woman’s experience and this is across colour, culture that, uhm j-. So I think it – maybe it does affect me, uhm, and even just because as a woman in this country, you always feel vulnerable, always.”*

Emma and other psychologists with daughters reflected a lot on the impact of working in the field of sexual trauma and how that served to fuel their fears about, not only their safety but that of their children. In the excerpt below she speaks directly to her concerns about being female and the vulnerability that goes with that as well as her fears about her daughter’s safety.

*“The nature of the trauma and I suppose being female and having a daughter, that too, you know, freaks me out. Something like that can happen to me or my daughter ja.”*

Bela reflected on how therapeutic engagement with clients was impacted by her identifying with the vulnerability of her clients. She revealed that being sexually assaulted is something she often thinks about as it is a fear she has and that as a woman she feels vulnerable and each story confirms that she is never out of danger herself.

*“For me, personally, it’s always been a fear of mine to somehow encounter that kind of trauma, I haven’t been through sexual trauma in my life, um, but it’s always been right there on top of my list of fears. So, it is something that I think about a lot...[It] makes me feel vulnerable, it makes me feel like I am not out of the loop, I am never going to be out of the loop, I could become a statistic any point in time.”*

Taylor, below, used one of her client’s words who viewed sexual trauma as a consequence of being a woman to depict her own sense of vulnerability as a woman. The client’s words resonated with Taylor as she notes in the excerpt below that sexual trauma is something that happens to women and includes herself when she says that it is ‘our’ reality.

*“[Sexual] trauma seems to be a thing that happens to women... These are things that happen to, ja, women are vulnerable and women get raped, this is our reality, ja. This other woman said to me, “Well, I have a vagina, so I expect to get raped so many times that’s what happens to us, we have got a vagina.””*

### **5.1.2.2 Increased Mistrust of Men: “we don’t hear about good men”**

Several participants spoke of shifts in their capacity for trust in their intimate relationships, as can be seen in the narrative below. Taylor’s account emphasised how engagement with survivors of sexual violence and hearing their stories of victimisation led to changes in her intimate relationships and alterations in her beliefs about all men, including her husband. It also points to her distrust of her husband’s fidelity as she sees him as having a potential to be a perpetrator of sexual violence. She does note that her beliefs about her husband had no basis in any evidence but were derived from hearing negative stories about men, which led her to generalise about all men.

*“Like, I remember here when I just started and I said to my husband: ‘I’m sure I won’t be surprised at you when you have an affair. I’m sure I won’t be surprised. I have not yet heard a man who is not – I have met so few good men... I will be surprised if you don’t cheat or hurt somebody.’ Do you know what I’m trying to say?... That is the sense of this work, we meet such few [men] we forget there are good ones out there... Which is unfair to him actually. He has never shown off that ever there’s any idea or history or anything that would suggest that – but it’s just that*

*we don't see good men in this work... And we don't hear about good men, so as I said 'I will be – I won't be surprised,' because this is what we know that men do"*

Bela, below, spoke of her distrust of men and how that manifested in profiling certain people as more likely to commit sexual trauma than others. She felt that she could not trust men as she did not know who she was dealing with when meeting a man. She also pointed to being fearful of men she did not know well as they might be perpetrators of sexual violence.

*"Okay also becoming more fearful of men, um, I think, um, like I mentioned the anger as well at times, it is fleeting but then it also makes me think about toxic masculinity and how the whole process of grooming, I think um, I think disgust is a strong feeling for me and not wanting, feeling as if I don't know who to trust anymore and don't know what I am really dealing with when I do encounter a male figure, obviously for people I don't know that well, you know, that there is fear that it could be one of those, those men that do such things. How do I know that? I do not know that for sure. So it's trust definitely, anger, um, maybe like displaced or misplaced anger I think towards men as well"*

*Interviewer: "And how would this manifest itself?"*

*Respondent: "I would say definitely I have been guilty of profiling specific people, like maybe, um, just thinking about the perpetrators themselves, um what race and social class they were, what kind of jobs they did and find myself feeling more suspect than usual and being more suspicious than what I should be."*

### **5.1.2.3 Increased vigilance around significant others: "even people so close to you like a brother, father and uncle can inflict harm on you."**

For Emma as well as other respondents with young children, mistrust of men played out in their need to be protective of their children as depicted below. Fear for the well-being of their children led to some participants avoiding sleep-overs outside of their homes. Male figures, including uncles, grandfathers and brothers, were perceived as a threat to the well-being of their children.

*"I think it made me realise more that we don't live in a safe society and even people so close to you like a brother, father and uncle can inflict harm on you. So with my daughter I am much protective of her, I won't allow her, I mean I am very protective*

*of her. My husband reminds me that I am anxious when she is concerned and I am over protective because of what I have been exposed to, I always tell him it does not matter if it is her uncle or grandfather she will not be allowed to sleep or sleep there, being in the care of just a male because I have seen so many clients that have been molested and raped by uncle rather a father, so ja, definitely with my daughter.”*

Bela’s beliefs about how others will behave had led to her preventing her daughters from going to sleepovers as a way of keeping them safe. She expressed that she would never be able to forgive herself if they were sexually traumatised as a result she adjusted her parenting to decrease chances of such a traumatic event from happening.

*“I think I, perhaps I expect too often that people will do bad things, you know? And so – and this is illustrated in how I parent my daughters, where I won’t allow the sleepovers because – it’s not that I’m expecting it to happen, but, uhm, I would never be able to forgive myself if it did”*

Speaking of her daughters, Kareena noted that she and her husband had made a decision to avoid sleepovers for them as well, however, their friends were allowed to sleep over at her place. This was because of her mistrust of the safety of her daughters amongst even males in their family, since ‘all sorts of things’ happen when it is dark.

*“My husband and I have decided that we won’t allow sleepovers, they can have their friends here. But I know how – how quickly these things happen, how the very nice uncle or father or brother or whoever, you know? Uhm when the lights go off, all sorts of things happen.”*

#### **5.1.2.4 “Sex causes so much s--t in the world”: Sex and Intimacy**

Participants in this study also reflected on the impact of working with cases of sexual trauma on their own spaces of sexual intimacy with their partners. Although some respondents related having thoughts about sexual trauma during sexual intercourse, for most it did not seem to adversely affect intimacy with their partners. Mavis (40s) below, shares how

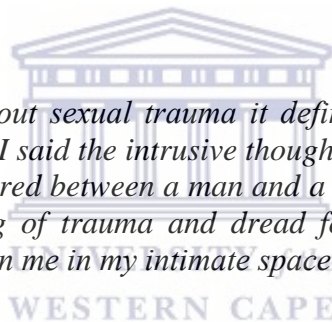


thoughts of some of the stories she hears would come to her while being intimate with her husband. However, she feels such thoughts make her aware of sexual trauma but does not necessarily stop her from engaging sexually with her husband.

*“I have had thoughts. I have, whilst we were making love, totally. But I don’t feel like it has affected me and I think trusting I definitely feel – I think I’m more aware of people and more aware of the potential for harm. But I don’t feel like it’s stopping me, I don’t feel – I think it has just made me more aware.”*

Similarly Emma spoke of her work as having an impact on her most intimate space with her husband. She spoke of having to deal with intrusive thoughts during sexual intercourse with her husband. She also expressed beliefs that sexual trauma has a way of destroying and tainting what is meant to be ‘sacred’ and felt that for some women sex becomes ‘an ugly thing of trauma and dread’.

*“I think also hearing about sexual trauma it definitely has an effect on my sexual health and wellbeing like I said the intrusive thoughts and how the fact that something that is supposed to be sacred between a man and a woman gets destroyed and tainted it becomes an ugly thing of trauma and dread for some women... I would say it definitely has an impact on me in my intimate space as well”*



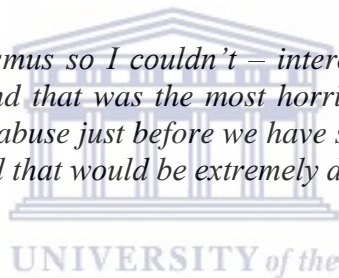
For Natalie there were moments when she could not engage in sexual activity with her partner due to having been exposed to stories or images of sexual trauma, however she notes that was also temporary. Some of the images she saw through her work in legal cases of sexual violence were so disturbing she felt she could not engage intimately with her partner after seeing them. She reported to sometimes expressing beliefs that sex was to blame for causing suffering in the world.

*“There are, well, there were definitely evenings where I couldn’t be intimate because I had seen or heard something. When I work with Legal Aid you see photos and stuff and you end up like, okay, maybe I’m into it tonight... For me there were the odd kind of occasions where I would say to my partner, “I just can’t do this right – I can’t tell*

*you what I have seen or heard today, and I just don't want to be intimate" and he was very respectful of that so I think it also depends on your partner. .. Now and then you will hear me make comments that are like "Yes, sex causes so much s--t in the world" you know what I am saying. Now and then I will be like "I can't believe the trouble people get themselves into just to get an orgasm, who needs it?"*

Lee reported that the work with sexual survivors had a very negative impact on her sexual well-being. She found engaging with her husband intimately difficult due to having developed a condition called vaginismus where the vaginal muscles contract during sexual intercourse causing her much pain. She also had to deal with intrusive thoughts and flashbacks from scenes that her clients had painted for her in therapy just prior to being intimate with her husband, which made sexual intercourse difficult. She notes, however, that she never stopped engaging sexually with her husband.

*"I had developed vaginismus so I couldn't – intercourse was very painful and that was also because of – and that was the most horrible thing, but sometimes I would think about the [client's] abuse just before we have sexual relations or whatever and I would get a flashback and that would be extremely difficult for me."*



## **5.2 Coping with sexual trauma: participants' self-identified coping strategies**

This section of the study will focus on self-identified coping strategies that participants used to deal with the negative effects of working with survivors of sexual violence. The themes that were drawn from participants' narratives included 1. Supervision 2. Peer Supervision 3. Social interactions 4. Recognising limitations 5. Spirituality and 6. Participants also spoke of positive outcomes from working with survivors of sexual trauma.

Supervision was an important element of coping that was identified by all participants. They identified both individual as well as peer supervision as being protective to them. Those who had families and young children highlighted the importance of playing with their children or siblings and making time to spend time with their families. They all seemed to understand the

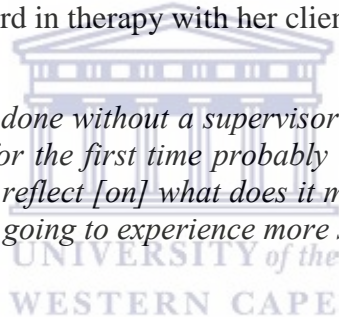
need to take time off and going on holidays at regular intervals. Some emphasised that their spiritual connection with God and faith practices were protective for them, others emphasised time in nature, exercise and a healthy balanced diet as coping strategies. However, all felt that they could do more self-care activities.

### **5.2.1 Supervision: “No, it (the work) can’t be done without a supervisor”**

All the respondents felt that supervision was “indispensable” to the work and were also involved in some form of therapy, with a majority in group therapy. The examples below show how participants were able to use supervision to understand their limitations.

Taylor, below, felt that supervision was so indispensable that the work could not be done without a supervisor. She felt that supervision gave a space to reflect on the ‘raw’ and unprocessed material she had heard in therapy with her client.

*“O ja, no, no, it can’t be done without a supervisor because it’s, like, the stories that you hear, you say them for the first time probably in supervision, while it’s all raw, and then you can at least reflect [on] what does it mean to me... Otherwise, next time I see that person, I’m just going to experience more stuff, so you need to process it...”*



Similarly, Andrea, ranked supervision, along with her own therapy, as invaluable to the work with survivors of sexual violence.

*“I belong to two supervision groups and then I’m also in my own therapy and I think it’s invaluable in, especially working in the public sector I feel – or actually let me revise that, I fell supervision and your own process are almost invaluable in doing this kind of work.”*

Mavis, below, felt that supervision was ‘self-care’ for her. She found supervision provided her with a space to talk about her cases as well as setting boundaries for herself. Through supervision, for example, she was able to limit her work engagement with a particularly challenging client.

*“I think supervision is self-care for me... it is very therapeutic for me... that’s supervision for me, it’s being able to talk about just what is going on and talking about that boundary. Like I said, last year I had supervision every week, and I think we spoke a lot about boundaries, about what I am able to do and what I am not able to do so ja, I think/ and also I had a patient that was very difficult for me and realizing I can’t see her every week and referring her to someone else or her – this particular patient really only wanted to see me, but I can only see her once a month for my own well-being.”*

Faith (50s), a clinical psychologist of 15 years, identified supervision as a space where she took cases she found particularly challenging. She felt being open to feedback and listening to her supervisor helped with identifying her ‘blind spots’.

*“I have supervision every week, where I take my most challenging case and sometimes my supervisor will say to me “Why did you do that or say that? Is there something going on in your life?... So I remain open to feedback and to listening and being aware of my blind spots that my colleagues might pick up.”*

Fiki (30s), a clinical psychologist with 5 years of experience, found in supervision as well as her own therapeutic process the place to reflect on her cases or elements of her cases that might have touched , and the support she needed for the work.

*“I belong to groups that go to supervision – I used to go to supervision weekly, I attend my own therapy every week – so I am thoroughly supported in order for me to unpack in different ways. In terms of supervision, I got supervision to unpack any cases that may – anything that touches.”*

### **5.2.2 Peer Supervision: “Yoh! This is a heavy case, I am stuck, what do I do?”**

Participants ranked conversations with colleagues about their difficult cases as highly beneficial. These conversations did not necessarily have to be scheduled meetings, even brief interactions with colleagues for debriefing purposes were seen to be protective by participants. For Andrea, discussions with colleagues, helped her with learning about coping

strategies that she could use in her work as well. She details how her struggle with sleep previously and her need to acknowledge what was happening to her led to having conversations with colleagues who helped her cope better.

*“Like, I told you about this period about two weeks ago where I started having dysregulated sleep and all this behavioural stuff and then I was thinking ‘Wait, I need to acknowledge this,’ at the same time I know that it’s ways that I’m trying to protect myself from exposing myself fully to what it is. But then I spoke to some of my colleagues, that of course is hugely beneficial if you are working as part of a team, you can speak to colleagues; not only about the casework but also about coping.”*

Phozisa, below, felt that discussing cases with others, be they colleagues or supervisors was highly beneficial as she could not be the ‘be-all-that-ends-all’. She felt that such engagements could not only be limited to face-to-face encounters but that having a phone conversation after a case helps her contain her negative emotions and encouraged her to constantly reflect on her own standpoint.

*“So I think this thing of constantly having to re-evaluate your position, it becomes important, which is why I say sometimes I feel that frustration and anger and then I call someone else after that, who is outside of the situation. They help me think, could this be what is happening, my own countertransference then gets dealt with in that process. I think that’s why we are always encouraged to seek supervision, talk to other people because if you are going to be the be-all-that-ends-all, you may fail the process.”*

Taylor, below, had a scheduled time with colleagues who work in similar settings to herself in order to discuss not only work-related issues but also things that pertained to their personal lives.

*“So I have peer supervision where we get together every Friday, there’s four of us who work at this clinics and we talk through stuff and sometimes it’s about work and sometimes it’s not. But just that we are together in it, that’s great, so once a week, every week.”*

Emma was able to use her colleagues to reflect on heavy cases and to seek support when she needed it.

*“There is peer supervision, um, here, so that and just casually chatting to one of your colleagues after having a heavy case, yoh, this is a heavy case, I am stuck, what do I do?”*

### **5.2.3 “Things... that are about filling you”: Social interactions**

The meaning of coping strategies in the context of working with sexual trauma was highlighted by participants. They acknowledged that the work was emotionally draining and potentially alienating, as a result, a person who engaged in it needed to fill themselves up with relationships and pleasurable activities as conveyed by Fiki below.

*“The reality is that as a mental health professional, you are so constantly embroiled or involved in understanding the lived experiences of others, that it’s so easy to get caught up and lost in that and it’s so important to cultivate things that are just about you, that are just about filling you, that don’t necessarily involve other people. If they do involve other people, it’s people that you choose to let in to your life, your friends, your family and your loved ones.”*

UNIVERSITY of the  
WESTERN CAPE

Participants with families and small children shared the value of having those social systems in their ability to continue doing the work that they do. Taylor found that her family allowed her to forget about work especially on days when she felt low emotionally.

*“There are times when, of course, you are miserable after a hard day... I have a family who let me forget, I have small children who I can just get lost in on weekends and start again from afresh.”*

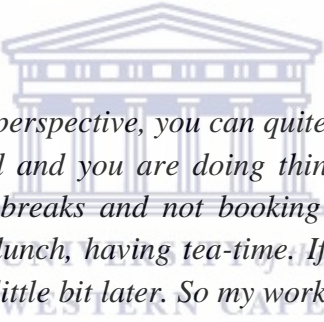
### **5.2.4 “Not trying to be a hero”: Recognising personal limitations**

All participants recognised that they had limitations and cited that they scheduled breaks in their work patterns in order to avoid being negatively impacted by working with survivors of

sexual trauma. Mavis, below, had devised a schedule that allowed her to take breaks after every 6 week working cycle.

*“I try to work six full weeks and then at least take a day off and six full weeks and sometimes it works out with public holiday and I don’t have to take a day off. I think also not trying to be a hero and going for months and months on end without having a break... I think it’s also what can I do, what can’t I do and I can’t be the saviour of (the place she worked at)”*

Faith felt that she had an awareness of her own limitations and that she was not God and as such was unable to do everything. She found that scheduling breaks in her work cycle was not only protective to her well-being but it was also being responsible to her clients. She felt she was able to serve all her clients well after taking time off work.



*“Unless one has another perspective, you can quite blindly just carry on doing things and imagine you are God and you are doing things right... It includes being very responsible about taking breaks and not booking patients back to back, having a space in-between; taking lunch, having tea-time. If I work long hours one day, then the next day I may start a little bit later. So my working hours, I need to be scrupulous around that, around my own personal well-being, going for walks, taking regular breaks in the year and not burning myself out and I think one of the things that I’m also aware of is I don’t want to feel that I’m giving the patient that I see first, a different session to the one that I see last.”*

In support of the above statements, Lee’s negative experience of working with survivors of sexual trauma, showed the necessity of self-care and learning to respond to her body. For her, it started with acknowledging her own needs as a way of separating herself from her work. Speaking of coping strategies, she notes:

*“Like I said, now my coping is more – I am seeing my supervisor weekly, I am on anti-anxiety medication as well from this year which helps a lot, so that helps a lot. I also limit myself in the amount of people that I see.”*

## 5.2. Spirituality “I would never be able to do this work if I didn’t have my faith.”

A number of participants reported that they engaged in spiritual practices that are beneficial to them. Spiritual practices varied for the participants but it was about Kareena, who actively practices Islam and makes time for prayer and meditation during the day, felt that she would not be able to do the work without her faith and her belief system.

*“So I – I’m Muslim, I practice Islam. So, something that I’ve figured is the great gift, is that we have five prescribed prayers a day, and it helps me to connect with God... I would never be able to do this work if I didn’t have my faith and if I didn’t have, uhm, my particular belief system.”*

Mavis, a Christian, related that practices such as attending Church and her relationship with God was protective for her and help her in her work.

*“Church is very important to me, it’s my relationship with God. So I definitely pray and read my bible and I focus on making sure I get time to do that every day”.*

For other participants, such as Paula below, spirituality was not confined to a particular set of beliefs but it was equated to mindfulness.

*“I am very mindful and I don’t particularly have religious rituals or stuff that I follow, um ja, so I just believe in, um not being religious but spiritual, if that makes sense. I am not following a particular, I mean, I do certain things but it does not define what I am, it is more spiritual but I am mindful of things”.*

### 5.2.6 Making trauma work bearable: “For me it’s almost bolstered a sense of hope”

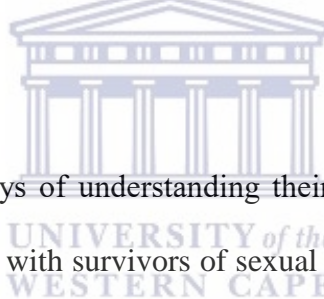
Some participants in the study reported experiencing positive outcomes from their work with sexual trauma survivors. For some, these positive consequences were connected to their clients’ resilience. In the account below, Taylor reflected on what she saw happening in therapy beyond the exchange of words, where clients bring not only their trauma but also their strengths and according to her, that is what makes the trauma bearable for her.



*“And it’s like, as if people come – people come with the goods that have helped them up already... So, some people come to you with their disease and trauma but they also come with other stuff that has held them in place and that other stuff is the stuff that helps the therapist. Their likeability, their pleasantries, the other places in their lives where they are able to show some sense of expertise, they are wonderful grandmothers, wonderfully humorous, amazing story tellers – that is stuff that they come with... People come with the trauma, but they bring something else that makes the trauma bearable for the listener. They bear this burden, you share in that load, it’s not just left with you. It’s the sharing of this load... And then they give you some of the stuff of how they managed to hold the stuff, they give you some of that.”*

Andrea’s account below summarised well the experience of many participants in the study, who felt a surge of positive emotions linked to their work with survivors of trauma.

*“For me it’s almost bolstered a sense of hope, which I don’t know if it’s just a defensive reaction or what it is but it’s made me more determined to understand actually.”*



Likewise, other respondents’ ways of understanding their roles protected them from being negatively affected by their work with survivors of sexual violence and helps them develop a positive outlook towards the work. Kareena’s experience with the work had helped her formulate an understanding of the work that serves as protective to her.

*“This is what it comes down to for me... And so, it helps to take the pressure off, so that I don’t feel like I am the end all and be all of this person’s existence, you know? That actually, they were managing okay before me and they will go on without me after I’m – long after I’m gone. So, uhm, so that helps me also to not – and it’s a constant struggle that, in the beginning especially, I would feel completely washed-out at the end of the session. Where I have realised now I need to hold back some, there is an amount of self-preservation I need to do, even in the session. And I need to almost remind myself “I’m not them, I’m not going through this” you know? I’m just walking beside them on this part of their journey.”*

While Fiki has been able to develop an understanding of her role as a therapist that protects her from the harmful effects of working with sexual trauma survivors.

*“Also I think for me, what helps cope is just to say that which I am doing, is healing. It is not just a mere opening of the wounds that are just going to be left to fester, but it’s a healing conversation, so my role is to help facilitate healing. So that’s how I am able to kind of cope with it all because I have a clear role from what I am doing.”*



## Chapter 6: Discussion

The study sought to explore self-reported experiences of VT among female clinical and counselling psychologists working with survivors of sexual violence. This section of the study will look at the main findings that materialised from the study and uses existing literature on VT to analyse psychologists' interpretations of their experiences. The discussion is embedded in the Interpretive Phenomenological Analysis theory.

### 6.1 Participants' Lived Experiences of VT

Existing international research on VT is still growing and some of the studies that have been published have involved therapists who work with sexual violence survivors (Johnson & Hunter, 1997; Schauben & Frazier, 1995; Steed & Downing, 1998; Brady et al., 1999; Baird & Jenkins, 2003; Way et al., 2004; Kadambi & Truscott, 2004; VanDeusen & Way, 2006) with only a few focusing on female therapists (Schauben & Frazier, 1995; Steed & Downing, 1998; Brady et al., 1999). This present study's focus on female psychologists is therefore addressing a gap in literature as it specifically investigates the population of clinical and counselling psychologists working with the client group of female sexual violence survivors.

Although the concept of VT was introduced into literature in the 90s by McCann and Pearlman (1990), very few studies have been conducted on the phenomenon in South Africa. The few research output in existence on this phenomenon has come from different fields, such as research and business. There have been some that have been generated from the helping field, such as VT in psychologists who work with trauma survivors (Sui & Padmanabannuni, 2016), in volunteers supporting intimate violence survivors in a community organisation (Howlett & Collins, 2014) while one focused on STS levels in trauma workers in South Africa (MacRitchie & Leibowitz, 2010). This study's contribution to the

understanding of what happens when female psychologists engage empathetically with sexual trauma survivors is therefore unique in the South African context and also timely as South Africa's rates of sexual violence against women is gaining widespread criticism.

Findings from both local and international studies have consistently established that VT is a common experience for most therapists working in the field of trauma (Sui & Padmanabhannuni, 2016) as well as sexual trauma specifically (Baird & Jenkins, 2003; Brady et al., 1999; Chouliara et al., 2009; Johnson & Hunter, 1997; Kadambi & Truscott, 2004; Schauben & Frazier, 1995; Steed & Downing, 1998; VanDeusen & Way, 2006; Way et al., 2004). Brady et al., (1999) has gone so far as to assert that therapists who work with survivors of sexual abuse are at greater risk of developing VT than those who do not. Participants in the present study also reported that hearing sexual trauma narrative drew from them high levels of empathy and led to negative emotional experiences. This is in keeping with research on the negative effects of sexual trauma work on therapists, for example Kadambi and Truscott (2004) in their comparison of sexual violence practitioners with those who provide cancer therapy and general trauma therapy found that those who treated sexual violence survivors felt that their work was potentially more traumatising than their counterparts on the qualitative scale. This was the case even though the quantitative scales that were used in the research yielded no significant differences between the 3 groups.

All the participants in the study reported experiencing various negative emotions due to engaging with survivors of sexual violence in their work. Bartoskova (2017), even though her work sought to determine the positive effects of working with trauma for therapists, found that all the respondents in her study had experienced deleterious effects from working with trauma with nine respondents experiencing psychological reactions to trauma stories. Similar

findings have been reported in other literature undertaken with both female and male mental health professionals who work with trauma survivors (Brady et al., 1999; Cohen & Collens, 2013; Knight, 1997; Merriman & Joseph, 2018; Steed & Downing, 1998; Tosone, et.al., 2012;).

Some of the negative affect that participants in this present study reported on during their engagement with clients included feelings of horror, sadness, anger, guilt, hopelessness, helplessness and despair. This is in keeping with literature on VT and sexual violence where therapists who work with survivors of sexual violence reported emotional distress with sadness (Cohen & Collens, 2013; Merriman & Joseph, 2018; Satkunanayagam et al., 2010; Schauben & Frazier, 1995; Shamai & Ron, 2009) helplessness (Shauben & Frazier, 1995; Steed & Downing, 1998), powerlessness (Cohen & Collens, 2013; Deighton, Gurriss & Traue, 2007; Satkunanayagam et al., 2010), horror (Merriman & Joseph, 2018), guilt (Tosone, et.al., 2012), anger towards the perpetrator being most reported on (Merriman & Joseph, 2018; Tosone, et.al., 2012) and despair (Cohen & Collens, 2013).

Avoidance, hypervigilance, intrusive thoughts and nightmares were some of the PTSD symptoms that some of the participants reported on. These findings reflect both national and international research on the impact of trauma work on those who treat survivors (Deighton, Gurriss & Traue, 2007; Kaminer & Eagle, 2010; Mason & Lodrick, 2013), for example Brady et al. (1999) found that female psychologists who work with survivors of sexual abuse reported experiences of mild symptoms of intrusion and avoidance. Similarly Robinson-Keiling (2014) reported on intrusion and avoidance in participants in his study. Hypervigilance for this present study's participants was seen as adaptive in the context of the Western Cape's criminality and all participants reported being hypervigilant due to their work

with survivors of sexual violence. Clemans (2004) also found a similar trend in participants who work with trauma where they reported being more hypervigilant. Nightmares featured prominently in literature as well (Jirek, 2015).

In their review of 20 published qualitative studies on VT and Vicarious Posttraumatic Growth, Collens and Cohen (2012) found that the effect of trauma work went beyond disturbances in the affect for participants but the experience had prompted disruptions in cognitive functioning leading to alterations in schemas. Such was the case with the present study. Changes in participants' cognitive schemas manifested in altered beliefs about the self, others and the world. For participants in this study, these included greater identification with clients that led to feeling vulnerable to experiencing sexual violence, mistrust of men, heightened vigilance towards significant others and sexual intimacy difficulties. Way, VanDeusen and Cottrell (2007) acknowledged the difficulties of sustaining a positive self-regard particularly for female therapists who work with sexual violence survivors mainly because they also experience the agony and outcomes of violent acts that are usually perpetrated by men.

All the participants in the study were female and could identify with female sexual survivors who were their clients. A majority of them, especially those with daughters, expressed fears for their safety as well as that of their children. They also reported feeling vulnerable to experiencing sexual assault. Bela, a 34-year-old clinical psychologist captured it this way: *“For me personally it’s always been a fear of mine to somehow encounter that kind of trauma, I haven’t been through sexual trauma in my life, um, but it’s always been right there on top of my list of fears. So, it is something that I think about a lot...[It] makes me feel vulnerable, it makes me feel like I am not out of the loop, I am never going to be out of the*

*loop, I could become a statistic any point in time.*” These findings corroborate well with local research on the disruption of cognitive schemas that trauma work led participants to (Sui & Padmanabhannuni, 2016). Similar to the participants in the present study, female participants in Sui and Padmanabhannuni’s study who worked with rape survivors were found to experience greater safety concerns for themselves and significant others. They also were more likely to indicate increased mistrust of men (Sui & Padmanabhannuni, 2016). A number of participants in this study described a rise in suspiciousness and mistrust of significant others in their lives who were men, including husbands, fathers and brothers. International research conveys similar findings with some participants reporting greater vigilance for possible threats in their environment (Clemans, 2004; Iliffe & Steed, 2000; Joseph, 2018; Merriman &), mistrust of others (Clemans, 2004; Iliffe & Steed, 2000; Merriman & Joseph, 2018; Shauben & Frazier, 1995) and beliefs about personal safety, which led to emotional disturbance (Deville, et. al., 2009). Cohen and Collens (2013) found that the element of mistrust of others was mostly related to those studies with participants that work with survivors of sexual violence and the mistrust was aimed primarily at men.

Changes in beliefs about the self and others also manifested in interpersonal relationships where some participants described thinking of the traumatic material shared by their clients prior to engaging in sexual activities. For Natalie, a clinical psychologist in her 40s, there were moments she could not engage sexually with her partner: *“there were the odd kind of occasions where I would say to my partner: “I just can’t do this right – I can’t tell you what I have seen or heard today, and I just don’t want to be intimate... Now and then you will hear me make comments that are like “Yes, sex causes so much s--t in the world”* However, all participants reported that the thoughts or images were fleeting and did not cause disruptions in their relationships. Although literature on VT maintains that there is a link between VT and interpersonal relationship disturbances (Collins & Long, 2003; Dutton & Rubinstein, 1995;

Yassen, 1995 as cited in Robinson-Keilig, 2014), there are no studies that have specifically looked at disruptions in sexual functioning of therapists due to their work with survivors of sexual violence. A few have found a correlation between trauma work and disruptions in cognitions regarding trust of others and intimacy (VanDeusen & Way, 2006). One study conducted by Robinson-Keilig (2014), which looked at sexual interest and sexual relationship satisfaction found no association between these variables and STS. Rich (1997), on the other hand, in his survey of 135 clinicians who treat trauma survivors found that 36.1 % reported that their sex lives were less satisfying since undertaking trauma work.

## **6.2 Participants' Self-Identified Coping Strategies**

Various self-identified methods of coping were discussed by the participants in this study. Chief among coping strategies adopted by all the psychologists was supervision and peer support. This is in line with international best practice as peer support and supervision is seen to help therapists deal with work challenges (Clemans, 2004; Iliffe & Steed, 2000; Jordan, 2010; VanDeusen & Way, 2006), reduces feelings of being isolated and opens up for ; participants a place for debriefing and expressing feelings. Participants in the present study found supervision supportive and also felt that it was where they were able to get different perspectives on the difficulties they were facing. Participants in the current study, however, did not differentiate between supervision and therapy and often used both terms interchangeably. Literature was consistent in terms of the role of supervision in ameliorating the effects of trauma work on therapists who work with survivors of sexual trauma (Sommer & Cox, 2005). It has been proposed that the quality of supervision and not the quantity, might be the key variable in determining its effectiveness (Sommer & Cox, 2005).

Support was not only related to peers but was also applied to friends and family members. Some participants reported that they relied a lot on their partners, friends and families for



support. One psychologist noted that playing with her children allows her to forget her distress over her work. Buchanan et al., (2006), Jordan, (2010), Killian, (2008) and Shoji et al., (2014) found that social support had a mediating effect on the development of STS with Killian asserting that it was an extremely vital element for predicting compassion satisfaction.

A number of participants felt that it was an ethical imperative and showed a sense of responsibility to take breaks from their work, which for some included limiting the number of trauma cases they worked with. Literature that speaks on this aspect of coping with trauma work emphasises the association between long hours of clinical contact with lower compassion satisfaction (Killian, 2008) as well as the importance of managing trauma caseload (Iliffe & Steed, 2000).

Connection to spirituality was noted as essential by a number of psychologists with some participants feeling very strongly that they would not be able to cope without their religious beliefs and practises. Research on spirituality has pointed out that it safeguards against the negative effect of trauma work (Bell, 2003 in Cohen & Collens, 2004; Dombo & Gray, 2013).

A number of participants related positive experiences of working with survivors of sexual violence. They noted that their clients' resilience was a significant factor that bolstered their own sense of hope. The field of Secondary Posttraumatic Growth is littered with literature on the positive effects of working with trauma for therapists (Barrington & Shakespeare-Finch, 2013; Pearlman & Caringi, 2009).

## Chapter 7: Conclusion

Sexual violence along with femicide has, in recent years, become a national concern in South Africa. With so many people living in a reality of violence, it is reasonable that some survivors will seek out the help of a psychologist to work through and heal from the pain they have had to endure. This study aimed to tackle a gap in the South African literature by seeking to understand the experience of female clinical and counselling psychologists who work with the survivors of sexual violence. The results are consistent with existing literature on VT as all the participants in this study could attest to being negatively impacted by hearing trauma stories. Although a majority were able to make meaning of their experiences, a few psychologists struggled with latent negative emotions that impacted on how they were able to carry on with their work. PTSD symptoms were present in some of the participants, however, all participants felt that in the context of South Africa, hypervigilance should not be understood as maladaptive but rather a very adaptive and necessary tendency. All the psychologists used coping strategies to deal with the negative effects of working with sexual trauma survivors with supervision identified as a necessity for continued well-being of the psychologist. A majority of psychologists also attested to have gained renewed hope and positive growth through engaging with survivors of sexual violence.

This is clearly an area that requires further exploration in South Africa as this study leaves more questions than answers. There is also a need for institutions of training to introduce trauma-specific training in their curriculum to support in-coming professionals with necessary resources for dealing with the negative effects of working with sexual violence in South Africa. It is also important to structure courses in such a way that self-care becomes part of the training of a psychologist. There was consensus among participants that self-care

is not a prescribed set of activities that need to be undertaken but mindfulness could serve as a powerful antidote to the deleterious effects of the work.

## **7.1 Recommendations**

There have been calls to address gender differences in response to trauma work (Buchanan et al., 2006). Various research studies have presented conflicting findings on the existence of gender differences in vulnerability to VT. Kassam-Adams (1999), for example, revealed that female therapists reported high on STS than their male colleagues regardless of age and years of experience. Given the sample of the present study, such a difference could not be determined, however, there was a clear pattern of identifying with the clients for the participants. Brady et al (1999) in attempting to account for these differences noted that therapist identification with the clients might be responsible for increased reporting of trauma symptoms in female therapists treating adult survivors of sexual violence as opposed to female therapists who treat child sexual abuse survivors, who report less symptoms. Baum (2015)'s review of literature to establish the proclivity of different gendered therapists to developing STS ascertained an increased female vulnerability to STS when assessed against PTSD symptoms but not against ProQOL. Various explanations have been presented to account for this difference including the tendency of females to disclose emotional distress more readily than male counterparts (Baum, 2015). Further investigation is therefore required to ascertain whether the difference is due to the tendency of females to recognise as well as to report on emotional distress than males or there is something in the physiology of females that makes them vulnerable to developing VT.

There is evidence in literature that the age and number of years in service of the therapist are factors in VT, with those therapists with fewer service years being more prone to developing VT. In this study, the psychologists with fewer years in service did report more severe VT

symptoms with one having been diagnosed with VT. There was one senior psychologist who reported severe symptoms, however, on the whole, those with 5 – 10 years in service were more likely to report mild disturbances. However, it could not be determined whether this was due to the expectations psychologists have that come with a certain number of years in service that such individuals should be able to cope better as opposed to those who have only a few years in service who still feel that they have a lot to learn and are more likely to expose what would be considered shortfalls.

The participants had varying degrees of prior exposure to trauma history, with 3 having experienced sexual trauma in their childhood, however, the one with the least exposure to trauma was the one who was most negatively affected by the work. Nevertheless, she did report a history of psychological disorder in her family. Literature on the history of personal experience of trauma on therapists being vulnerable to developing VT has been inconclusive (Michalopoulos and Aparicio, 2012; Adams et al., 2001; Way et al., 2004) as in the present study. Instead this study introduces another variable, which is diagnosed disorders either in the family or in the individual and vulnerability to VT.

## **7.2 Limitations**

In keeping with the aim of this study, a qualitative approach was used which limited the number of participants that could be engaged and meant that the findings could not be generalised to other settings.

The population at study, female clinical and counselling psychologists, does not carry a lot of trauma cases outside of the public hospital setting in the South African context. Only 4 psychologists in the study worked in the public health system, the rest ran private practices and their trauma caseloads ranged between 25% and 35%. As a result, it could not be

determined convincingly whether the experience of VT was linked to the number of sexual violence cases treated.

The present study did not look at the work settings in which the psychologists practised to determine whether certain settings are more likely to cause different outcomes in terms of the development of VT. Different settings mean different access to resources and as such, an exploration of the work setting would have answered the question of the role of work setting in the development of VT.

The study did not compare the effect of VT to other trauma work or females to males and this remains a gap in the study.



## References

- Adams, S. A. and Riggs, S.A. (2008). An exploratory study of vicarious trauma among therapist trainees. *Training and Education in Professional Psychology*, 2:1, 26 – 34. DOI: 10.1037/1931-3918.2.1.26
- Aisbett D.L. (2006). Interpretative phenomenological approaches to rural mental health research. *Rural Social Work and Community Practice*, 11 (December): 52-8
- Babbie, E. and Mouton, J. (2009). *The practice of social research*. (South African ed.). Cape Town: Oxford University Press
- Baird, S., & Jenkins, R.J. (2003). Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence and Victims*, 18, 71\_86.
- Barrington, A. J. and Shakespeare-Finch, J. (2013). Working with refugee Survivors of torture and trauma: An opportunity for vicarious post-traumatic growth, *Counselling Psychology Quarterly*, Vol. 26:1, March, 89 – 105
- Bartoskova, L. (2017). How do trauma therapists experience the effects of their trauma Work, and are there common factors leading to post-traumatic growth? *Counselling Psychology Review*, Vol. 32, No. 2
- Brady, J.L., Guy, J.D., et al. (1999). Vicarious traumatization, spirituality, and the treatment of sexual abuse survivors: A national survey of women psychotherapists. *Professional Psychology: Research and Practice*, 30, 386\_393.
- Buchanan, M., Anderson, J. O., Uhlemann, M.R. and Horwitz, E. (2006).

Secondary Traumatic Stress: An investigation of Canadian mental health workers.

*Traumatology*, Volume 12 Number 4, 272 – 281. DOI: 10.1177/1534765606297817

Burton, P. and Leoschut, L. (2013). School violence in South Africa: Results of the 2012 national school violence study. Centre for Justice and Crime Prevention, *Monograph Series*, 12.

Centre for Study of Violence and Reconciliation (CSV). (2008). A state of sexual tyranny: The prevalence, nature and causes of sexual violence in South Africa, CSV.

Chouliara, Z., Hutchison, C. and Karatzias, T. (2009). Vicarious traumatisation in practitioners who work with adult survivors of sexual violence and child sexual abuse: Literature review and directions for future research. *Counselling and Psychotherapy Research*, 9:1, 47 – 56. DOI: 10.1080/14733140802656479.

Cieslak, R., Shoji, K., Douglas, A., Melville, E., Luszczynska, A. and Benight, C.C. 2014. A Meta-Analysis of the relationship between job burnout and secondary traumatic stress among workers with indirect exposure to trauma. *Psychological Services*, 11:1, 75 – 86.

Cohen, K. and Collens P. (2013). The Impact of trauma work on trauma workers: a metasynthesis on vicarious trauma and vicarious posttraumatic growth. *Psychological Trauma, Theory, Research, Practice and Policy*. 5:6, 570 – 580.

Crotty, M. (1996). Phenomenology and nursing research. Churchill Livingstone, Melbourne

Creswell, J.W. (2007). *Qualitative Inquiry & Research Design: Choosing among five approaches*. (2<sup>nd</sup> Ed). London: SAGE

- Dartnall, E. and Jewkes, R. (2013). Sexual violence against women: the scope of the problem. *Best Practice & Research Obstetrics and Gynaecology*, 27, 3 – 13.
- Deighton, R. M., Gurriss, N. and Traue, H. (2007). Factors affecting burnout and compassion fatigue in psychotherapists treating torture survivors: is the therapist's attitude to working through trauma relevant? *Journal of Traumatic Stress*, 20:1, 63 – 75. DOI: 10.1002/jts.20180
- Devilly, G.J., Wright, R. and Varker, T. (2009). Vicarious Trauma, Secondary Traumatic Stress or simply burnout? Effect of trauma therapy on mental health professionals. *Australian and New Zealand Journal of Psychiatry*. 43:373 – 385.
- Dombo, E. A. and Gray, C. (2013). Engaging spirituality in addressing vicarious trauma in clinical social worker: A self-care model. *Social Work & Christianity*, 40:1, 89 – 104
- Finchilescu, G. & Tredoux, C. (2010). The changing landscape of intergroup relations in South Africa. *Journal of Social Issues*, Vol. 66, No. 2, 2010, pp. 223--236
- Guillemin, M. and Gillam, L. (2004). Ethics, reflexivity, and “ethically important moments” in research. *Qualitative Inquiry*, 10:2, 261-280. DOI: 10.1177/1077800403262360
- Harton, H.C. and Lyons, P.C. (2003). Gender, empathy and the choice of psychology major. *Teaching of Psychology*, 30, 19 – 24.
- Hensel, J.M., Ruiz, C., Finne, C. and Dewa, C.S. (2015). Meta-analysis of risk factors for secondary traumatic stress in therapeutic work with trauma victims. *Journal of Traumatic Stress*, April 28, 83 – 91.



Janoff-Bulman, R., 1992. *Shattered assumptions: towards a new psychology of trauma*.

New York: The Free Press

Jirek, S.L. (2015). Soul Pain: The hidden toll of working with survivors of physical and

sexual violence. *SAGE Open*, July – September, 1 – 13. DOI:

10.1177/2158244015597905

Johnson, C.N.E., & Hunter, M. (1997). Vicarious traumatisation in counsellors working in the New South Wales Sexual Assault Service: An exploratory study. *Work & Stress*, 4, 319\_328.

Jordan, K. (2010). Vicarious trauma: Proposed factors that impact clinicians. *Journal of*

*Family Psychotherapy*, 21, 225 – 237. DOI: 10.1080/08975353.2010.529003.

Kadambi, M.A., & Truscott, D. (2004). Vicarious trauma among therapists working with sexual violence, cancer and general practice. *Canadian Journal of Counselling*, 38, 260\_276.

Kaminer, D., Hardy, A., Heath, K., Mosdell, J. and Bawa, U. (2013). Gender patterns in the contribution of different types of violence to posttraumatic stress symptoms among South African urban youth. *Child Abuse & Neglect*, 37, 320 – 330.

Kaminer, D. and Eagle, G., 2010. *Traumatic Stress in South Africa*. Johannesburg:

Wits University Press

Killian, Kyle D. (2008). Effects of working with trauma survivors. *Traumatology* Vol. 14, No. 2, June

LoBiondo-Wood G. and Haber, J. (eds) *Nursing research methods, critical appraisal and utilisation* (5<sup>th</sup> edn.) Mosby, St Louis

Mason, F. and Lodrick, Z. (2013). Psychological consequences of sexual assault. *Best Practice & Research Clinical Obstetrics and Gynaecology*, 27, 27 – 37. DOI: [org/10.1016/j.bpobgyn.2012.08.105](https://doi.org/10.1016/j.bpobgyn.2012.08.105)

McCann I.L., and Pearlman, L.A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3, 131 – 149.

Merrimen, O. and Stephen, J. (2018). Therapeutic implications of counselling psychologists' responses to client trauma: An interpretative phenomenological analysis. *Counselling Psychology Quarterly*, Vol. 31, No. 1, 117–136, <https://doi.org/10.1080/09515070.2016.1266601>

Michalopoulos, L.M. and Aparicio, E. (2012). Vicarious Trauma in social workers: The role of trauma history, social support, and years of experience. *Journal of Aggression, Maltreatment & Trauma*, 21: 646 – 664. DOI: 10.1080/10926771.2012.689422

Nimmo, A. and Huggard, P. (2013). A systematic review of the measurement of compassion fatigue, vicarious trauma, and secondary traumatic stress in physicians. *Australasian Journal of Disaster and Trauma Studies*. 1, 37 – 44

Optimus Study South Africa. (2016). *Sexual victimisation of children in South Africa: Final report of the Optimus Foundation Study*. Zurich: Optimus Study Foundation

Padmanabhanunni, A. (2015). *The phenomenology of rape in South Africa*. In A. Herbst & G. Reitsma (chapter 6), *Trauma Counselling*. Juta and Company: Johannesburg, South Africa

Pearlman, L.A. and Caringi, J. (2009). Living and working self-reflectively to address vicarious trauma. In Courtois, Christine A. and Ford Julian D. (Eds). *Treating Complex Traumatic stress disorders: An Evidence-based guide*, (pp.202 – 242). New York: The Guildford Press

Pearlman L. A. and Saakvitne, K. W. (1995). Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors. New York: Norton

Quinn, C., Clare, L., Pearce, A. and Van Dijkhuizen, M. (2008). The experience of providing care in the early stages of dementia: An interpretative phenomenological analysis, *Aging & Mental Health*, 12:6, 769 - 778, DOI: [10.1080/13607860802380623](https://doi.org/10.1080/13607860802380623)

RAPCAN. (2014). Learning brief, 31 March 2014.

Saakvitne, K. W, Tennen, H. and Affleck, G. (1998). Exploring thriving in the context of clinical trauma theory: Constructivist self development theory. *Journal of Social Issues*, 54:2, 279 - 299

Sabo, B.M. (2006). Compassion fatigue and nursing work: Can we accurately capture the consequences of caring work? *International Journal of Nursing Practice*

Sandfort , T.G. M., Baumann, L. R. M., Matebeni, Z., Reddy, V. and Southey-

- Swartz, I. (2012). Forced sexual Experiences as Risk Factor for self-reported HIV infection among Southern African lesbian and bisexual women. *Plos One*, 8:1, 1 – 9.
- Schauben, L.J., & Frazier, P.A. (1995). The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly*, 19, 49\_64.
- Shoji, K., Lesnierowsda, M., Smoktunowickz, E., Bock, J., Luszczynska, A., Benight, C.C. and Cieslak, R. (2014). What comes first, job burnout or secondary traumatic stress? Findings from two longitudinal studies from the US and Poland. *PLOS One*. August 2015, 1 – 15.
- Smith, J., Flowers, P., and Larkin, M. (2009). *Interpretative phenomenologica analysis: Theory, method and research*. London: SAGE
- Smith, J. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*. 1, 1, 39–54.
- Smith, J. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology & Health*, 11:261-71
- Snodgrass, L. and Bodisch, A. (2015). Why are we such a violent nation? The legacy of humiliation in South Africa. *Africa Insight*. Vol 45(3) – December 2015
- Sommer, C.A. and Cox, J.A. (2005). Elements of supervision in sexual violence

counselors' narratives: A qualitative analysis. *Counselor Education & Supervision*, 45, 119-134.

Statistics South Africa. (2015). *Victims of crime survey, 2013/14*. Pretoria: Statistics South Africa

Statistics South Africa. (2000). *Quantitative research findings on RAPE in South Africa*. Pretoria: Statistics South Africa

Schauben, L.J., & Frazier, P.A. (1995). The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly*, 19, 49\_64.

Sprang, G., Clark, James J. & Whitt-Woosley, A. (2007). Compassion Fatigue, Compassion Satisfaction, and Burnout: factors impacting a professional's quality of life. *Journal of Loss and Trauma*, 12, 259 – 280. DOI: 10.1080/15325020701238093

Snodgrass, L. & Bodisch, A. (2015). Why are We Such a Violent Nation? The Legacy of Humiliation in South Africa. *Africa Insight*, Vol 45 (3) – December 2015

Tosone, C., Nuttman-Shartz, O. & Stephens, Tricia. (2012). Shared trauma: When the professional is personal. *Clin Soc Work J*, 40, 231 – 239. DOI: 10.1007/s10615-012-0395-0

VanDeusen, K.M., & Way, I. (2006). Vicarious trauma: An exploratory study of the impact of providing sexual abuse treatment on clinicians' trust and intimacy. *Journal of Child Sexual Abuse*, 15, 69\_85.

Versola-Russo, J. M. (2005). Vicarious victims of trauma: A literature review. *Journal of*

*Police Crisis Negotiations*, 5:2, p. 59 – 80. DOI: 10.1300/J173v05n02\_05

Vetten, L. (2014). Rape and other forms of sexual violence in South Africa. ISSN Policy

Brief 72, 1-7

Watts, J., and Robertson, N. (2011). Burnout in university teaching staff: A systematic

literature review. *Education Research*, 53, 33-50. DOI:

10.1080/0013188.2011.552235

Way, I., VanDeusen, K. and Cottrell, T. (2007). Vicarious trauma: Predictors of

clinicians' disrupted cognitions about self-esteem and self-intimacy. *Journal of Child*

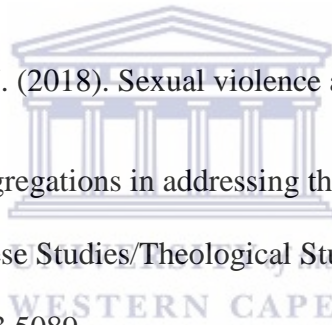
*Sexual Abuse*, 16:4, 81 – 98

Weber, S. and Bowers-DuToit, N. (2018). Sexual violence against children and youth:

Exploring the role of congregations in addressing the protection of young girls on the

Cape Flats, HTS Teologiese Studies/Theological Studies 74(3), a5089. [https://](https://doi.org/10.4102/hts.v74i3.5089)

[doi.org/10.4102/hts.v74i3.5089](https://doi.org/10.4102/hts.v74i3.5089)



## Appendix A: Information Sheet



UNIVERSITY *of the*  
WESTERN CAPE

### PARTICIPATION IN AN INTERVIEW

**Title of Research Project:** Exploring the experience of vicarious trauma among female clinical/counselling psychologists working with survivors of sexual violence in the Western Cape

#### **What is this study about?**

This research project is conducted by Nondumiso Gqomfa, a psychology Masters student from the University of the Western Cape. It aims to explore the experience of vicarious trauma (VT) among psychologists working with sexual violence survivors in the Western Cape. Vicarious trauma refers to negative emotional, cognitive and behavioural changes that occur on the part of the clinician as a reaction to hearing stories of trauma from their clients. VT is universal (impacting life in its entirety), cumulative (having a snowballing effect where each client narrative strengthens beliefs of, for example, an unsafe world), and is a result of ongoing interactions with trauma survivors in a counselling relationship. Some of the symptoms that are linked with VT include PTSD-like symptoms, such as intrusive and avoidant behaviour, heightened sense of alertness, and feelings of powerlessness and isolation.

#### **What will you be expected to do if you agree to participate?**

As a participant, you will be expected to take part in an hour-long semi-structured interview session with the researcher. The researcher will ensure that all participants receive the broad interview questions prior to the interview, so as to allow time for participants to prepare themselves, both

mentally and emotionally, for the interview. Questions to be asked will cover 1) personal experience of vicarious trauma and 2) coping strategies employed for dealing with vicarious trauma.

### **Ethical considerations**

This research will be conducted with due regard for ethical considerations that guide psychological research in the University of the Western Cape. As such, this research will ensure that subjects of the research are exposed to no harm; protection, where necessary, of the identities of the participants as well as their rights will be extended; and information gained from this study specified use d for any other purpose than that specified.

### ***Potential risk***

It is expected that relaying personal experiences of vicarious trauma might be anxiety-provoking for some participants. At the first sign of such provocation by the interview, the interview will be terminated instantaneously in order to safeguard the participant from emotional harm and so as to uphold the ethical code of the profession. All participants who participate in this research project do so on a voluntary basis and may withdraw at any time. Participation or non-participation in the study will not lead to any negative consequences with the University of the Western Cape.

### ***Benefits***

The benefits of participating in this research project include taking part in a study that aims to augment research knowledge in the area of vicarious trauma among therapists working with sexual violence survivors in the Western Cape. The researcher also aspires to benefit, through the results of this research, the field with greater understanding of vicarious trauma and to propose coping strategies that they can use to deal with it.

If you have concerns or question about the research you may call the following:

Dr Anita Padmanabhanunni (Supervisor)      apadmana@uwc.ac.za

Ms Nondumiso Gqomfa (Researcher)      nondumiso7@gmail.com



## Appendix B: Consent Form



**UNIVERSITY** *of the*  
**WESTERN CAPE**

PROJECT TITLE: The experience of vicarious trauma among female clinical/counselling psychologists working with survivors of sexual violence in the Western Cape

I, \_\_\_\_\_ (Name Printed), the undersigned, hereby give consent for the psychologists in the clinic to participate in the research study.

By signing below, I am agreeing that:

1. I have read and understood the information sheet,
2. questions about psychologists' participation in the study have been satisfactorily answered,
3. I am aware of potential risks of this study,
4. I am aware that psychologists' participation in this study is voluntarily, and
5. the results of the study will be disseminated to the public via publications.

\_\_\_\_\_  
Participant's Name (Printed)

\_\_\_\_\_  
Participant's signature

\_\_\_\_\_  
Date

## Appendix C: Semi-structured interview questions

**Dear Research Participant,**

Thank you for your willingness to participate in this research project. The existing academic literature has emphasized that therapists who work with survivors of traumatic events (e.g. rape, childhood sexual abuse, domestic violence, motor vehicle accidents) are not left unscathed by the stories of trauma they hear. By participating in this project, you will be helping us to increase our understanding of the experiences of vicarious trauma among psychologists who work with sexual violence trauma survivors in the Western Cape. Vicarious trauma refers to psychological alterations that therapists undergo as a result of working with trauma material. These may be manifested in PTSD-like symptoms as well as in long-lasting changes in the clinician's self-concept, spirituality, view of the world as well as behavioural changes.

**Here is a sample of questions that you may be asked during your interview:**

1. How long have you worked as a psychologist?
2. When did you first start with survivors of trauma?
3. What was it like for you when you started?
4. How long have you been involved in trauma work
5. Have you received any training in working with trauma?
6. What are the most common types of trauma you work with?
7. Are there cases that you find particularly difficult to deal with?
8. Can you share with me your experiences of working with survivors of sexual violence?
9. In what ways has this work affected you?

10. Have you seen any changes in how you view yourself and others due to your working with sexual violence survivors?
11. What are some of your coping strategies do you use to deal with stressors in your work?/ What self-care activities do you feel are helpful to practise?



## Appendix D: Ethical Clearance



UNIVERSITY of the  
WESTERN CAPE

### OFFICE OF THE DEAN DEPARTMENT OF RESEARCH DEVELOPMENT

19 June 2015

#### To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by:  
Ms N Gqomfa (Psychology)

Research Project: Exploring the experience of vacarious trauma among female clinical/counseling psychologists working with survivors of sexual violence in the Western Cape.

Registration no: 15/4/50

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

A handwritten signature in black ink, appearing to read 'Josias'.

*Ms Patricia Josias  
Research Ethics Committee Officer  
University of the Western Cape*

Private Bag X17, Bellville 7535, South Africa  
T: +27 21 959 2988/2948 . F: +27 21 959 3170  
E: pjosias@uwc.ac.za  
www.uwc.ac.za

A place of quality,  
a place to grow, from hope  
to action through knowledge