

**COUNSELLING SURVIVORS OF CRIME:
THE PSYCHOLOGICAL IMPACT ON VOLUNTEERS**

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DECLARATION

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I would like to dedicate this thesis to the victim support volunteers of South Africa, and the invaluable service they offer to their communities. I greatly appreciate the honesty with which the participants of this study reflected on their experiences of supporting survivors of crime.

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ABSTRACT

The purpose of this study was to explore the negative and positive psychological impacts on victim support volunteers who counsel survivors of crime as part of the Victim Empowerment Programme (VEP). A qualitative, multiple case study research design was employed. Semi-structured interviews were conducted with 12 Cape Town based participants who are volunteer counsellors of the VEP. The data were analysed using thematic analysis. While the majority of the sample had experienced negative symptoms at some stage in their volunteering history, these symptoms were generally of a transient nature. The themes relating to these negative consequences included: continued concern for or unwanted thoughts about past clients and cases; sleep disturbances; feelings of despondency in relation to the work; avoidant behaviours; difficulty regulating emotions; and reduced empathy and tolerance for certain types of crime survivors. All of the participants reported positive consequences of a long-term nature as a result of their support work, including: the witnessing of benefits to crime survivors; the volunteers' experience of the work as rewarding and fulfilling; and, personal growth and development. A final theme which defied simple categorisation as either positive or negative was the participants' increased awareness of safety and security needs due to their volunteer work. Factors raised by participants that were considered to have an impact on their negative and positive experiences were: training and education; organisational processes and support structures; partnerships with other organisations; and individual factors. Recommendations for future research are offered, as well as suggestions regarding ways to better protect volunteers from the possible negative psychological consequences associated with their support work, and to enhance their potential to experience positive impacts.

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CHAPTER ONE: INTRODUCTION

For many years, South Africa has struggled under the burden of high rates of criminal violence. Data collected by the United Nations Office on Drugs and Crime (2012) comparing incidences of crime in countries throughout the world, found South Africa to have among the highest rates of murder globally. Despite small improvements in South Africa's crime levels over the past few years the country's murder rate is still 4.5 times greater than the global average (Newham, Burger, Gould, & Lancaster, 2012). A national survey of South African adults found that 25% had been a victim of non-sexual criminal assaults, 24% had been a victim of partner violence, and 3% (which is likely to be an enormous under-estimation) reported being a victim of sexual assault (Williams, Williams, Stein, Seedat, & Moomal, 2007). Not only does crime in South Africa appear to be more prevalent than in many other countries, it is also particularly violent in nature: firearms are used in approximately 80% of reported robberies, whereas only 20% of all recorded robberies in developed nations involve the use of a firearm (Altbeker, 2007). Besides South Africa's very high homicide rate, both rape assaults and intimate partner violence are also far more severe, and likely to result in death, than in most other countries (Abrahams et al., 2009; Martin, 1999; Newham et al., 2012).

The consequences of crime for South African society are manifold. Besides its negative impact on the physical health of crime victims, and consequently on the economy (Stone, 2006), survivors of violent crime can present with a range of emotional disturbances, particularly, posttraumatic stress disorder (PTSD), depression and substance abuse (Kilpatrick & Acierno, 2003). Indeed, both international (Breslau, Peterson, & Schultz, 2008) and South African research (Kaminer, Grimsrud, Myer, Stein, & Williams, 2008) has established that victims of assaultive violence are at far greater risk of developing PTSD than survivors of natural or accidental traumas. Amongst South African adults, assaultive violence is also more strongly associated with general distress levels than are other forms of trauma exposure (Williams et al., 2007). The high prevalence of violent crime in South Africa increases the number of South Africans at risk for developing these abovementioned conditions. Furthermore, untreated victims of crime may themselves become perpetrators of violence (Department of Social Development, 2007).

In order to respond to the needs of victims of crime in South Africa, the Victim Empowerment Programme (VEP) was initiated by the National Crime Prevention Strategy of 1996 (later replaced by the Justice Crime Prevention Strategy in 1999) and launched in 1998. VEP is a collaborative approach between government departments, businesses, academics, research institutions, volunteers, non-governmental organisations and community based organisations, led by the Department of Social Welfare (Department of Social Development, 2009).

In the VEP, a victim is defined as an individual who has been exposed to physical and/ or psychological damage or economic loss due to the illegal action of another, as well as the violation of a person's human rights through another's action or inaction (Department of Social Development, 2008). VEP is based on a victim centred and restorative approach to crime prevention and justice. Its aim is to facilitate access to services that provide support, empowerment and protection to all victims of crime and violence in an attempt to reduce the long term effects of crime and the possibility of secondary victimisation. The United Nations' Declaration of Basic Principles of Justice for Victims of Crime and Abuse (1985, cited in The United Nations Office on Drug Control and Crime Prevention, 1999) defines secondary victimisation as "The victimisation that occurs not as a direct result of a criminal act but through responses of institutions and individuals to the victim" (www.uncjin.org/standards/9857854.pdf). In addition, the VEP strives to educate the public on victim issues, to continuously strengthen its resources and to increase volunteer participation in the programme (Department of Social Development, 2009).

Victim support is an important part of the victim empowerment process in the VEP. It involves empathic, person-centred assistance as well as practical support provided by an organisation or individual following an incident of victimisation (Department of Social Development, 2007). A victim support room (or victim friendly facility) is a furnished room at police stations where traumatised and vulnerable victims can have their statements taken in privacy. VEP volunteers from the community are available to offer assistance and support to victims referred by the South African Police Service (SAPS). This assistance and support is provided by: contacting the victim's friends and family members; arranging transport if required; counselling and debriefing of the victim; informing the victim of their rights; assisting the victim while their statement is taken by police and referring the victim on to more specialised service providers where necessary (Department of Social Development,

2008; Nel & Kruger, 1999). Volunteers and role-players throughout the programme are generally guided by two policy documents: the *Victims Charter* and the *Minimum Standards of Service for Victims of Crime* (Nel & Kruger, 1999). In addition, a report by Nel and Kruger (1999) commissioned by the National Crime Prevention Strategy Victim Empowerment Programme Reference Team provides role players with recommendations as to how to set up the various aspects of VEP. Despite these recommendations, there is no official directive provided by the Department of Social Development (who is responsible for this part of the VEP) to the victim support co-ordinators regarding the management of the victim support rooms or the training and support of the victim support volunteers who offer assistance to victims of crime at police stations throughout the country (Department of Social Development, 2009; Nel & Kruger, 1999). Considering the importance of victim support, it is of concern that there are no systems and procedures set in place for the monitoring and evaluation of this aspect of the VEP programme (Frank, 2007). The aim of this research is to explore volunteer counsellors' experiences of their work. Previous research has indicated that counselling trauma survivors entails psychological risks (Figley, 1993; McCann & Pearlman, 1990), and can also potentially be a source of growth (Arnold, Calhoun, Tedeschi, & Cann, 2005; Linley, Joseph, & Loumidis, 2005). However, there is little local research with trauma counsellors to guide the training and support of volunteers in programmes like VEP.

Chapter Two of the thesis reviews the existing literature on the pathogenic and salutogenic consequences of working with traumatised individuals, elucidating the constructs of burnout, vicarious trauma, secondary traumatic stress (STS), compassion fatigue, empathic strain, compassion satisfaction, vicarious post-traumatic growth, and vicarious resilience. The chapter will track the development of each construct and review their respective theories or explanatory models, as well as highlighting risk and protective factors for their development.

Chapter Three explains the methodology applied to execute this study.

Chapter Four presents and discusses the findings of the study, in light of existing literature.

The concluding chapter offers a summary of the major findings, a consideration of the study's limitations, and recommendations to further safeguard VEP volunteers from unnecessarily making themselves vulnerable to negative consequences and to promote their experience of positive outcomes as a result of their volunteering efforts. The relevance of

these findings for the victim support branches included in the study and their possible transferability to other branches throughout SA is considered and suggestions are included for future research on the subject within a South African context.

CHAPTER TWO: LITERATURE REVIEW

Although post-traumatic stress responses have been recognised throughout history (Figley, 1993; Shalev, Bonnie, & Eth, 1996) post-traumatic stress disorder (PTSD) was only formally recognised as a psychiatric diagnostic category in 1980 (American Psychiatric Association, 1980). The DSM IV-TR (American Psychiatric Association, 2000) defines PTSD as a series of reactions to trauma that can include intrusive thoughts, nightmares and restriction of emotional responses, avoidance behaviours and increased physical arousal. In addition to a large body of research into the psychological effects of trauma on survivors that has emerged since the inclusion of PTSD into the DSM system, the past two decades has also seen the emergence of literature focusing on the effects on therapists and other trauma workers of working with traumatised populations. This literature has focused primarily on the negative impacts on counsellors and therapists, however more recent research has explored potential positive impacts. The existing literature describing the possible negative consequences associated with trauma work will be presented, followed by a review of the literature regarding the potential positive consequences.

2.1. The Negative Consequences of Trauma Counselling

The negative psychological consequences associated with trauma counselling have been described through the constructs of burnout, vicarious trauma, secondary traumatic stress, compassion fatigue, and empathic strain. These terms are often used interchangeably to describe the stress that results from counselling a traumatised person (Adams & Riggs, 2008), however each of these terms does in fact have its' own specific meaning. Each construct is reviewed below.

2.1.1 Burnout

Pines and Aronson (1998, cited in Newell & MacNeil, 2010, p. 58) describe professional burnout as “a state of physical, emotional, psychological, and spiritual exhaustion resulting from chronic exposure to (or practice with) populations that are vulnerable or suffering”. The initial articles on burnout appeared in the 1970's in the United States, and were penned by

Freudenberger (1974, 1975). In these writings he provided direct accounts of his own personal experiences and those of his colleagues' of what he termed "burnout", as a result of their work in an alternative health care agency that provided assistance to drug addicts and the homeless. In 1976 further research on the burnout phenomenon emerged as a result of Maslach's work with human service personnel regarding their experience of emotional stress as a result of their work. This research was conducted through interviews and observations, suiting the exploratory nature of the subject at this time. At this stage "burnout" was mostly identified as something that occurred amongst those working in the helping professions (Cordes & Dougherty, 1993; Maslach, Schaufeli, & Leiter, 2001). In the 1980s more quantitative studies were undertaken, making use of questionnaires and surveys and involving larger samples. In 1981 Maslach and Jackson developed the Maslach Burnout Inventory (MBI), a psychometric self-report scale used to measure burnout in an individual. This scale was initially developed for use in the caring professions as this is where burnout seemed to be a particularly significant problem, but a second version was soon developed for the education sector. In the early 1990s the construct of burnout was extended to include those working in fields other than human services and education such as the legal profession and corporate sectors (Cordes & Dougherty, 1993; Maslach, 2003*b*; Maslach et al., 2001).

2.1.1.1 Dimensions of burnout

Initially there was no standard definition of burnout. However, there was general agreement with regards to the three core aspects of the construct: exhaustion, depersonalisation or cynicism, and a reduced sense of personal achievement or professional efficacy (Maslach et al., 2001). Further research into these three dimensions led to the creation of a multidimensional model of burnout (Maslach & Jackson, 1981) which is still used currently (Deville, Wright, & Varker, 2009). According to this model, burnout is a cumulative process that occurs in response to ongoing emotional and interpersonal stressors in the workplace. The emotional exhaustion reflects the stress component of burnout and is the most commonly reported symptom of the condition. It is characterised by an employee experiencing a loss of energy and feeling emotionally depleted as a consequence of the chronic demands imposed on them by clients, supervisors and/or organisations, as well as personal conflict in the workplace (Cordes & Dougherty, 1993; Maslach & Goldberg, 1998; Maslach et al., 2001). Depersonalisation, also termed cynicism, refers to the negative, callous and detached response that the affected employee has toward their clients, fellow colleagues and the

organisation as a whole, and can also be recognised as a loss of idealism. This interpersonal dimension of burnout is a result of extreme emotional fatigue and while it can be self-protective at first, serving to protect the employee from the seemingly overwhelming demands of his or her working life, it can ultimately lead to a decrease in productivity and quality of output (Cordes & Dougherty, 1993; Maslach & Goldberg, 1998; Maslach et al., 2001). The third dimension of reduced sense of personal achievement or professional efficacy is regarded as the self evaluation aspect of burnout. This dimension is characterised by reduced feelings of competency in the affected individual. It can be a consequence of excessive administrative demands, but may also be exacerbated by a lack of social support (Maslach & Goldberg, 1998; Newell & MacNeil, 2010).

2.1.1.2 Models of burnout

The two leading models of burnout are Leiter and Maslachs' model, developed in 1988 and the phase model developed by Golembiewski, Munzenrider, and Stevenson in 1986 (Lee & Ashforth, 1993). Leiter and Maslachs' model explains that overwhelming work demands lead to exhaustion which prompts the individual to distance him/herself, emotionally and cognitively, from these demands. Exhaustion and depersonalisation or cynicism then interfere with the person's sense of efficacy surrounding their work performance (Maslach et al., 2001). However, in some work environments where there are inadequate resources to do one's work well, a lack of efficacy may develop simultaneously to the first two dimensions, rather than sequentially (Leiter, 1993). Golembiewski et al.s' phase model of burnout maintains that depersonalisation occurs first. They argue that an element of professional detachment is necessary in certain fields and is often encouraged by supervisors and colleagues, however excessive detachment can lead to depersonalisation which can affect an individual's ability to form relationships with others and to perform their job well. As depersonalisation increases, the individuals' sense of accomplishment will decrease, causing work stress which then leads to emotional exhaustion. This model also proposes that each dimension of burnout can be scored from high to low. The various combinations created from the scoring of the three dimensions results in eight possible phases of burnout (Golembiewski et al. 1986, cited in Lee & Ashforth, 1993). While a limited number of studies have compared these two models, very few have used longitudinal data. Longitudinal studies are preferable to cross sectional research in that they are better able to bring about an understanding of the

sequential process of burnout and to identify which factors compound the development of the condition, as well as highlighting the outcomes (Lee & Ashforth, 1993). The longitudinal studies that have been conducted have reported conflicting results, although Leiter and Maslach's model does receive slightly more support (Cordes, Dougherty, & Blum, 1997; Lee & Ashforth, 1993; Taris, Le Blanc, Schaufeli, & Schreurs, 2005; van Dierendonck, Schaufeli, & Buunk, 2001).

2.1.1.3 Factors affecting the development of burnout

Persons employed in human services work are most at risk for the development of professional burnout due to their continuing use of empathy, and the demands of having to either mask or express their emotions according to the needs of their clients (Zapf, Seifert, Schmutte, & Mertini, 2001). Furthermore, service providers could be left feeling overburdened and exhausted if they feel that the successful outcome of their clients' difficulties is solely their responsibility (Maslach, 2003a). Maslach and Leiter (1997) posit that burnout is an indication of dysfunction within an organisation and, while acknowledging that there are other contributing factors related to both the individual and populations served, they place the bulk of accountability for burnout firmly on the shoulders of the organisation where the individual is employed (Maslach et al., 2001). The organisational factors that have been shown to compound the development of professional burnout include organisational bureaucracy, overwhelming administrative demands, inadequate support from supervisors and colleagues, conflictual relationships with colleagues, insufficient on-the-job training, and very high workloads (Maslach & Leiter, 1997; Maslach et al., 2001). In the helping professions it is not only the number of cases that is important but also the nature of the cases that make up a service providers caseload. Working with clients who show little sign of improvement, or who repeatedly return with the same problems, can negatively impact on a service provider's stress levels, placing them at risk of developing burnout (Maslach, 2003a). At the individual level it has been found that people with low levels of hardiness (a feeling of control over things that happen in their lives, engagement in daily living and a willingness to try new things), an external locus of control (attributing events, whether good or bad, to external uncontrollable factors), diminished self esteem and who display a passive and defensive way of coping with stressful situations are more prone to developing burnout (Maslach et al., 2001).

While professional burnout is regarded as a more general phenomenon which can occur in many different work settings, including organisations that work with trauma survivors, vicarious trauma, secondary traumatic stress, compassion fatigue, and empathic strain are considered to be directly related to work involving traumatised populations (Newell & MacNeil, 2010), and will be reviewed below.

2.1.2 Vicarious trauma

Subsequent to the emergence of the literature on professional burnout, Danieli (1980) in her work with Holocaust survivors noted that the effects of working with trauma survivors were different to those experienced when engaged with other challenging groups, due to the therapist's vicarious exposure to disturbing images and intense suffering. Danieli (1980, 1984) understood the therapists' feelings of guilt, shame, rage, horror and disbelief, as well as their use of defences such as numbing, denial and avoidance, as a form of traumatic countertransference. The traditional Freudian definition of countertransference includes the therapists' emotional response to their clients' transference which arises as a result of the therapists past unresolved conflicts. This classical view considers countertransference as a negative consequence of therapy that can threaten the therapeutic alliance that exists between therapist and client (Dalenberg, 2008). The more contemporary perspective, known as the universal or totalistic view, regards countertransference as consisting of all the therapist's emotional reactions to a client, which may arise from the client's transference and from actual traumatic material shared in therapy. This universal view considers countertransference to be a valuable source of information into the world of the client (Dalenberg, 2008).

Countertransference provides a basis for understanding vicarious trauma, which Saakvitne and Pearlman (1996, p.40) define as a "transformation of the helper's inner experience, resulting from empathic engagement with the client's trauma material". It is considered to be a normal, predictable and unavoidable response to working with traumatised individuals (McCann & Pearlman, 1990) and develops as a result of repeated exposure to traumatic material over time and with different clients (Saakvitne & Pearlman, 1996). However, if caregivers do not engage with the internal changes taking place, vicarious trauma can have serious negative effects on both their professional and personal life (McCann & Pearlman,

1990; Pearlman & Saakvitne, 1995b). For this reason education about the negative consequences of trauma work on caregivers is vital to their preparation for this type of work and their future well being (Figley, 1995). While the literature on burnout places its focus on the specifics of the situation, the theory behind vicarious trauma is integrative in that it considers the therapist's responses to a particular client's material to be an interplay between the specifics of the context and the therapist's psychological needs and belief systems.

2.1.2.1 Constructivist self-development theory

McCann and Pearlman (1990) provide a conceptual framework within which to understand vicarious trauma, known as constructivist self-development theory (CSDT). According to the theory there are specific ways in which engagement with traumatised populations can affect the trauma worker's imagery system of memory and schemas about the self and others (McCann & Pearlman, 1990). Schemas are cognitive structures that people develop to interpret events in order to make sense of their reality. CSDT takes into account the variability in reactions amongst trauma workers who have undergone a similar vicarious trauma and this indicates that each person's response is based on the interaction between themselves (their defensive styles, personal schema's and coping styles), the nature of the traumatic event, and their specific work and social-cultural contexts (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995b). Thus, the effects of vicarious trauma are different for every trauma worker (Dunkley & Whelan, 2006). Vicarious exposure to another's trauma can challenge a trauma worker's schemas related to one or more of the following areas of basic need: dependency/ trust, safety, power/ independence, esteem and intimacy (McCann & Pearlman, 1990).

First, through their work with trauma survivors therapists are regularly confronted with situations in which people are betrayed or deceived by others, often by the very people their clients depend on most. These vicarious experiences may affect the therapist's trust schemas so that they begin to question people's intentions more and become increasingly cynical and distrustful of others. Second, being exposed to clients' accounts of how their safety has been threatened or violated may result in a heightened sense of vulnerability in the therapist, especially if the therapist has a strong personal need for security. Third, in witnessing their clients' feelings of helplessness or vulnerability, therapists may begin to question their own sense of power in their lives. Therapists who have a great need to feel in control of their own

lives may then encourage their clients to take action so as to deal with their own personal sense of powerlessness, instead of assisting their clients in understanding the underlying meanings behind their response to the trauma. Therapists may also become more aware of how little control they have over unplanned life events. This sense of helplessness may lead to feelings of despair and depression in those therapists who have a strong need for independence. Fourth, in this context McCann and Pearlman (1990) regard esteem as being an individuals' need to perceive others as kind and deserving of respect. When faced with accounts of how innocent people have been harmed through the indifference or maliciousness of others, the therapist's own perception of human nature may grow increasingly negative. Feelings of anger, bitterness, cynicism and despondency may arise as the therapist's previously held, more idealistic, view of humanity is dismantled. Finally, just as a survivor often feels stigmatised through their trauma experience and alienated from those around them, so too the therapist who is vicariously exposed to the horrors of their client's trauma may feel a sense of separateness from the people closest to them. This sense of alienation is exacerbated by the confidentiality required of the therapist, making it impossible for them to share any details of their cases. Disruptions in one or some of these schemas can reduce the level of empathy that the helper experiences toward their client's feelings of pain and loss. CSDT also stresses the value of a frame of reference through which the therapist is able to make sense of the experiences they are exposed to (McCann & Pearlman, 1990).

Also important to CSDT is the imagery system of memory. McCann and Pearlman (1990) posit that therapists may internalise their clients' memories and may experience this traumatic imagery in the form of nightmares, flashbacks or intrusive thoughts. These alterations to the system of memory may be temporary or permanent and will bring about changes in the therapist's schemas as they accommodate this vicariously experienced material into their reality (McCann & Pearlman, 1990).

McCann and Pearlman's theory has been corroborated by other researchers (Adams & Riggs, 2008; Iliffe, 2000; Johnson & Hunter, 1997; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995), confirming that therapists and trauma workers experience changes in their cognitive schemas as a result of their exposure to their clients' traumatic material. These studies have involved trauma therapists (Pearlman & Mac Ian, 1995), trainee therapists (Adams & Riggs, 2008), and therapists working with domestic violence survivors (Iliffe, 2000) and survivors of sexual assault (Johnson & Hunter, 1997; Schauben & Frazier, 1995). However, CSDT explains only the negative effects on a trauma worker's frame of reference and doesn't take

into account the possibility that caregivers may experience positive changes as a result of their work. Therefore the theory is inadequate to explain the full range of possible responses to trauma work (Steed & Downing, 1998 cited in Collins & Long, 2003).

2.1.2.2 *Factors influencing vicarious trauma*

Not all trauma workers will experience vicarious trauma. The risk for doing so depends on a number of factors. The most common factors that have received attention in the empirical research on vicarious trauma are the trauma worker's personal trauma history, their degree of experience and level of trauma specific training, and the trauma worker's case load (Adams & Riggs, 2008; Dunkley & Whelan, 2006).

Pearlman and Saakvitne (1995a) have suggested that therapists with a personal history of trauma may be drawn to working with trauma survivors. While their personal experiences may provide them with greater empathy and understanding of their traumatised clients' needs, it can also increase their vulnerability to developing vicarious trauma. However, research findings on this factor have been conflicting. A study by Pearlman and Mac Ian (1995) involving 188 trauma therapists found that therapists with a personal history of trauma displayed more cognitive disruptions than those with no trauma history. However, an investigation by Schauben and Frazier (1995) of a similar sized sample of female psychologists and counsellors working with survivors of sexual abuse found that their development of vicarious trauma was not related to their personal history of victimisation. A more recent study into vicarious trauma among trainee therapists suggests that these contradictory findings may be explained by the difference in the defence style of the (trainee) therapist. They found that the relationship between a personal history of trauma and vicarious trauma is moderated by defence style; specifically, a self sacrificing defence style was found to be an important risk factor for vicarious trauma (Adams & Riggs, 2008).

With regard to level of experience, more experienced trauma counsellors report fewer trauma related symptoms than their less experienced counterparts (Chrestman, 1999; Pearlman & Mac Ian, 1995). In relation to trauma specific training, it has been found that trainee therapists who are lacking in this area are more likely to report symptoms of vicarious trauma regardless of their defence style (Adams & Riggs, 2008), as are inexperienced counsellors who are not receiving supervision (Neumann & Gamble, 1995). Finally, research shows that

therapists who have higher case loads report a greater number of trauma symptoms (Chrestman, 1999; Kassam-Adams, 1999) and spend less time engaging with friends and family than therapists with a lower percentage of trauma clients in their case loads. This may indicate the trauma therapist's feelings of isolation as a result of the extreme nature of their work (Chrestman, 1999). In line with these findings, a more recent study by Linley and Joseph (2007) suggests that pursuing a lifelong therapeutic career may not lead to a high degree of personal well being. Their research involving a sample of 156 therapists found that the participants who were engaged in therapeutic work over a greater number of years experienced more negative psychological changes; however, the extent of their case loads during these years was not stipulated.

2.1.3 Secondary traumatic stress and compassion fatigue

Another popular term used to describe the negative consequences of trauma work on care givers is secondary traumatic stress (STS). Figley describes STS as "the natural, consequent behaviours and emotions resulting from knowledge about a traumatizing event experienced by a significant other; it is the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1999, p.10). This stress often leads to the helper sacrificing their own needs to assist the traumatised individual(s). Figley's research into what he initially termed secondary victimisation (1983) occurred relatively simultaneously to the work surrounding vicarious trauma. STS was first identified in sexual assault and combat veterans' immediate families and was later expanded to apply to trauma workers such as nurses, police and trauma therapists, whereas with vicarious trauma the focus has always been on mental health professionals, as can be seen from the research cited in the previous section (Jenkins & Baird, 2002).

The symptoms of STS are behavioural in nature and are identical to the symptoms of PTSD which may develop in the primary survivor of a trauma. These symptoms include: re-experiencing of the client's traumatic material through intrusive thoughts, recollections and disturbing dreams of the traumatic event reported by the client, avoidance of the client or of situations and stimuli that serve as reminders of the client's traumatic material, a general feeling of detachment from others, sleep disturbances, irritability and uncharacteristic outbursts of anger, hyper-vigilance and difficulty maintaining concentration (Figley, 1995).

Figley (1999) asserts that the term compassion fatigue is interchangeable with STS and is preferable as it carries less stigma. The term compassion fatigue was first used in 1992 by Joinson in a nursing publication to describe the worn out feeling of nurses who had to deal with medical emergencies on a daily basis. However, recently critics have argued that there are distinct differences between the two constructs (Devilley et al., 2009; Newell & MacNeil, 2010). Newell and MacNeil (2010) report that while compassion fatigue seems to mirror STS in many ways, in more recent publications compassion fatigue serves more as an umbrella term that describes the emotional and physical exhaustion that arises from the chronic expression of empathy in those who work in the helping professions generally, not just with survivors of trauma (Figley, 1995). A further distinction is that compassion fatigue tends to develop cumulatively whereas STS is more immediate in onset (Newell & MacNeil, 2010). Devilly et al. (2009) also note that compassion fatigue includes a burnout aspect of physical and emotional exhaustion, which is not the case with STS.

In his revised causal compassion stress and fatigue model, Figley (2002) posits that there are a number of variables that predict compassion fatigue in trauma workers. Firstly, for compassion fatigue to develop it is necessary for the caregiver to be vicariously exposed to a clients' traumatic experience. Figley considers empathy to be an essential ability for those working in the helping professions. However, he also cautions that empathic ability coupled with the desire to assist in alleviating another's distress increases a caregiver's vulnerability to developing negative consequences as a result of their work. These negative consequences may also be intensified by the extent to which the caregiver attempts to alleviate the distress of the traumatised individual through their empathic understanding. In so doing the caregiver may experience some of the same emotions as their client. While this has positive benefits for the therapeutic relationship, it can have negative implications for the trauma worker. Figley (2002) describes prolonged exposure to traumatised clients, traumatic recollections of the client's traumatic material and disruptions in the personal life of the caregiver (which on their own would not normally result in high stress levels) as serving to exacerbate stress levels which may then lead to the caregiver developing compassion fatigue. The ability to detach from their work and the degree to which the caregiver experiences a sense of achievement as a result of their work can both serve a protective function against the development of compassion fatigue. Figley (2002) also advises that to reduce the risk of developing compassion fatigue caregivers should take time to enhance their support systems both in size and diversity, so as to express aspects of themselves distinct from their caregiver persona.

From this complex interplay of factors it is not only possible to predict compassion fatigue but to put measures in place so as to attempt to prevent this condition (Figley, 2002). In addition to the theoretical literature explicating the concepts of STS and compassion fatigue, systematic studies by Arvay and Uhlemann (1996), Bride (2007), Follette, Polusny, and Milbeck (1994), Ghahramanlou and Brodbeck (2000), and Steed and Bicknell (2001), using self report surveys, provide evidence that individuals engaged in working with traumatised populations are at risk of experiencing PTSD-like symptoms as a result of indirect exposure to trauma. These surveys have incorporated standardised measures such as the Secondary Traumatic Stress Scale (Bride, 2007), Trauma Symptom Checklist -40 (Follette et al., 1994) and Impact of Event Scale (Arvay & Uhlemann, 1996) in order to measure stress levels, as well as collecting information pertaining to the participants' demographic information, personal history, coping styles and work circumstances (Arvay, 2001). It is important to note that while all these studies describe the existence of PTSD-like symptoms in their samples, these symptoms were seldom experienced at a clinically significant level (Arvay & Uhlemann, 1996; Bride 2007; Follette et al., 1994; Zimering, Munroe, & Gulliver, 2002).

The abovementioned studies also reported on risk factors that increase an individual's vulnerability to developing these symptoms. Results surrounding whether a person's personal trauma history is a factor in the development of STS are contradictory (Follette et al., 1994; Ghahramanlou & Brodbeck, 2000), as is also the case with research pertaining to risk factors for vicarious trauma. Regarding caseload as a factor in the development of STS, both Kassam-Adams (1994, cited in Arvay, 2001) and Schauben and Frazier (1995) reported that the higher the percentage of sexually and generally traumatised clients in a therapist's caseload, the higher the therapist's level of PTSD symptoms. However, Follette et al.'s (1994) research involving mental health and law enforcement professionals working with victims of child abuse showed no significant correlation between the percentage of abuse cases in the participants' case loads and their degree of PTSD symptoms. Both Arvay and Uhlemann (1996), and Munroe (1991, cited in Arvay, 2001) found that trauma therapists with a greater number of years of experience presented with more intrusive symptoms than less experienced therapists. However, the same research also shows that trauma workers of a younger age are more at risk of developing STS (Arvay & Uhlemann, 1996; Munroe, 1991 cited in Arvay, 2001.) So it would seem that it is those therapists and trauma workers at either end of the experience spectrum who are most at risk of developing STS. Finally, trauma

workers with more education and training were found to be less susceptible to developing symptoms of STS (Arvay & Uhlemann, 1996; Follette et al., 1994).

A South African study investigating the responses of a group of non-professional, part-time counsellors, trained specifically to assist their corporate colleagues in the event of a bank robbery, found that while the participants did report experiencing STS symptoms these symptoms did not fall within the clinical range for a diagnosis of STS according to the self-report Compassion Satisfaction/ Fatigue Test developed by Stamm and Figley (1998, cited in Ortlepp & Friedman, 2002). It was suggested that the absence of clinically significant STS may be due to the part-time nature of the participants' counselling duties (Ortlepp & Friedman, 2002).

2.1.4 Comparisons between burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue

While vicarious trauma and STS may be similar in many respects, particularly as they both result from direct interaction with victims of trauma, the defining distinction between the two is that vicarious trauma brings about a cognitive change within the therapist which alters their view of the world they live in while STS manifests as physical symptoms for the therapist (McCann & Pearlman, 1990; Saakvitne & Pearlman, 1996). These two conditions may occur separately or an individual can present with symptoms of both conditions concurrently (Newell & MacNeil, 2010).

Jenkins and Baird in their 2002 study found that there is sufficient evidence to indicate that STS and vicarious trauma are two separate constructs. They highlight the major differences between the two constructs as follows. While STS focuses on PTSD symptomatology with rapid onset, vicarious trauma uses constructivist self development theory to explain shifts in an individual's belief system. However, both constructs do contain elements of the other. STS allows for the possibility of some cognitive shifts while McCann and Pearlman (1990) make reference to the PTSD symptom of flashbacks, nightmares and intrusive imagery as an element of vicarious trauma. Lastly, symptoms of STS can occur after exposure to only one persons' trauma but vicarious trauma develops from cumulative exposure to traumatised populations over time. Despite this, Jenkins and Baird (2002) maintain that the construct of burnout is better developed with regards to its' theory and measurement validity than either vicarious trauma or STS. Other critics believe that burnout is sufficient to explain the

negative consequences of trauma work on therapists (Devilley et al., 2009). In contrast, research by Schauben and Frazier (1995) found that female counsellors working with survivors of sexual assault reported more disrupted beliefs, both about themselves and the world around them, and more PTSD symptoms than counsellors with fewer sexual violence survivors in their case loads. They also noted that this kind of work did not seem to be linked with depression and anxiety or burnout, suggesting that burnout and vicarious trauma are two distinct constructs. Other research has also found STS to be a separate construct to burnout (Arvey & Uhlemann, 1996; Jenkins & Baird, 2002). A more recent study by Devilly et al. (2009), which sampled therapists who worked with trauma survivors and those that did not, found exposure to client's traumatic material was not associated with STS, vicarious trauma or burnout. Rather, therapist distress was better predicted by organisational factors such as excessive workloads, lack of organisational support, role conflict and role confusion, as well as the stress of being new to a job. These findings led the researchers to question the actual existence of vicarious trauma and STS and they suggest that the negative impact of working with trauma survivors is over estimated.

2.1.5 Empathic strain

In 1994 Wilson and Lindy developed a model to explain the countertransference reactions of therapists working specifically with clients diagnosed with PTSD. Exposure to a client's accounts of extreme loss and suffering can result in intense countertransference reactions in the therapist. This countertransference can be a result of a combination of factors such as the particular details of a client's traumatic experience, the client's personal characteristics, attitude and behaviour, as well as the therapist's own unresolved conflicts or personal issues.

Empathic strain develops when, due to one or more of the abovementioned factors, the therapist is unable to maintain a supportive empathic response to their client. Wilson and Lindy (1994) identified two major types of countertransference reactions; Type 1 countertransference characterised by avoidance and Type 2 characterised by over-identification with the client.

These two types of countertransference responses are then further categorised as being either objective or subjective. A response is said to be objective in nature if the clinician's negative countertransference reaction is due to their client's particulars, such as the details of the

client's traumatic experience, their personality, attitude or behaviour. Should empathic strain arise as a result of the therapist's own personal issues or idiosyncrasies it is classified as a subjective process. These two classifications combined with Type 1 and Type 2 responses produce four possible modes of empathic strain (Wilson & Lindy, 1994).

The first two modes of empathic strain, empathic withdrawal and empathic repression, fall under the Type 1 countertransference response of avoidance. Empathic withdrawal is defined as an objective response to a client. Therapists with limited personal experience of trauma or insufficient trauma specific training may be unable to cope with the severity of their client's trauma. The therapist's incapacity to deal with any painful feelings their client's trauma may arouse in them may result in them unwittingly distancing themselves from their client through intellectualising the client's feelings. The clinician may also dismiss the reality of their client's story or use the blank screen facade. On the other hand empathic repression is a result of subjective processes. When a client's story raises a therapist's own unresolved issues the therapist's focus will turn inward away from their client thereby creating distance between them. This distance serves as a denial of the significance of the issues raised by the client. This mode of empathic strain is most likely to affect therapists with a personal history of significant trauma, especially if it mirrors that of their client (Wilson & Lindy, 1994).

The third and fourth modes of empathic strain are both Type 2 countertransference reactions characterised by a therapist's overidentification with their client. The first of these is empathic enmeshment which is classified as a subjective process. In this style of empathic strain the therapist becomes overinvolved with the client and ignores their professional boundaries. The clinician may develop an inappropriately intense connection with their client and may even try to rescue the traumatised individual in an unconscious attempt to resolve their own past un-integrated conflicts. (Wilson & Lindy, 1994). The fourth mode is empathic disequilibrium, caused by objective processes and characterised by the therapist's experience of somatic symptoms and feelings of uncertainty surrounding their ability to successfully treat their client. They may also experience intrusive images related to their client's trauma (Wilson & Lindy, 1994).

Although a clinician will generally be predisposed to developing either a Type 1 (avoidance) or Type 2 (overidentification) countertransference response, it is possible to experience one or more (and even all four) modes of empathic strain during the course of treatment with a traumatised client. Empathic strain causes a weakening of the therapeutic alliance between

professional and client and can disrupt treatment, preventing the client from integrating their traumatic experience (Wilson & Lindy, 1994). A criticism of the empathic strain model is that its' constructors have not addressed the issue of those clinicians whose therapeutic abilities are not negatively affected by their client's traumatic experience, despite being emotionally impacted by their client's stories (Shubs, 2008).

Herman (2001), in her discussion of therapeutic work with survivors of abuse, similarly recognises that the therapist may alternate between overidentification with the client, (resulting in poor boundary management as a defence against overwhelming feelings of helplessness), and more critical or punitive responses, (such as blaming the client for their traumatic experiences). Either of these responses can serve to derail therapy. These countertransference reactions are often inevitable and serve as a challenge to the therapist to maintain his/her emotional balance when working with traumatised individuals (Herman, 2001).

2.2 The Positive Consequences of Trauma Counselling

While research has focused mainly on the negative effects that working with traumatised populations has on therapists and those in the caring professions (Linley & Joseph, 2007), it has also been noted that therapists and trauma workers can experience salutary benefits as a result of their work (Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). These positive changes have been referred to by a number of different terms, namely: compassion satisfaction, vicarious post traumatic growth and vicarious resilience (Arnold et al., 2005; Figley, 1995; Hernández, Gangsei, & Engstrom, 2007). While all these terms indicate a relatively new focus of psychological exploration, the idea that positive outcomes and personal growth can result from tragedy is old and has existed throughout the ages in various religious, philosophical and mythical traditions (Tedeschi & Calhoun, 1995). Many major world religions consider suffering born of tragedy as having a positive effect on an individual's personal growth and believe it plays a role in the development of wisdom (Linley, 2003; Tedeschi & Calhoun, 1995).

2.2.1 Compassion satisfaction

Figley (1995) describes compassion satisfaction as the sense of achievement and ensuing satisfaction that caregivers experience when helping alleviate the suffering of others, without becoming emotionally overwhelmed themselves. Figley (2002), in his compassion stress and fatigue model, considers compassion satisfaction to act as a factor which assists caregivers in protecting themselves against the development of the negative consequences of their work with traumatised individuals. A South African study, involving a sample of lay trauma counsellors working in the corporate sector, reported that the extent to which the cohort considered their training to be sufficient positively impacted on the level of satisfaction they gained from their work as counsellors. This finding suggests that effective trauma specific training can enhance compassion satisfaction and serve as a protective factor against the development of STS/ compassion fatigue (Ortlepp & Friedman, 2002). This was also found to be the case for mental health professionals (Sprang, Clark, & Whitt-Woosley, 2007).

2.2.2 Vicarious post-traumatic growth

The concept of posttraumatic growth (PTG) amongst trauma survivors has received considerable attention in the trauma literature in the past decade (Tedeschi & Calhoun, 1995, 2004; Zollner & Maercker, 2006). PTG refers to the “...positive psychological change experienced as a result of the struggle with highly challenging life circumstances” (Tedeschi & Calhoun, 2004, p. 1). PTG is an experience of improved functioning in certain areas of a person’s life after the experience of trauma, and appears to occur in a range of individuals who have experienced a variety of very different life crises (Tedeschi & Calhoun, 2004). Research shows that these improvements usually include the following: increased appreciation of life and an altered set of priorities, improved intimacy in close relationships, enhanced personal strength, spiritual growth, and a heightened awareness of new possibilities and/or directions for one’s life path (Tedeschi & Calhoun, 2004).

However, it has been recognised that trauma workers may experience VPTG in the same way that they can experience vicarious traumatisation (Arnold et al., 2005). The first study that included in-depth exploration of the positive consequences of engaging in trauma work on therapists was undertaken by Arnold et al. in 2005. The qualitative research included a cohort of 21 psychotherapists engaged in a naturalistic interview that focused on the impact of

trauma work on the research participants. They found that all the therapists interviewed had experienced positive consequences as a result of their work with traumatised clients. The most common reported benefits were positive changes in the therapists' perceptions of themselves. The majority of research participants felt that their trauma work had led to increased levels of sensitivity, tolerance, insight, compassion and empathy within themselves, all traits that they felt enhanced their work as therapists. Many participants also cited enhanced inter-personal relationships as one of the positive outcomes of their work. These improvements were brought about as a result of the therapists' enhanced compassion and empathy, which allowed them to have a greater understanding of, and therefore a better connection with, others. With regard to their life philosophies, participants reported changes in their world views which included a re-ordering of their priorities, enhanced appreciation of the simple things in life, as well as valuing the resilience of the human spirit. A change in one's life philosophy often includes a spiritual component. This was expressed through the participants' vicarious exposure to their client's trauma often precipitating a spiritual search or causing a deepening of an existing religious practice or spiritual belief system. Several of the participants also noted that it was sometimes difficult to differentiate between which aspects of their personal growth were a result of their trauma work or due to their own personal life experiences (Arnold et al., 2005).

A 2009 study into the implications for therapists of treating cases of family violence in Israel found that the sample's description of the positive consequences of their work was consistent with the findings of Arnold et al. (2005). However, a unique outcome for the sample was that through their work in the field of domestic violence they were able to confront their own feelings of aggression and violence (Ben-Porat & Itzhaky, 2009). In a study of interpreters to traumatised refugees in the United Kingdom many participants also expressed a greater sense of appreciation and valuing of their work (Splevins, Cohen, Joseph, Murray, & Bowley, 2010). Research focusing on other trauma workers, such as emergency ambulance personnel has been conducted, and findings of personal growth amongst these groups have been reported. However, this growth has not been considered vicarious in nature due to the fact that these trauma workers tend to be present at the scene of the trauma and so their exposure to this trauma is often direct and their resultant growth categorised as PTG (Paton, 2005; Shakespeare-Finch, Smith, Gow, Embelton, & Baird, 2003).

2.2.3 Vicarious resilience

The construct of vicarious resilience goes beyond the experiencing of a sense of satisfaction as a result of one's work, and encompasses the positive changes that occur in a therapist's inner world in response to their clients' resilience in the face of trauma (Hernández et al., 2007). Three qualitative studies have been conducted to establish the existence of vicarious resilience (Engstrom, Hernández, & Gangsei, 2008; Hernández et al., 2007; Hernández, Engstrom, & Gangsei, 2010). All three cohorts include therapists, in Colombia and the USA, who were involved in the treatment of victims of political violence, kidnapping and torture. Like compassion fatigue, vicarious resilience is considered to serve as a protective factor against the development of the negative consequences of trauma work (Hernández et al., 2010). The positive effects experienced by the therapists and conceptualised as vicarious resilience include: witnessing and reflecting on their clients' ability to overcome horrific trauma, confirming the importance of therapeutic work, gaining perspective on the significance of their own problems, cultivating hope, understanding the value of spirituality in treatment, and feeling uplifted and empowered through their recognising the power of community, and being able to raise professional and public awareness regarding political violence. The participant therapists also noted how their own awareness and acknowledgement of their client's resilience further strengthened that client's resiliency (Hernández et al., 2007; Hernández et al., 2010). There have been no further studies to ascertain whether these findings can be extended to therapists of other countries and/or to those who treat clients grappling with more general types of trauma, as well as no investigations into the factors that influence the development of vicarious resilience.

While the developers of vicarious resilience have made comparisons between vicarious resilience and the existing construct of post-traumatic growth (Engstrom et al., 2008) they made no reference to Arnold et al.'s (2005) research into VPTG or Linley and colleagues' (2005) exploration into positive well being in therapists, both of which were produced and published prior to the work on vicarious resilience. In comparing the literature it would seem that the major difference between vicarious resilience and VPTG is that for the latter to occur the therapist or trauma worker has to experience a higher level of functioning as a result of their vicarious traumatic exposure, and resultant growth. This higher level of post trauma functioning is not a requirement for vicarious resilience which rather emphasises the process whereby therapists are positively impacted on by the resiliency of their clients (Arnold et al., 2005; Engstrom et al., 2008).

2.2.4 Factors associated with positive wellbeing in therapists

While studies such as those outlined above confirm the possibility of experiencing positive outcomes as a result of engaging with traumatised populations, they do not explain the variables that impact on a trauma worker's potential for experiencing these positive consequences. A 2007 study conducted by Linley and Joseph investigated a sample of 156 therapists in the United Kingdom (who did not work exclusively with traumatised clients) using self report questionnaires. A number of factors that predict positive wellbeing (defined by the researchers as including both compassion satisfaction and personal growth) in therapists were identified. It was found that the sense of coherence (SOC) personality construct, empathy (the ability to understand another's emotions or to experience something from their perspective), the therapeutic bond and social support were all associated with positive well being. Furthermore, it was found that the therapeutic bond, described as the feelings and attitudes that participants in the counselling relationship have toward each other and how these are played out between those involved (Gelso & Carter, 1994), is representative of the empathic connection that the therapist develops with their clients and it is through this empathic engagement that the therapist may experience positive psychological change as a result of engaging and grappling with the traumatic material of their clients (Linley & Joseph, 2007). It has been suggested that an empathic connection allows for growth through a process whereby the therapist identifies with his/her client, thereby intensifying the personal impact and the need for the therapist to accommodate the vicarious experience into their current schemas (Brockhouse, Msetfi, Cohen, & Joseph, 2011). However, if the accommodation process brings about negative psychological change in the therapist this could result in their experiencing vicarious trauma (McCann & Pearlman, 1990). So it would seem that possessing a high degree of empathy could make a person susceptible to either positive or negative sequelae (Brockhouse et al., 2011).

The SOC personality construct refers to the degree to which an individual views the world as comprehensible, manageable and meaningful. The greater a person's SOC the better able they are to respond to stressors in a positive way (Antonovsky, 1987). Resources that aid an individuals' resistance to stressors include: physical strength, emotional intelligence, cognitive intelligence and coping strategies, cultural belief systems, and resources relating to money, power and status (Griffiths, Ryan, & Foster, 2011). SOC was found to be the factor that provided the most protection against the negative consequences of trauma work, as well as predicting positive well being in therapists (Linley & Joseph, 2007; Linley et al., 2005).

This finding was confirmed in two South African studies involving non-professional counsellors (Fourie, Rothmann, & van der Vijver, 2008; Ortlepp & Friedman, 2002). However, in a study by Brockhouse et al. (2011) undertaken in Ireland, SOC was found to negatively predict VPTG. The researchers concluded that this was possibly due to their highly coherent sample. Should a therapist have a high sense of coherence, which allows them to cope very well with any major disruptions caused by vicarious exposure to clients traumatic material, this would mean they would have a lesser need to accommodate new information positively and therefore less VPTG (Brockhouse et al., 2011).

Research has also established that therapists who have undergone personal therapy at some point in their professional lives are more likely to report advantageous psychological changes and fewer accounts of burnout (Linley & Joseph, 2007). Other factors that predict greater levels of self reported personal growth included: gender (female therapists report higher levels of growth than their male counterparts), a personal history of trauma, and the receiving of clinical supervision (Linley & Joseph, 2007). These findings highlight the value of supervision and indicate that a personal history of trauma may not only function as a risk factor for vicarious traumatisation (Pearlman & Mac Ian, 1995) but may possibly predict a therapists potential for personal growth (Linley & Joseph, 2007).

Research on the relationship between therapists' vicarious exposure to trauma and their experience of personal growth are inconsistent. Some studies show that a lifetime spent engaging in therapeutic work increases the possibility of therapists reporting negative consequences as a result of their work (Linley & Joseph, 2007), whereas another more recent study by Brockhouse et al. (2011) found that the greater the degree of cumulative vicarious exposure to trauma, the greater the degree of self-reported personal growth among therapists. The study by Linley and Joseph (2007) found that therapists who worked a greater number of hours per week reported higher levels of personal growth, which is in contrast to other research which reported that therapists with higher caseloads were likely to report more trauma related symptoms (Chrestman, 1999; Kassam-Adams., 1999). Linley and Joseph (2007) suggest that the therapists in their study may have taken on more cases due to the benefits they were experiencing as a result of their work, rather than their high case loads accounting for their positive sequelae. It would seem that further research is required to reach a greater degree of clarity on this aspect.

2.2.5 The relationship between positive and negative consequences

It is important to note that, as with PTG and PTSD, research suggests that the subjective experience of VPTG does not indicate the absence of, or an end to, any negative consequences caused by exposure to another's traumatic experiences, such as vicarious trauma or STS. In studies involving therapists (Arnold et al., 2005) as well as other trauma workers including social workers (Gibbons, Murphy, & Joseph, 2010), ambulance personnel (Shakespeare-Finch, Smith, Gow, Embelton, & Baird, 2003) and a group of individuals working as interpreters to refugees (Splevin et al., 2010), most respondents reported that they had experienced both positive and negative sequelae as a result of their work with survivors of trauma. These findings are all in line with the results of a South African study involving counsellors working at a community crisis centre. Although the participants felt that there was a cost to caring, they found that they also grew as a result of their counselling experiences (Mason & Nel, 2009). This combination of positive and negative consequences is consistent with the experiences of direct trauma survivors (Tedeschi, Calhoun, & Cann, 2007) and emphasises the complexity of the impact of trauma. The interpreters to traumatised refugees described their journey toward personal growth more specifically; initially, they experienced negative effects such as intrusive thoughts and rumination but as they became more able to cope with their distress they became conscious of the enduring, positive changes within themselves (Splevins et al., 2010). Tedeschi and Calhoun, in their theory of PTG (1995, 2004), propose that it is inevitable for an individual to experience some degree of distress when their assumptions about the world are challenged; but they contend that it is the process of accommodation that serves as a catalyst for PTG to take place, which then results in the individual's improved psychological well being. Some studies have found that the relationship between PTG and PTSD is curvilinear, meaning that the greatest degree of PTG is experienced at a moderate level of PTSD. Too mild a trauma may mean there is less need to attribute meaning to the event, and a great trauma that results in severe PTSD symptoms may hamper the processes required for the necessary accommodation of the event to occur (Levine, Laufer, Hamama-Raz, Stein, & Solomon, 2008). However, little research or commentary exists on the relationship between negative and positive outcomes for those who treat the traumatised.

As the measurement of PTG and VPTG are based on self reports by trauma survivors and trauma workers, respectively, a degree of caution is advised. It has been argued that some self reports of PTG may be illusory (Zollner & Maercker, 2006). This illusory aspect of PTG may

act as a defensive cognitive avoidance strategy that could have adverse affects on the survivors' adjustment to trauma in the long term. However, the illusory aspect of PTG can act as a short-term coping mechanism as long as it does not prevent the survivor from taking action to deal with their experience of trauma (Zollner & Maercker, 2006). Hobfoll et al. (2007) contend that self-reported PTG is a product of self enhancing cognitive bias, but other research presents evidence that survivors' perceptions of personal growth are not correlated with social desirability (Weinrib, Rothrock, Johnson, & Lutgendorf, 2006) and that their reports of growth tend to be supported by people close to them (Park, Cohen, & Murch, 1996).

2.3 Conclusion

The purpose of this chapter was to review the possible negative and positive sequelae that trauma counsellors may experience as a result of their work. A substantial body of literature exists that explores the negative outcomes of trauma work on therapists, including burnout, vicarious trauma, secondary traumatic stress, compassion fatigue and empathic strain. While limited, there is also evidence that therapists experience salutary benefits as a result of their work. These positive outcomes have been termed compassion satisfaction, vicarious post traumatic growth, and vicarious resilience. Common factors that impact on the development of both positive and negative consequences include: the therapists level of training and experience, their personal history of trauma, gender, the availability of both organisational and social support, the therapists coping style as well as organisational issues that may facilitate or hinder their therapeutic work (Figley, 2002; Maslach et al., 2001; McCann & Pearlman, 1990).

While there is some research on the psychological effects of counselling traumatised populations, very little of this research has been conducted with lay counsellors in general and with those lay counsellors who counsel survivors of crime in particular. South African studies are very limited, despite the country's high crime rate. One such study, already mentioned, involved a sample of non professional counsellors where some of the counsellors did present with STS symptoms. However, none were within the clinical range and many of the counsellors reported positive outcomes as a result of their counselling work (Ortlepp & Friedman, 2002). A second more recent local study reported that counsellors working with

traumatised clients similarly found that the consequences of their work were both positive and negative (Mason & Nel, 2009).

Government policy stipulates that crime survivors are to be offered emotional and practical support in the immediate aftermath of a crime (Department of Social Development, 2008). However, no research has been conducted to ascertain the effect that this support role has on the volunteers who provide this service. These volunteers, who receive little or no formal training (Department of Social Development, 2009; Nel & Kruger, 1999), are providing support to survivors of crime in a society where criminal violence is both highly prevalent and particularly severe in nature (Abrahams et al., 2009; Seedat, Van Niekerk, Jewkes, & Ratele, 2009; Williams et al., 2007). Developing an understanding of how counselling crime survivors may impact on volunteer counsellors in South Africa is important, not only for protecting the psychological well-being of counsellors but also for enhancing the support received by crime survivors.

This study aims to qualitatively explore the psychological impact, both positive and negative, on lay counsellors of counselling crime survivors at selected police stations in the Cape Metropole. In the next chapter the research methodology will be explicated.

CHAPTER THREE: METHODOLOGY

3.1 Research Aim

The purpose of this research was to explore the pathogenic and salutogenic psychological impacts on volunteers who counsel survivors of crime in the Cape Metropole. In light of the limited local research on the subject this study aims to explore whether the existing literature on the negative and positive consequences of working with traumatised populations is relevant to volunteers working with crime survivors in the South African context.

3.2 Research Design

Quantitative research, which is predominantly positivist in its philosophy, aims to explain the objective „truth’ of phenomena under investigation. This is accomplished by manipulating operationally defined variables in order to test a pre-generated theory using empirical research methods. The use of deductive techniques aims to explain causal relationships between variables (Pidgeon & Henwood, 1992; Stake, 1995). In contrast, qualitative research is largely oriented in the interpretative paradigm, which maintains the perspective that social reality needs to be interpreted and understood as opposed to being observed and explained. Interpretivism assumes the subjective nature of knowledge and recognises that the relationships that exist between variables need to be viewed within their social reality in order for their complexity to be understood (Corbetta, 2003). Rather than imposing an existing theory onto data, interpretivism utilises inductive reasoning which allows for the emergence of themes from the data. The analysis of these themes forms the basis for the development of tentative hypotheses (Pidgeon & Henwood, 1992). A qualitative research paradigm was used in this research as it was deemed most appropriate for the exploratory nature of this study. Rather than attempting to determine a specific objective „truth’ or testing a particular hypothesis, qualitative research aims to develop a deeper understanding of the complex inter-relationships between the issues that make up the research question (Pidgeon & Henwood, 1992; Stake, 1995). The data analysis followed a largely inductive process. While the interview questions were partly framed by existing research findings (in deciding which broad areas to explore), they were phrased openly and allowed scope for participants to introduce their own unique experiences in relation to their work. In the data analysis process, no coding schedule was developed prior to coding; rather, codes and categories emerged from

the data. The emerging data were then considered in light of existing literature, in order to explore similarities and differences with previous findings.

This is a descriptive, exploratory study involving the use of collective case studies. The case study allows the researcher to gain an in-depth knowledge of the topic under investigation and is suitable for use when the researcher proposes to investigate current phenomena in a real-life situation, where they have limited influence over events that occur in the research context (Yin, 1994). Therefore the use of case studies, based on interviews, was ideal for this particular study as the sample of lay volunteer counsellors who support crime survivors in a South African context may have experiences and perspectives that differ from those of professional trauma counsellors not working in South Africa. The use of collective case studies enables the identification of similarities and differences between individual cases (Stake, 2000; Terreblanche, Durrheim, & Painter, 2006). A multi-case design is preferable to that of a single case study in that any analytical conclusions that emerge separately from more than one case will hold more weight. There also exists the likelihood that the contexts of multiple cases will differ, even if only slightly, and so, should the researchers analysis lead to a common conclusion from the multiple cases despite these different circumstances this will enhance the generalisability of the findings (Yin, 2003). As this is an area in which limited research has been done in the South African context, particularly with regards to volunteer lay counsellors, the advantage of conducting collective case studies is their ability to provide rich and detailed contextual information which could give rise to further research (Yin, 2003).

3.3 Sample

Patton (cited in Coyne, 1997) describes purposive sampling as selecting participants according to the extent to which they are able to offer thick description and in-depth information about the topic under investigation. Ease of accessibility to a potential research participant may encourage a researcher to select a particular subject to form part of the sample but Stake (2000) cautions against using this as the primary selection criterion so as to prevent the creation of an homogenous sample. Ideally, cases should be selected that offer the most variety and the greatest opportunity for learning (Stake 2000). Stake (2006) recommends that collective or multi-case studies be made up of between 4 and 15 cases to allow for the optimal variation in the data collected. In accordance with this recommendation

12 participants were selected for this study. All of the participants were victim support volunteers at one of five selected police stations in the Cape Metropole. The sample was chosen according to the extent to which the participants were able to offer thick description and in-depth information about the research topic. Permission to conduct the study was obtained from the VEP co-ordinator at each of the selected police stations prior to the commencement of the research. At two of the five stations the researcher attended the volunteers' monthly meeting. At this meeting the researcher explained the purpose of the study, details of the data collection process, and issues regarding confidentiality, emphasised that it was solely the choice of the volunteer should they wish to participate in the research project and that they would be required to sign an informed consent form prior to their inclusion in the study. Volunteers were left with a leaflet highlighting the abovementioned information. At the other three stations the VEP co-ordinators opted to distribute the leaflet to volunteers themselves. In both cases the researcher's contact details were made available so volunteers could get additional information if necessary and so that those volunteers willing to participate could make their intentions known privately. More than the required number of participants volunteered to be a part of the study and selection of the participants was based on ensuring diversity across station, age, gender, level of training, and level of counselling experience.

As previously mentioned, the volunteers were based at one of five SAPS stations included in the study. All the stations were based within the Cape Town area in one of the following locations: Grassy Park, Hout Bay, Manenberg, Rondebosch and Woodstock. The participants included 9 women and 3 men; the overrepresentation of women is representative of the gender split at the various stations. The participants' ages ranged from 36 – 68 years with a mean age of 48.75 years. A majority of the cohort were married or in a long-term relationship (9 interviewees), three were divorced (one of these three is now in a long term relationship) and one other had never been married. Nine members of the sample had children. English was the home language of seven interviewees; the remaining participants' first language was either Afrikaans (four participants) or isiXhosa (one participant).

With regard to the participants' level of education, nine of the 12 participants had completed secondary schooling, one of the interviewees had obtained a grade seven pass, another had passed grade eight, while one had a grade 10 pass. Six of the participants had obtained either a diploma or a degree after completing high school. A number of the interviewees currently

worked or were trained to work in human services. More specifically, two of the participants had completed a counselling diploma through the South African College of Applied Psychology (SACAP) and currently work part-time as counsellors, while a further two participants are in the process of studying towards this same qualification. A fifth interviewee has a degree in Industrial Psychology and works as a clinic sister. Another of the volunteers is also a qualified nurse but no longer works in the profession. A seventh participant is employed as a community nurse. 11 of the participants were currently employed, with four of the 11 being self-employed and one participant working part-time only. The twelfth participant was voluntarily unemployed.

The years of VEP counselling experience amongst the participants ranged from one month to 12.5 years with a mean of 5.76 years of experience as victim support volunteers. All of the participants had received some form of training, the extent of which varied between stations from two full days to a 12 module training course run over a fortnight. All of the interviewees completed training, which sometimes included shadowing shifts where they worked with a more experienced volunteer, before being permitted to work with survivors on their own. There was an exception of one volunteer who assisted crime survivors, sometimes with another volunteer and sometimes on her own, for six months prior to attending any training and officially becoming a victim support volunteer. Individual profiles for each participant are provided in Table 1.

3.4 Data Collection

Individual semi-structured interviews, compiled specifically for this study, were conducted with participants. The interviewer began with open ended questions and supplemented these with probing questions if participants showed difficulty in expressing their perspectives. The advantage of semi-structured interviews is that while the same questions are asked of all the participants, allowing for cross-comparisons between responses, the open-ended style of the questions will allow the necessary flexibility for participants to tell their own stories (Marks & Yardley, 2004). Participants were offered the option of speaking English or Afrikaans in the interview, alternatively they were offered a translator if they preferred to communicate in a language other than the two stipulated above. All of the participants chose for the interviews to be conducted in English. The interviews were administered face-to-face at a

Table 1.
Schedule of Participants

Participant	Gender	Age	Home Language	Marital Status	Children	Level of Education Achieved	Currently Employed	Years of Experience at VEP	Level of Training	Hours Volunteered Per Week
1	F	58	English	Married	No	University Degree	No - by choice	9	Counselling diploma, Lifeline training, basic 2-day VEP training, additional workshops	8 hours - partly at the station and partly on call
2	F	48	Afrikaans	Married	Yes	Grade 7	Self-employed	8	Basic 5-day VEP training, 6 additional workshops	24/ 7 on call
3	F	43	English	Married	Yes	College Diploma	Yes	5	12-module VEP training, 2 additional workshops	2 hours at the station
4	M	38	Afr/ Eng	Married	Yes	Matric	Yes	2	2-day VEP training, 4 additional workshops	24/7 on call
5	M	37	Afrikaans	Single	Yes	Matric, NQ qualification	Yes	8	2-day VEP training, 2 additional workshops	4 hours at the station and on call 3 nights/ week
6	F	36	Afr/ Eng	Divorced/ Single	No	Grade 10, NQ qualification	Part-time	1 month	5-day VEP training	16 hours on call
7	M	59	Eng/ Afr	Married	Yes	Matric, N5 qualification	Yes	11	5-day VEP training	One weekend per month on call

8	F	50	Eng/isiXhosa	Married	Yes	University degree	Self-employed	1.5	Counselling diploma, 2-day VEP training	8 hours - partly at the station and partly on call
9	F	55	English	Married	No	Matric (UK), alt. health courses	Self-employed	1	2-day VEP training, signed up for courses at SACAP	16 hours on call
10	F	44	English	Married	Yes	College diploma (UK)	Self-employed	3	Trained nurse, 2-day VEP training, 4 additional workshops, currently studying toward a counselling diploma	8 hours - partly at the station and partly on call
11	F	68	English	Divorced/ Long term relationship	Yes	University degree	Yes	12.5	Industrial Psychology degree, trained nurse, 12-module VEP training, 4 additional workshops	4 hours at the station
12	F	49	isiXhosa	Divorced	Yes	Grade 8	Yes	8	2-day VEP training, 3 additional workshops	1x 8 hour shift every 2nd week

venue selected by the participant. Eight of the interviews were conducted in the victim support rooms at the various SAPS stations included in the study; two were conducted at the interviewees homes; one at the participant's place of work and another at a coffee shop. In order to provide a context within which to understand the psychological impact of their counselling work, participants were first asked about the following:

- Their demographic profile (age, relationship status, educational level, and occupation), as well as their length of service on the programme, how often they are on call, their level of counselling and trauma-specific training, previous counselling experience, and their own personal experiences of trauma.
- The level and frequency of supervision and support offered to volunteers at the police station at which they volunteer.
- The types of crimes they are most often exposed to in their counselling work with survivors.
- What motivated them to volunteer as counsellors on the programme.

Thereafter, the interview explored how the volunteers' experiences of counselling crime survivors have impacted on them. This information was elicited using open-ended questions, followed by some probes to explore aspects of vicarious trauma, STS, compassion fatigue, burnout and empathic strain, as well as compassion satisfaction, vicarious post traumatic growth and vicarious resilience. See Appendix A for the Interview Schedule.

3.5 Procedure

All of the participants in this study were interviewed by the researcher and interviews were conducted in English. Terreblanche and colleagues (2006) advise conducting pilot interviews, to ensure that the questions compiled by the researcher elicit the kinds of responses that will fulfil the aims of the research. Two pilot interviews were conducted with participants from two different victim support branches and minor adaptations, in the form of two additional questions, were subsequently made to the interview schedule. The interviews, conducted at a venue of the participants choosing, were between 30 to 90 minutes in length, and were conducted over one session. The interviews were audio-recorded. Prior to the start of the interviews the respondents were each asked to sign a form consenting to take part in the

study. Contained in this consent form (Appendix B) was notification that the interview was to be audio-recorded and subsequently transcribed. Also included was the researcher's assurance to maintain the confidentiality of the participants.

Five of the interviews were transcribed by the researcher, and the remaining seven transcriptions were completed by two independent individuals. The interviews not transcribed by the researcher were checked for accuracy by the researcher before commencement of the data analysis. The audio-recordings and interview transcripts are stored in a secure place to which only the researcher will have access.

3.6 Data Analysis

Qualitative data analysis was selected for this research as it allows for the identification and exploration of categories of information in detail (Terreblanche et al, 2006). The interview transcripts were analysed using thematic analysis. Thematic analysis is a foundational method of qualitative analysis and is essentially a categorising strategy for qualitative data. It guides the researcher in a process that begins with the general reading of the data, to the division of the data into codes, to the discovery of patterns of meaning within the data and finally the development of themes (Boyatzis, 1998; Braun & Clarke, 2006). There is some disagreement among researchers surrounding whether thematic analysis exists as an actual method of analysis. Some regard it simply as a process for encoding qualitative data that forms part of other methods of data analysis, such as grounded theory or discourse analysis (Boyatzis, 1998). Others maintain that it is a method of data analysis in its own right. Braun and Clarke (2006) argue that, being free from theoretical limitations, thematic analysis is a flexible analytical method that provides dense and detailed descriptions of data. This makes thematic analysis a useful method for the current study which involves participants whose views and experiences are largely unknown. Use of this technique allows for the inductive identification of themes, so that they emerge from the data rather than being predetermined by the researcher. While both thematic analysis and grounded theory seek out the repetition of themes within a data set, thematic analysis does not have as its ultimate goal the generation of theory, as is the case with grounded theory (Braun & Clarke, 2006).

Thematic analysis of the interview transcripts proceeded according to the following steps:

Step 1: As the researcher conducted all the interviews she was already familiar with the interview content. The researcher then transcribed five of the audio-recorded interviews, sending the remaining seven interviews to two independent individuals for transcription. The transcriptions that were not completed by the researcher herself were checked for accuracy against the audio recordings. Through the transcribing of the interviews, the checking for accuracy and repeated reading of the interviews the researcher was able to immerse herself in the data.

Step 2: Once familiar with the data, the researcher commenced analysis of the first three interview transcripts. The interviews were analysed phrase by phrase, in an analytic process known as open coding. This process of breaking down data into smaller units of analysis assisted the researcher in identifying the feelings, perspectives, behaviours and incidents contained within the data. These concepts were then allocated a label or code. The codes identified in these three transcripts were used to construct an initial coding schedule.

Step 3: The remaining nine transcripts were then analysed using the technique of constant comparison between units of analysis in the transcripts and the initial coding schedule. New codes that emerged were added to the coding schedule. Constant comparison was used from this point through to step six. In this method continuous comparisons are made between data and data, data and codes, codes and codes, codes and themes and finally themes and themes. Theoretical sensitivity is described as the sum of knowledge the researcher has about the topic under investigation. A good theoretical knowledge enhances a researcher's ability to identify concepts in the data. Theoretical sensitivity often develops as the research project progresses and so on occasion it was necessary for the researcher to recode parts of the first few coded interviews due to the emergence of new insights regarding the recognition and significance of certain concepts.

Step 4: When the initial open coding of data was completed, the researcher proceeded to sort the codes into higher order or more abstract themes, known as axial coding. Axial coding is a process whereby codes that are conceptually similar to each other are grouped together as one broader concept. In this step the researcher considered the relationships (their variation and similarity) that exist between the codes, and assigned names and definitions to the higher order themes that emerged. Each theme has its own particular properties and characteristics that were identified through the posing of basic who, what, where and why type questions.

Step 5: Selective coding occurs only once the majority of themes have been identified within the data. At this point the relationship between each of these themes was considered. This process permitted the researcher to make distinctions between the properties of the central themes or sub-themes that were conceptually contained within the core themes.

Step 6: The frequency of repetition of each core category across the transcripts was explored, in order to examine which categories were most, as well as, least common across all participants. However, consideration was not only given to the number of participants who raised a particular theme but also to whether or not the theme captured anything of significance in relation to the research question (Braun & Clarke, 2006; Charmaz, 2006; Glaser, 2002; Stauss & Corbin, 1997; Strauss & Corbin, 1998).

3.7 Ethical Consideration

An informed consent form (see Appendix B) was given to each volunteer, which they were required to sign before the commencement of the interview. The consent form stipulated that each participant may withdraw from the study at any time, and that their personal information will remain confidential and the transcripts will be anonymised to ensure that neither the participants nor any clients or cases they may discuss can be identified from the text. There was a low risk that the study would have a negative impact on the participants, and the interviews provided them with an opportunity to reflect on and consolidate their experiences as counsellors of survivors of crime. Though none of the participants appeared distressed by the interview process, all participants were provided with the number for Life Line. Should any of the participants have experienced any emotional upset, at some stage after the interview and as a result of the interview content, they could call and speak to a telephone counsellor or make an appointment for a face-to-face counselling session.

The following chapter will discuss the results of the study with reference to the existing literature.

CHAPTER FOUR: RESULTS AND DISCUSSION

The data analysis yielded ten themes, six related to negative impact, three related to positive impact and one which defied simple categorisation as either positive or negative. Some of the reported impacts were short term, transient consequences lasting from a few minutes to a few days, while others were longer term, more enduring consequences. The most commonly reported psychological impacts of supporting survivors of crime are discussed below. Direct quotes from the research participants' interviews have been included to illustrate the themes.

Table 2. Themes		
Theme Name	Description	No. of participants who raised theme
Negative Psychological Impacts		
1. Continued concern for or unwanted thoughts about past clients and cases	General concern for and thoughts surrounding the future wellbeing of past clients, particularly child victims of crime and cases involving death.	7/12
2. Sleep disturbances	An increased need for sleep, or short-term and long-term insomnia, and nightmares experienced as a result of the participants involvement on a case.	5/12
3. Feelings of despondency	Feelings of despondency with regards to being uncertain of how to deal with certain cases as well as feeling helpless to assist crime survivors in the face of high crime rates and overwhelming socio-economic deprivation.	3/12
4. Avoidant behaviours	Avoiding cases that mirrored the participants own direct exposure to a similar trauma.	3/12
5. Difficulty regulating emotions	Overwhelming feelings that resulted in participants being unable to support survivors appropriately or caused them to act out in their normal lives.	2/12
6. Reduced empathy and tolerance for victims of	Reduced empathy and feelings of frustration	2/12

crime	experienced toward victims of domestic violence and substance abusers.	
Positive Psychological Impacts		
7. Witnessing benefits to crime survivors	Perceiving their volunteering as having a beneficial impact on crime survivors.	12/12
8. Volunteers experience the work as rewarding and fulfilling	Experiencing the work as rewarding and fulfilling in relation to their engagement with crime survivors, the support they shared with fellow volunteers and in terms of experiencing a greater connection with their communities.	12/12
9. Personal growth and development	Experiencing increased self-insight, improved understanding of and empathy towards others, and greater degrees of patience and tolerance as a result of their volunteering efforts.	9/12
Impacts Described as Both Positive and Negative		
10. Increased awareness of safety and security needs	Increased knowledge of neighbourhood crime led to heightened vigilance amongst participants.	8/12

4.1 Negative Psychological Impacts

11 of the 12 participants reported experiencing some form of negative psychological impact in response to their work with survivors of crime. Amongst these, those respondents who reported the most severe negative consequences were currently experiencing trying personal circumstances or were resident in economically disadvantaged areas where they faced the impact of crime and unemployment in their communities on a daily basis. The 12th participant specifically noted that she had never suffered any negative consequences as a result of their volunteering work. While this could be attributed to the individual's personality and coping styles or their length of service as a VEP volunteer, the participant in question had been volunteering for just one year and had only worked on a few cases. According to studies by Chrestman (1999) and Kassam-Adams (1999), therapists who are faced with larger workloads are more likely to develop a greater number of trauma symptoms. Therefore this

participant's low level of engagement with crime survivors could have served as a protective factor against negative outcomes.

The six different negative outcomes most commonly reported by participants were: continued concern for, or unwanted thoughts about, past clients and cases; sleep disturbances; feelings of despondency; avoidant behaviours; difficulty in regulating emotions; and reduced empathy and tolerance for victims of crime. These are discussed below.

4.1.1 Continued concern for or unwanted thoughts about past clients and cases

The most common negative consequence, reported by seven of the 12 respondents, was the experience of continued concern for, or unwanted thoughts about, past clients and cases at some point in their volunteering lives. Some of this concern was of a general nature, where the volunteer felt concern for all or most of their clients, but more commonly heightened and involuntary concern was experienced with regard to particular types of cases. These types of cases were usually those involving children or death. In the current study the volunteers reported:

“[Sometimes] it would be difficult to shake it off because it would keep on playing in my mind and [I would be] thinking what could I do and finding myself wanting to fix it, and that's where I have to contain the fixer.” (P8)

“A lot of cases I am thinking about – about what happens to the people.” (P6)

“...but still you know I worry about that little girl, how she is you know, because a nine year old is-well it was two years ago so she's probably eleven now. So child cases one worries about...you refer them and then you've got to leave it, and that's hard to sort of leave it and not worry... The rape cases are sad that involve minors, anyone under the age of 18, young women, girls – that sort of stays in the back of my mind as I sort of worry about their future.” (P1)

The concern in this theme was reported by participants to be long term or enduring in nature and is different to the mental and emotional processing that many of the participants in this

sample reported experiencing immediately after working on a case. They described this normal mental and emotional processing as time spent, immediately after a case, identifying their feelings and concerns associated with the crime survivor and the specifics of the case. Those who reported engaging in this type of processing felt it was a necessary part of their dealing with the psychological impact of their work. However, as demonstrated above, some cases resulted in prolonged preoccupation with the well-being of the client.

When comparing this theme to the literature it seems to relate most to the intrusive thoughts that are symptomatic of both vicarious trauma and STS (Figley, 1995; McCann & Pearlman, 1990). However, there is an important distinction between the intrusive thoughts of vicarious trauma and STS and the concern experienced by the seven participants. In vicarious trauma and STS the intrusive thoughts, imagery or nightmares are related to the re-experiencing of the client's traumatic event, whereas in the current study the respondents thoughts focus more on the client's current or future wellbeing. In addition to this, the intrusive thoughts of both vicarious trauma and STS are described as being distressing to the therapist or caregiver (Figley, 1995; McCann & Pearlman, 1990), whereas none of the seven respondents described their concern as impacting on them in such a severe way. It did not seem that this concern affected the participant's ability to support other survivors of crime unless combined with other negative psychological impacts. The participants' concern for the future wellbeing of past clients may be due to the very short-term nature of VEP counselling (ranging from one to not more than three sessions), which makes it difficult for the victim support volunteers to know anything about the longer-term adjustments of their past clients and whether or not their brief intervention was sufficient to assist the crime survivor.

As previously mentioned, the cases in which participants' experienced increased concern were those involving children and death. This finding regarding cases involving death is at odds with that of a study by Ortlepp and Friedman (2002), in which part-time trauma counsellors who worked on such cases did not report more STS-type symptoms than counsellors who had not counselled on cases involving mortality.

Whilst the above refers to the impact of the counsellors' indirect exposure to their clients' trauma material, three of the seven respondents had also been directly exposed, either through being present at, or viewing photographic images of, the crime scene. All three experienced intrusive thoughts and images related to this direct exposure, which is one of the symptoms of PTSD as listed in the DSM IV-TR (American Psychiatric Association, 2000). The

respondents all maintain that the cases that involved their direct exposure to disturbing imagery resulted in greater negative consequences for themselves than those cases where they were indirectly exposed to a client's traumatic experience, which highlights the seriousness of these types of occurrences for volunteers. One volunteer describes an incident of direct exposure and their response to it:

“So I didn't know anything about it [the case]...so she [the client] walked in and she sat down and she was really shaken. I made her a cup of tea and then I said: „Ok tell me why you're here?’ And she said: „This is why I'm here...’ and she gave me her cell phone and I made the mistake of looking and it was the image of her son who had just been murdered and he was all cut up, beaten up. You know when you look at something and you think: „What am I looking at?’, and you realise it's a face I'm looking at and I had to try and compose myself and then – because no matter what someone tells you, you can never imagine exactly what they've been through. So now I had this image of what she had just experienced and it was the most difficult session, and it shouldn't have been a difficult session, but it was the most difficult because I knew exactly what she had seen, and I had to try and deal with it while I was trying to help her. And that out of all my cases has been the most difficult to do... [that visual image] *it stays there (emphasis added)*, so I had to be debriefed after that because it *really, really stuck with me (emphasis added)*...” (P3)

4.1.2 Sleep disturbances

Almost half of the sample (five of the 12 participants) reported having experienced some form of sleep disturbance as a result of their work. These disturbances were generally of a transient nature, with two of the interviewees experiencing short-term sleeplessness of between one and three nights in duration following a traumatic case, while another two respondents found the opposite in that they had an increased need for sleep after supporting survivors. The transient sleep disturbances were not viewed as being of major concern by the four participants. One of the respondents who reported experiencing short-term insomnia on a few occasions noted that it generally occurred when she was called out to a case at night. The disturbance of her night-time routine coupled with the need to process her experience of and

emotions surrounding the case resulted in her temporary sleeplessness. However, for working volunteers this could have a negative impact on their ability to function as necessary the following day.

A fifth participant had, on one occasion while working on a few difficult cases back to back, experienced nightmares related to one of the cases. The participant explains:

“I had a couple of cases where I had two rapes together, and I had two very nasty aggravated house robberies, where people were tied up and the women in that family came forward for support, and they were very traumatised. And they were like bang, bang, bang, these cases all together. And that’s the only time I’ve shown some symptoms of absorbing some secondary trauma or maybe it sparked stuff in me but – from my past. But I was quite aware of it. I woke up – I dreamt actually that my daughter had been raped...it was nightmares. It was definitely rape...it was just the vividness of the dreams and waking up in the night. It was only sort of once after those sort of series of cases.” (P10)

This respondent’s experience mirrors the findings of both Kassam-Adams (1994, cited in Arvay, 2001) and Schauben and Frazier (1995), whose research concluded that there exists a positive correlation between the number of sexually abused and generally traumatised clients in a therapist’s caseload and the therapist’s expression of PTSD-like symptoms.

The two participants who had experienced some of the more transient sleep disturbances also mentioned suffering from longer term insomnia lasting from one week to one month following direct exposure to trauma at a crime scene. Both respondents spoke at length of the trauma they experienced as a consequence. The first volunteer had witnessed a crime scene where a child had been murdered:

“Ja, that is the only one [case] that I can think of ,cause I had to go to my own private doctor. Yes, because I couldn’t sleep for a whole month...” (P2)

The second volunteer who was at the scene of the accidental death of a man who had been caught in a machine said:

“Now the bodies laying, now the photographer comes. Now the time – I don’t see that they going to open the thing already and the time when I pass by they

open the body. Sister, it was awful – no eyes, flattened...Oh G-d...after that I couldn't sleep for one week..." (P6)

The insomnia experienced by these participants is in accordance with the arousal aspect of STS (Figley, 1995) in the case of indirect exposure, and PTSD in the case of direct exposure (American Psychiatric Association, 2000), and was viewed by both participants as impacting significantly on their daily lives. The increased need for sleep experienced by two of the five respondents is, however, more characteristic of the exhaustion aspect of burnout or compassion fatigue. However, the exhaustion of burnout and compassion fatigue is described as being long term whereas in the current research the respondents reported that this symptom was transient (Figley, 1995; Maslach et al., 2001). Nightmares are considered as part of the same group of symptoms as intrusive thoughts and images, which comprise one of the symptoms of STS (Figley, 1995).

4.1.3 Feelings of despondency

Three of the participants reported that, at times, they felt despondent when assisting survivors of crime. The first respondent's sense of despondency arose from feelings of helplessness and uncertainty of how best to support crime survivors. She said:

"I feel helpless...I am thinking always what is the solution to this problem? If there is no solution what we do then? So *they (emphasis added)* know all the contacts – who to call and who deals with what. And so I am learning."
(P6)

These feelings of uncertainty bear some similarity to the countertransference response of empathic disequilibrium, one of the four modes of empathic strain, which can affect the degree of support and empathy a therapist is able to experience toward their client (Wilson & Lindy, 1994). It is important to note that while the respondent had already been assisting with VEP duties and responsibilities for approximately six months she had only recently received any formal training. Various research studies show that a lack of training can increase a therapist's vulnerability to developing negative consequences as a result of trauma work (Adams & Riggs, 2008; Arvay & Uhlemann, 1996; Follette et al., 1994).

The other two respondents felt despondent in relation to the high levels of crime that exist in South Africa as well as the socio-economic difficulties that many of the survivors continue to face. One volunteer shared:

“...sometimes it’s difficult. Sometimes you have a case where I feel hopeless but then the next case will be better...it’s that feeling of hopelessness because it’s [the social problems and crime] so wide-spread, so rife. And the whole thing that’s happening up here with the foreigners being attacked and the legacy of apartheid is so alive.” (P8)

These feelings of despondency were transient for all of the respondents. McCann and Pearlman (1990), in their theory on vicarious trauma, note that when continuously faced with examples of human malice, indifference and brutality towards innocent people therapists may feel increasingly despondent about the state of their society. It is possible that the part-time nature of the volunteers’ duties may serve in protecting them from experiencing more intense bouts of despondency. After a longer time spent engaging with crime survivors (two of the respondents had been volunteering for less than two years) or with an increased case load it is possible that the participants’ feelings of despondency may intensify and/or increase in frequency.

4.1.4 Avoidant behaviours

Three of the 11 participants who reported negative consequences had also experienced avoidant behaviours at times in their volunteering history. These avoidance symptoms were transient for all three participants and dissipated when the individual had dealt with their emotions surrounding their trauma. The researcher considered these avoidant behaviours to indicate awareness, whether conscious or unconscious on the part of the volunteer, of their limitations in being able to support survivors of crime at these times or in certain types of cases. One of the three participants found herself avoiding crime scenes and cases involving death after suffering from negative consequences as a result of direct exposure to trauma on the scene of an accidental death. She said:

“When I drive past that place [the scene of the accident] I feel funny.
The next week [after the incident] there was a sudden death up the road but I wouldn’t get out of the van. I said to my colleague I am not getting

out of the car. I don't know if I am going to see something [a dead body] again, how I will react after that I don't know." (P6)

The second and third respondent both avoided cases that mirrored elements of their own personal trauma histories. One of the interviewees said the following in relation to her personal experience of crime and the effect it had on her VEP volunteering:

"I think possibly after my personal brush with a gun – I had a bit of a wobbly then...and for a while I did not do cases that involved a similar scenario. But now I am fine..." (P11)

Because all three respondents experienced the avoidance symptoms in response to their direct exposure to trauma, this response would be categorised as a PTSD-type symptom rather than a symptom of vicarious trauma, STS, compassion fatigue or empathic strain (Figley, 1995). However, their VEP experiences re-activated avoidant defences at times, due to resonances with their own personal experiences.

4.1.5 Difficulty in regulating emotions

Two of the volunteers shared that they had experienced difficulty regulating their emotions as a result of their engagement with crime survivors. This negative response was described as being transient in nature, emerging when the respondents were dealing with particularly traumatic cases. One of the volunteers reported that on a few occasions she found it difficult to contain her sadness when in the presence of the victim.

"You know the tears that come but I must hold mine back because you can't show them that I am feeling emotional, I must remain strong. It's very difficult though." (P6)

While all the participants acknowledged that hearing crime survivors' accounts of their traumatic experiences did, at times, leave them feeling sad, shocked or upset, none besides the above quoted participant felt overwhelmed by these feelings while in the room with the victim. Her feelings of intense sadness whilst engaging with a crime survivor may signify a countertransference response of over-identification with the client which could negatively impact on her ability to provide support (Wilson & Lindy, 1994). Herman (2001) notes that

countertransference responses, ranging from over-identification on the one hand to avoidance on the other, are inevitable when working with traumatised populations. It is therefore somewhat surprising that not more of the participants experienced these types of countertransference reactions.

The second volunteer found that his emotions surrounding particularly trying cases, usually those involving violence towards women, occurred away from the victim and spilled out into everyday life.

“...like sometimes that changed a lot, towards other people and that and my attitude towards people is like changing...if somebody tries to make me angry I would get angry but then I am like swearing at them and just going on...[this happens] around the time I am doing difficult cases and that.” (P5)

This respondent's feelings of uncontrollable anger are consistent with the symptoms of STS (Figley, 1995), and were a cause of concern for the (self-reportedly) mild mannered individual. While the participant volunteered at a station that did not have access to debriefing by a mental health professional he was able to access professional assistance through the Employee Assistance Programme offered at his place of work. Figley (2002) cautions that personal difficulties, as well as being inadequately prepared to deal with traumatised clients, may serve to exacerbate a caregiver's stress levels, leaving them vulnerable to developing STS/ compassion fatigue. However, this particular participant did not report experiencing any personal problems at the time of the interview and as a victim support volunteer for eight years he had received a good amount of training, including a workshop on domestic violence. The counsellors at this particular station reported that they dealt mostly with cases of domestic violence, perhaps continued exposure to these types of cases resulted in the participant's experience of delayed feelings of anger (Maslach, 2003a).

4.1.6 Reduced empathy and tolerance for victims of crime

Two respondents expressed reduced empathy and tolerance for the victims of crime. These feelings were directed towards those involved in cases of domestic violence and substance abuse. The researcher considered this reported lack of empathy and tolerance to be of concern

in terms of the level of support the two participants would be able to render to these particular crime victims. A negative experience with victim support could adversely affect a victim's motivation to access care and social assistance in the future. One of the volunteers recounted two cases involving domestic violence that had left her feeling particularly frustrated:

“...she told me how he hits her and abused her and how she had enough and she had this panic attack. I phoned the ambulance to come and the husband was arrested, and the next day they were walking in the road hand-in-hand! It hurt me...the next day they are back together again...to me then you really don't need help...it makes me negative...then I will turn around and walk away, because now I give my best of help and tomorrow you do the same. If you really want help then walk away.” (P6)

The second volunteer stated:

“And I don't encourage people to feel sorry for themselves, if your husband has abused you I will tell you exactly what you need to know in terms of the court processes, what they can do...I always say if you do not want to get out of an abusive relationship then do not come and complain at the police station – if that is the case then go home and take your punishment, which I don't encourage at all. We know it that life is all about choice. If you choose that type of life well then that is your thing ...but don't let the kids suffer, don't make the husband suffer, don't let the family members suffer because of you. And I always say the world does not revolve around you. I say people simply carry on with their life with or without the person.” (P4)

The negative, somewhat callous, attitude that the respondents express towards particular clients is characteristic of the cynicism or depersonalisation that is symptomatic of burnout. Depersonalisation can arise as a result of the emotional depletion experienced by those in the helping professions in response to continually emotionally demanding work. It may serve to protect the therapist or caregiver from the on-going demands of their work but eventually will lead to a reduction in the quality of support or assistance they are able to offer their clients (Maslach et al., 2001). Maslach (2003a) expanded on this by noting that individuals working in the helping professions who engage with a number of clients who show little or no sign of

improvement and/or who keep returning for assistance with the same problems (as in the abovementioned scenarios) can further exacerbate a caregiver's stress levels, increasing their vulnerability to burnout.

The responses of the above two participants also resonate with Wilson and Lindy's (1994) notion of empathic withdrawal. Empathic withdrawal, a form of empathic strain, is most often experienced by clinicians who have a limited personal experience of trauma and/ or insufficient trauma specific training. This unpreparedness may leave the clinician feeling overwhelmed by their client's trauma. Should the clinician tend toward an avoidant defensive style these feelings may result in them needing to withdraw from their client through intellectualising or dismissing their client's trauma or possibly even blaming the client for their situation, as is the case with the abovementioned participants.

4.2 Positive Psychological Impacts

Each of the respondents reported some form of positive outcome from their experiences as a VEP volunteer. The three themes related to positive impact were: witnessing benefits to crime survivors; volunteers experience the work as rewarding and fulfilling; and personal growth and development.

4.2.1 Witnessing benefits to crime survivors

The 12 participants all considered their volunteer work as being beneficial to survivors of crime, and they experienced this as a long term and enduring consequence of their volunteering efforts. This perceived benefit served to motivate the participants to continue to volunteer their services to the VEP. It may also encourage volunteers to seek out or request additional training in order to be better equipped to assist and support crime survivors. A number of participants commented that they often observe a difference in a client at the end of just one session. They reflected that the clients show changes emotionally, in how they communicate their feelings surrounding their traumatic experiences, as well as in how they hold themselves physically.

“I have certainly seen a tremendous change in the client that has come in and then an hour later how they reflect their feelings.” (P11)

Another volunteer summed it up by saying:

“...you can see suddenly this person who comes in all huddled over, feeling the victim and then leaves the survivor.” (P3)

The same participant also noted that the support the victim support rendered was not only emotional but at times was also of a practical nature.

“A woman was mugged twice on Table Mountain and she just really didn’t feel safe and I know the police [in our area] do mountain patrols so I organised that she could go on mountain patrols with them so that she could see that there is something being done and that has now branched out because she organises mountain walks [and] the police are now going with her to find new areas where they might find people hiding. Every Thursday she goes up with them now and feels really safe and the odd Saturday one of the police will do one of their six hour walks with the group, so I mean that’s really community work.” (P3)

Another volunteer added:

“There was one particular case that involved a 9 year old girl who was raped and we referred her to Childline for counselling...and the mother, I counselled the mother, and that to me was actually the most rewarding thing was actually because she really didn’t know how to handle her child and I gave her lots of good hints as to how she could and it made the world of difference to their relationship.” (P1)

This positive perception that the volunteers have regarding the importance of their work is consistent with the findings of a study by Splevins et al. (2010) where a group of interpreters to refugee clients experienced a greater valuing of their work through their vicarious exposure to clients’ traumas. These comments also bear some similarity to Arnold and colleagues (2005) finding that therapists frequently reported that observing and encouraging clients’ post-traumatic growth was the most positive outcome of their work. This theme is also consistent with an aspect of vicarious resilience where, through witnessing their clients overcome horrific trauma, the trauma workers were able to reaffirm their belief in the value of therapy (Hernández et al., 2010). In the research on vicarious resilience the therapists and trauma workers have a much longer involvement with clients so it is interesting that the VEP

volunteers, who often have just the one interaction with crime survivors (and as previously noted never see their clients for more than three sessions), all highlighted this beneficial aspect.

4.2.2 Volunteers experience the work as rewarding and fulfilling

All respondents stated that they found the work to be rewarding and fulfilling. Again, this theme was experienced as being enduring and long term in nature. Like the previous theme, this speaks to a sense of achievement and an ensuing sense of satisfaction experienced by participants when assisting to reduce the suffering of others. These two themes are inter-related in that through perceiving the support they offer to crime survivors as being beneficial, the volunteers experience a sense of reward and fulfilment. However, the theme of reward and fulfilment encompasses more than just the interaction between volunteer and crime survivor, as is indicated by the following series of quotes. Here, one of the volunteers describes her experiences as being rewarding on a number of different levels: from working with the crime survivors to the contact and support she has with her fellow volunteers, as well as feeling a greater sense of connection with her community:

“...it’s [the work] been quite inspirational for me, its’ been quite rewarding because I’m interested in psychology and always have been. I’m also interested in being hands on, being able to see the difference it [the work] can make...I find it extremely rewarding to be able to see the difference that you can make in a person’s life in just one hour, through just listening.

We have a tremendous group of volunteers and just to see what we give each other is superb. So, and you feel part of belonging to something that’s really worthwhile and that’s an incredibly rewarding feeling.

I’ve learned a lot about the community that I never knew before. One can become very blinkered, and I’ve met a lot of people through what I do, so that’s been rewarding.” (P1)

With regard to the existing literature these feelings of reward and satisfaction experienced by the participants are consistent with the outcomes of earlier research (Kassam-Adams, 1999). The sense of satisfaction experienced by care workers as a result of assisting in the alleviation

of another's suffering is known as compassion satisfaction, and serves as a protective factor against the development of compassion fatigue (Figley, 2002).

Five of the participants in the current study expressed a long-standing interest in psychology and six respondents described supporting survivors of crime and contributing to their communities as something they felt very passionate about. One volunteer explained:

“I would like you to know that this kind of work is in my blood, I like it a lot. Sometimes I miss being there [at the police station] and I just go there and walk around – I like (*emphasis added*) it. My friends wouldn't believe me when I said I don't get paid, they can't believe it! But I just like it so much.”
(P12)

Another said:

“I think all my experiences here in this police station and [the] whole victim support thing have been, even if it has been very traumatic for the client involved, I've always felt very strong and I've felt that my place is here.” (P10)

Individuals who choose psychology as a career have been found to be unknowingly motivated by a variety of psychological needs including a desire to be affirmed by others and a need to feel a deep connection with people (Sussmann, 1992). Maeder's (1989) hypothesis as to why therapists select this career path maintains they do so, consciously or unconsciously, by the promise of filling a position of authority with their client's dependent on them for help, by wanting to appear benevolent or in the hope of helping themselves through helping their clients. Another frequently noted theme in the existing literature on this topic, is that therapists have a strong need to understand their own and others behaviour (Farber, Manevich, Metzger, & Saypol, 2005). It is possible that the volunteers' attraction to this kind of work fulfils similar psychological needs within themselves. Fulfilment of these needs may then enhance their self-concepts and thus serve to further motivate them to continue volunteering.

4.2.3 Personal growth and development

Nine of the 12 respondents said that working with survivors of crime had led to personal growth and development in their own lives.

Self insight is one the areas in which five of the respondents felt they had grown as a result of their volunteer work with VEP. One of the respondents reflected:

“I think it’s changed me because I was a very hard person before I was doing this, even at church when I used to do mentoring or counselling. I am very hard, very practical and very realistic you know. But working with victims, it’s almost like bringing the – putting the emphasis on being empathetic you know, being patient and having more self control, because I used to lose it very quickly with people. So it has changed me in a sense where I became a bit more wise and contented...and more understanding. I think volunteering has influenced my opinion and it’s really, really changed my outlook on life with regards to others. Yes, not thinking the worst, but always thinking the best. So yes, that’s what it has done.” (P7)

Whereas other participants noted more specific personality traits that had developed, their observation of these particular aspects also indicates a certain level of self insight. The most common form of growth and development, described by seven of the participants, was that of being more understanding of and empathic towards others. One volunteer commented that:

“For me as a person it changed me a lot. It changed me a lot because I could put myself in their [the victims’] shoes and try and deal with it from their point of view and how they felt.” (P5)

Half of the sample (six participants) also noted that they displayed increased levels of patience and tolerance for others.

“...my worst characteristic is impatience and not tolerating fools gladly. I can see how things should be done. So it has been very good for me to temper that impatience and to learn to relax. To listen and not to, in anyway, be affected by time. So that has been very good for me.” (P11)

Other types of growth and development mentioned were (in order of frequency): skills development (four participants), increased self confidence (three participants), more social contact (two participants), finding new direction in life (two participants) and enhanced inter-personal relationships (one participant). These findings are similar to the types of growth described by the therapists in Arnold et al.'s study (2005) on VPTG, which in turn was similar to the results of other studies on post traumatic growth amongst direct trauma survivors (Tedeschi & Calhoun, 1995). The therapists' description of growth in Arnold et al.'s (2005) study included: an increased degree of tolerance, understanding and compassion for others, as well as improved self-insight. They reported that these improvements then led to improvements in their inter-personal relationships. Some of the therapists also noted an increased appreciation of human resilience which led them to feel more hopeful about the future, which was not specifically noted by any of the VEP volunteers in this study. In the study by Arnold and colleagues (2005), three quarters of the clinicians also reported that their trauma work had developed their spirituality through witnessing their clients' spiritual and existential growth. Spiritual development and an increasing respect for human resiliency were also outcomes noted by trauma workers in research by Kassam-Adams (1999) and Schauben and Frazier (1995). None of the VEP volunteers noted any changes to or enhancement of their spiritual belief systems, however many of the volunteers noted that their faith assisted them in coping with and making sense of their vicarious exposure to trauma. A lack of growth in this area may be due to the volunteers' limited interaction with each crime survivor, as the clinicians in Arnold et al.'s (2005) study reportedly experienced gains in their spirituality as a result of their ongoing engagement with their clients.

One of the participants noted that it was difficult for her to pick out which aspects of her growth and development were directly attributable to her experiences at VEP and which were due to other factors, such as growing older or as a result of her own personal struggles throughout her life, or which were a combination of these factors. This is consistent with existing research where studies involving therapists and direct survivors of trauma also note participants' difficulty in differentiating between personal growth as a result of a traumatic event or simply as a result of their overall life experiences (Arnold et al., 2005; Tedeschi & Calhoun, 1995). Therefore, some of the positive responses reported by the sample may not solely be a result of their trauma work experience and may reflect the volunteers' general personal growth over time.

Of the three interviewees who reported no growth or development as a result of their volunteering efforts, two had been volunteering for less than one year, which possibly speaks to the more long term nature of this theme. The third volunteer, despite feeling a sense of reward and fulfilment in relation to his volunteering, appeared quite negatively affected by his experiences at VEP. This was expressed through his concern regarding the inadequacies of the criminal justice system, his complaint that the local police often displayed a disregard for his privacy, and that of his family, by directing people to his house for counselling, and his diminished empathy for the victims of certain crimes. The researcher also considered it noteworthy that the participant was open about the fact that he chose to ignore the boundaries recommended by the victim support training, firstly by giving the crime victims his personal telephone number and encouraging them to call him anytime, secondly, by seeing them more than the permitted three times and finally by visiting them at their homes. By choosing to ignore these boundaries the respondent could over-extend himself putting himself at risk of developing negative psychological consequences. Overstepping boundaries can also cause his clients to become overly dependent on him which could lead to more problems. It was not only what the participant shared but the level of anger that was evident throughout the interview that was cause for concern to the researcher. We can only speculate as to the degree to which the abovementioned factors, or the existence of other factors, impacted on this volunteer's self-reported absence of growth, but it is important to note that he had such a different experience to the other participants.

4.3 Psychological Impacts Considered both Positive and Negative

4.3.1 Increased awareness of safety and security risks

Participants' responses surrounding their awareness of the prevalence of crime in their area defied simple categorisation as either positive or negative. While eight of the 12 respondents reported being more conscious of the risks to their own physical safety and that of others due to crime in their area, their perceptions as to whether this was a positive or a negative consequence varied. Three of the respondents considered their increased knowledge about their community, crime levels and crime prevention strategies as being a positive impact of their VEP work, while another felt that being informed carried with it both positive and negative aspects:

“Sometimes I do worry that I know too much [about the crime levels], but then other times I think at least I know what’s going on, so I’m informed and I can make informed choices.” (P8)

Another two respondents felt more cautious in their everyday lives but that they did not feel fearful or paranoid about the threat of crime. One commented:

“You know it hasn’t made me paranoid but it has made me more aware, you know at night, so many people have had that experience, just being more cautious and aware.” (P3)

Another volunteer said that there were times in the past, particularly during periods of political instability in the country, when she felt scared being at home alone and found herself being overly cautious, but that at present she no longer lives in fear of crime. However, this does indicate that at times increased knowledge about crime activity in ones community may restrict a person’s normal activities or behaviours. Another volunteer who claimed not to feel restricted contradicted herself when she said:

“...but it doesn’t make me overly vigilant or no I am not going to do this. I don’t stay in the house on my own though, I’ve got quite a large spacious open plan place.”

One mother was particularly fearful of anything happening to her teenage daughter:

“I am worried about [some of the cases I see]...And I used to think about my little girl when she was 13 years old. When I had a case of rape with children of her age it used to be a nightmare. It makes me scared and nobody wants to make her child scared...I make it a story for her, I just change the story at the end – a story but not a nice story. I don’t know what to say but that is what I am doing to her. If I face a case like that I come home and say: You know what I am coming from a friend she told me this and this and that. Just to make her careful.” (P12)

A further two respondents commented that they or their colleagues were sometimes fearful while volunteering, especially if they had to be present at a crime scene.

“...especially when it’s [the crime scene] in an impoverished area you know – you do not feel safe, that’s number one, although SAPS is with you...And so you will always be alert and vigilant and watch every move. You feel a bit on edge while you try and assist and support those who have maybe lost someone.” (P7)

According to McCann and Pearlman (1990), in their constructivist self-development theory on vicarious trauma, therapists who are exposed to regular accounts of how their clients’ safety has been violated may experience an increased sense of vulnerability in their everyday lives, particularly if they have a strong personal need for safety. It seems that for some respondents, detailed knowledge of neighbourhood crime has led to feelings of increased anxiety and more cautious behaviour. However, it must be noted that these reports of increased vigilance by some of the volunteers should be viewed within the context of living in a country beset with high levels of criminal violence. This heightened vigilance may be indicative of an awareness of the very real criminal threats that South African citizens face rather than being viewed as an overly anxious countertransference to supporting victims of crime (Ortlepp & Friedman, 2002).

4.4 Factors which may be associated with Negative and Positive Psychological Impacts of VEP work

The participants provided information on factors that were perceived to influence volunteer’s propensity to develop negative or positive psychological consequences as a result of their engagement with traumatised populations. Some of these factors were consistent with the existing literature and others were unique to this specific sample and the research context. These factors constituted four different categories, namely: training and experience, organisational processes and support structures, partnerships with other organisations, and individual factors. Each category is described and discussed below.

4.4.1 Training and experience

The first of these categories involves the training that volunteers receive to prepare them for their role. Five of the participants noted specifically that they felt equipped once they had completed the training, which ranged from anywhere between two and twelve sessions,

depending on which police station they were volunteering at. There are no standardised training programmes recommended by government, or funds specifically allocated for the training of volunteers. The responsibility of arranging training with an NGO or creating an „in-house’ training programme is left to the co-ordinator(s) of each VEP branch (Department of Social Development, 2009; Nel & Kruger, 1999).

Seven of the respondents had, through their own efforts, enrolled for additional training in counselling skills.

“...or I go myself to the NGO’s when I just hear or somebody just calls me or I just look in the newsletter and see ok FAMSA’s having a training course of some [sort] – then I just go.” (P4)

“Yes, as far as I know at the time [the initial 2-day basic training prepared me adequately], because when you’re doing something like this, you’re not quite sure what you are going to encounter anyway. And I have taken myself off and done numerous courses with FAMSA mainly...I self fund it...I did a two-day workshop on trauma debrief and a domestic violence one...the perpetrator one...” (P10)

Some of these workshops were provided free of charge, through various government and non-governmental agencies, to a few of the volunteers. However, the seeking out of additional training by more than half the sample may speak to a need for more advanced training to be made available. The additional training sought independently by the seven participants included: SACAP counsellor training, domestic violence training, and trauma debriefing workshops. It is interesting to note that three of the seven respondents who attended additional training courses also felt that the initial training they received had equipped them adequately enough for their role. Perhaps, for some volunteers, an initial training course that includes too much information may be overwhelming and it may be more advantageous to offer additional workshops at a later stage in their volunteering experience.

In line with this, two of the respondents felt there was a need for refresher courses or workshops. One said:

“[I would enjoy a refresher workshop on] victim empowerment...it is when we deal with a victim and how we should speak to [the] victim and how to address their problems and counsel the victim through the process and that...”

(P5)

Another two respondents expressed concern that the training they received did not include information on how to support child victims of crime and felt that were they to receive such training it would benefit the service they offer tremendously. It is also interesting to note that the cases volunteers continued to be concerned about long after their completion were those involving children. Perhaps more extensive training in this area would better prepare volunteers to deal with the emotional and practical aspects of such cases. As previously mentioned, one of the respondents had assisted with the supporting of crime survivors for a number of months without the benefit of any trauma specific training. Insufficient training is considered to be a risk factor for burnout, vicarious trauma and STS (Adams & Riggs, 2008; Arvay & Uhlemann, 1996; Follette et al., 1994; Maslach & Leiter, 1997, Ortlepp & Friedman, 2002). Only one volunteer noted that, while they felt ready for their support role, it was only because they had an existing SACAP counsellor qualification and, from what they could see, the two day training that new volunteers at their station received was not always sufficient to prepare them for their role as supporters of victims of crime.

“[The two day training] was a good introduction to it but what I can see from the others...the two day training is not really enough for anybody to learn anything...” (P8)

Beyond formal training, four of the interviewees found that their monthly meetings and group debriefings were opportunities for mutual learning as well as support. All four respondents were based at the same station where the debriefings were run by SACAP trained counsellors. It is possible that the availability of a trained counsellor enhances the value of these meetings for them. Research by Neumann and Gamble (1995) shows that inexperienced counsellors who do not receive clinical supervision are more at risk of developing negative consequences as a result of their engagement with traumatised clients. In addition, Linley and Joseph (2007) found that therapists who receive clinical supervision report more personal growth.

Another four participants believed that their level of experience served as a protective factor against potential negative outcomes. This perception is consistent with the research of Chrestman (1999) and Pearlman and Mac Ian (1995), who found that more experienced therapists displayed fewer negative symptoms than their less experienced counterparts, but is in contradiction to research findings by Arvay and Uhlemann (1996) and Munroe (1991, cited in Arvay, 2001) who reported that trauma therapists with a greater number of years in the field presented with more intrusive symptoms than those who had fewer years of experience in the profession.

4.4.2 Organisational processes and support structures

The participants perceived issues surrounding VEP's organisational processes and support structures to contribute to both positive or negative psychological impacts on volunteers. Each branch of VEP is structured according to how the co-ordinator and/ or volunteers wish the programme to run, and while there are recommendations as to the support that should be offered to the volunteers, there are no specific guidelines in place (Department of Social Development, 2009; Nel & Kruger, 1999). The majority of the sample (nine of the 12 participants), across all the stations included in the research, noted that an insufficient number of volunteers negatively affected the service VEP offered. This not only impacted on how soon a victim could be seen after a crime but also affected the level of support and supervision offered to volunteers. Four respondents noted the limited access to, or complete absence of, debriefing services. Professional debriefing and supervision is only available to volunteers if mental health professionals offer their services free of charge, as no budget is available for the provision of this service. Under ideal circumstances it would be beneficial for VEP volunteers to receive debriefings and guidance from professionals so as to prevent negative psychological consequences of trauma work (Nel & Kruger, 1999). However, at the time of the interviews volunteers at only one of the five stations included in the study had access to a professional psychologist, and this access was limited as the psychologist was only available telephonically but did not attend the group monthly meetings and debriefing sessions. A second station had a number of volunteers who are qualified counsellors trained at SACAP and these volunteers led the monthly meetings and group debriefings. The volunteers at the remaining three VEP branches relied on the support and experience of their fellow volunteers when dealing with difficult cases. One of these four respondents, who

volunteers at a station where the monthly group debriefings are led by fellow volunteers who are SACAP trained counsellors, said:

“...we have a wealth of volunteers and knowledge and qualifications, we used to have a clinical psychiatrist who’d sit in, who wasn’t part of the dealings but she would listen and advise. For me personally I liked that. I found it was much more – made it more professional for me. And I think because what we are dealing with is huge. It really is. So for me I think it should actually be a mandatory thing...I prefer to have a proper [psychologist], because in a group, sometimes it’s more difficult to do that. I’m not a big group person, so I tend to hold back a bit.” (P10)

Research has found that therapists and caregivers who receive supervision and/ or support in their work are less likely to succumb to negative outcomes (Figley, 2002; Neumann & Gamble, 1995) and are likely to experience greater levels of self-reported growth (Linley & Joseph, 2007). This would suggest that support in the form of professional or peer supervision can assist in maintaining the emotional well being of volunteers and in turn ensure healthy support for the survivors of crime. It is therefore encouraging that the majority of the sample (10 of the 12 participants) felt that they received a good deal of emotional support from their fellow volunteers and four participants commented that their monthly meetings were a space in which they received and gave support to their fellow volunteers and viewed these gatherings very positively. Following on from this, seven of the interviewees experienced a strong sense of group cohesion and a feeling of belonging within their VEP group and another seven respondents, spread across four of the five VEP stations, noted that there was good teamwork amongst volunteers which they felt positively impacted on their VEP experience. The existing literature notes that a lack of support from colleagues and/ or supervisors, as well as any conflictual relationships in the workplace, exacerbates the development of burnout (Maslach & Leiter, 1997; Maslach et al., 2001). Therefore the participants’ positive perception of their relationships with the other volunteers may serve as a protective factor against the development of negative outcomes and can enhance the potential for positive consequences.

As previously mentioned, volunteers considered the impact due to direct exposure to have a more severe impact on their well being than indirect exposure to their client’s trauma.

Volunteers are most likely to be directly exposed to trauma at a crime scene. While the VEP Policy Draft (Department of Social Development, 2007) advises that survivors of crime be provided with emotional support and practical support immediately after a crime has occurred (i.e. at the crime scene where possible), this may not be in the best interest of the volunteer. A participant who serves as one of the co-ordinators for her VEP branch expressed concern about the negative impact exposure to direct trauma has on her fellow volunteers.

“And it generally happens [that volunteers are called out to a crime scene] when there is either a murder or a, you know, a very serious crime, a very serious robbery, where there really is trauma. Ja, so we probably have on average, maybe one call out to a scene every two months or something you know. So it’s very rare but the rule is we do what we do in the room at the police station we don’t go out into the community and even if we are called to the scene of a crime we have to obey crime protocol and we actually should not go into the place where the crime was committed, and certainly if somebody has been killed or if there’s a lot of, a lot of mess, blood or anything around we don’t want our volunteers to go anywhere near it. We don’t want them to see that sort of thing. Unfortunately sometimes it has happened. I mean for example one of our volunteers got called to the scene of a suicide once and the body was somebody who’d hanged himself. And the body was still there and she didn’t know so...and that was a big shock. So we try to absolutely avoid that sort of thing where possible but our volunteers if they are called to give support they need to make sure that they don’t go in and traumatise themselves.” (P1)

4.4.3 Partnerships with other organisations

A third issue that was raised by participants involved other organisations with which VEP is in partnership. As previously mentioned, all VEP branches included in the study are located within the SAPS station of the area they service. VEP volunteers are made aware of crime victims who require assistance and support by SAPS personnel. The volunteers at all stations included in the research project also have access to the SAPS case book to ensure all cases are followed up on. While more than half the respondents (seven of the 12) experienced their relationship with the police as being something that could be improved upon, four of the

seven still rated the relationship as good overall. In addition to the four, another two participants (who were not part of the aforementioned seven) experienced their relationship with the police as entirely positive and felt it needed no improvement. Amongst these seven aforementioned respondents, four felt there was a lack of communication between the police and VEP, two maintained that the police did not understand the volunteer's role and three volunteers perceived SAPS view of the VEP as negative. The seven respondents were spread across four of the five stations included in the research project showing that this issue is not limited to one area.

“It's more communication. I think there is a long, long way to go with the police. In terms of the volunteers, connecting and working more together. I think it will be fantastic if we could at least have two regular constables in on our debriefs, and maybe they could help I mean they could also talk about some incidences or have an opportunity to do so. It would be nice to be sort of slightly amalgamated, we're all coming from the same side...But I think communication would be, is the main thing. In terms of how we all communicate with each other, more time with the police to get to know them a bit...” (P10)

“The major problem with the police station is communication from the top down in terms of victim support as to what our role is. Sometimes the police officers do not always know what our role is where they are concerned.” (P4)

“The one thing I think is the lack of interaction with the police at the station; I would like to know them a little better. Up to now being here almost one and half years I know some of them and I greet them...some of them are very friendly and some of them are very offish – so I am never really sure how they view victim support. I am sure some of them view it as a nuisance because I must fill in a form and now that is extra work and others see it as support but generally I don't think it's really seen as being very helpful, that's just my feeling – it's seen as something that has to be done.” (P8)

Difficult relationships like the one described above are considered to be one of the organisational risk factors for burnout (Maslach et al., 2001).

Almost the entire sample, 11 of the 12 participants, expressed dissatisfaction with some aspect of SAPS' work performance. When asked what their main frustrations were one of the participants responded:

“And the police do have a tendency to take the easy way out and say I'm sorry but there's no volunteer available which is not true because there is always a volunteer available. I have difficulty dealing with situations where the police are perhaps not doing a brilliant job. They are fallible as we all are, but you know we're there to actually help them and it's pretty annoying when they don't call us in and they could.” (P1)

Another volunteer said:

“...if we not getting cases or the police are not giving us all the facts then we can go to them [the Community Policing Forum]. If we feel that the case we're dealing with needs more police intervention we can go through the colonel of the police station.” (P7)

The volunteers' negative perception of the police's performance could leave them feeling unsupported and concerned that the crime survivors may be exposed to secondary victimisation. According to Maslach (2003a) human service providers could end up feeling overburdened and exhausted if they feel totally responsible for resolving their clients' difficulties.

Seven of the 12 respondents expressed concern over the lack of free referral services within their areas and the limited effectiveness of existing agencies. For example, according to one participant:

“It's very difficult, it depends if they can afford to go somewhere or not. Because there's very little in the way of state subsidised places to send them to so...ja, it depends on what it is but we've got a handbook – but we find the numbers keep changing and you've got to keep on following up on them. But we have a few places that we can refer them on to...”

Considering that the VEP volunteer's role is simply one of providing initial support to survivors in the aftermath of a crime and then to refer them on to other agencies for further assistance, this concern could have negative consequences for volunteers. If they are only

trained to offer a supportive debriefing service but feel uncertain whether the referral agencies will be able to assist their clients further they may feel pressured to offer assistance beyond their level of expertise. As previously noted trauma workers with insufficient training, who are providing services they were not trained for, could be placing themselves at risk of developing negative outcomes as a result (Adams & Riggs, 2008; Maslach et al., 2001; Ortlepp & Friedman, 2002).

4.4.4 Individual factors

Other issues raised by the participants that they perceived to compound or enhance the negative and positive consequences of volunteering included: the maintenance of boundaries between their volunteering and personal lives, the level of personal support they receive, their own personal experience of trauma and/ or crime, their degree of self care, their current experience of challenging personal circumstances, their self insight and lastly the volunteers' perception of the work as difficult. These issues were categorised by the researcher as factors related to the individual, rather than to clients, the organisation or external agencies.

4.4.4.1 Boundaries

Nine of the 12 respondents raised the topic of boundaries. The first three respondents noted that their ability to detach from and to maintain boundaries in their support work served as a protective factor against their developing negative psychological responses to their work. A caregiver's ability to detach from their work has been identified as one of the protective factors against developing STS/ compassion fatigue (Figley, 2002). The remaining six respondents shared that they sometimes had difficulty maintaining boundaries in their work. While the ability to maintain boundaries can be attributed to individual personality styles, four of the six respondents commented that their communities knew of their volunteer work at the police station and sometimes approached them directly for assistance in their "off duty" time. The police themselves also exacerbated this situation by directing people to the volunteers' homes or giving out their telephone numbers to people requiring assistance. A volunteer said:

“...because if you are at the police station you tend to have people know exactly where you stay, cause sometimes the police comes and fetches you sometimes twice or thrice in one day. So people will get to know there is someone living there or the police station will tell the people to come to your house. I don’t have a problem with that but keep them at the police station until [I can get there]...” (P4)

Another volunteer cautions:

“...and they know me very well at the community so they used to come to my house and I say no not here... there is a boundary. They don’t have to come to our houses, they don’t have to call us, we don’t have to give the numbers – we do this to keep ourselves safe.” (P12)

4.4.4.2 *Personal support*

Four of the respondents mentioned that they had strong relationships with their partners and six participants said that their partners and/ or families were supportive of their VEP volunteering. The respondents emphasised the positive impact this support had on their volunteer work. One of the interviewees shared:

“Well my husband is very supportive, and my family is very supportive... he [the husband] will be there to assist me, open the gate for me ,cause I’m too slow. He doesn’t like the victim to wait, he wants me, if that phone rings, get dressed, be ready on that stoep. I must wait for the van; the van mustn’t wait for me.” (P2)

Figley (2002) in his writings on secondary traumatisation notes that social support serves as a protective factor against the development of STS/ compassion fatigue, and is associated with positive well being in trauma workers (Linley & Joseph, 2007).

4.4.4.3 *Personal experience of crime and/ or trauma*

This topic has received much attention in the existing literature on the effects of trauma work on human service providers. It has been suggested that a personal history of trauma may

serve as a catalyst for an individual's entry into human service work due to their greater understanding of and empathy for another's distress (Pearlman & Saakvitne, 1995a). However, research findings as to whether a personal history of trauma increases a trauma worker's susceptibility to developing negative responses to the work are conflicting (Follette et al., 1994; Ghahramanlou & Brodbeck, 2000; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). Some studies indicate that a history of trauma can also predict self reported personal growth amongst therapists (Linley & Joseph, 2007). With regard to this particular study none of the volunteers consciously felt that their own experience of crime had led them to volunteer for VEP (though of course such motivations may be largely unconscious), although six participants acknowledged that their personal experience of crime and/or trauma enabled them to better assist others with their traumatic experiences. However, five of these six participants also reported that working on cases that mirrored their own personal trauma sometimes raised difficult emotions for them.

For example one participant who lost her child in a car accident explained:

“There have been a number of incidences where children have been killed in car accidents where I was quite involved in one of the cases and the other one was a big debriefing, a situation very similar to my own experience which was – I mean I handled it – it was painful and I was touched by it, I feel sad but I can contain my own emotion...I feel quite qualified to do it, because I know I will not try to patch up and say oh don't worry it will be ok or the child's in a better place, all these kinds of things. I would never do that and I trust myself to never do that...” (P8)

4.4.4.4 *Self care*

As has been highlighted in the interview extracts throughout this chapter some of the cases that the volunteers deal with are very traumatic. It is vital that volunteers utilise effective coping strategies to protect themselves from the negative consequences of their supportive role (Griffiths et al., 2011; Mason & Nel, 2009), in order that they can be in the best possible position, psychologically, to assist survivors of crime. Six of the respondents supplied information, unprompted, regarding their self care strategies, which ranged from spending time outdoors, to reading, to regular time spent with friends.

“...but my main thing is running. I get out. I started running two years ago. Talking, I’m a real talker, I love talking to my mates and friends. I don’t discuss what’s going on here at all obviously, but they know I do that. And yeah, I talk my feelings out. I talk to my kids, but appropriately. Yeah, and my husband and I talk a lot.” (P10)

“I go up the mountain every weekend and I have my flower arranging. I go to the Mountain Club, the Historical Association. I go to the Royal Engineers’ lectures; I go to Astronomy; I go to the Historical Society and the Natural History Society to the Museum lectures. I have friends round and I go to friends for dinner. I try to send e-mails to family that live far away. I read books...” (P11)

4.4.4.5 *Difficult personal circumstances*

Four of the interviewees were going through trying personal circumstances at the time of the interviews. These difficulties ranged from unemployment to divorce to a death in the family.

“And nobody knows that I am going through a thing [divorce] – they always see me smiling. Nobody knows what I am going through. But there is sometimes when I sit and just start crying.” (P6)

Figley (2002) cautions that caregivers simultaneously dealing with traumatic cases and disruptions in their personal lives may become increasingly vulnerable to developing STS/compassion fatigue. One of the four respondents had reduced their involvement at VEP due to the increased stress at home.

“You know for all this couple of years he [husband] has been very fruitful but when he lost his job, it became... then I couldn’t you know concentrate a lot on the trauma room as I did in the past...now that my husband is unemployed, my eldest son is not working, the burden’s a bit, a lot, and that’s why I can’t spend a lot of time at the station, as much as I want to. My husband has a little part-time work now...for us to put some food on the table which is not much but we try to cope, we try to cope.” (P2)

A second respondent, despite experiencing trying circumstances in their home life, seemed to be managing well. Both this participant and P2 received a high level of emotional support at the stations where they volunteered, which could account, to some degree, for their ability to cope with these multiple concurrent stressors. However, the remaining two participants displayed a variety of symptoms, including difficulty in regulating emotions when dealing with survivors, overstepping boundaries, as well as reduced tolerance for certain victims of crime. These suggested they might not be coping with the strains of their volunteering efforts combined with their personal hardships. The following quote highlights the conscious overstepping of boundaries by one of the interviewees.

“I will say let’s go to the beach. Sit down with them and you will be surprised what it does. It shouldn’t really be done like that because the correct thing is to see them at the police station, but that is how I do it. Or you could even say: „Come let’s go for coffee or supper’, or whatever the case may be and then you take it from there. Bearing in mind of course that you keep your distance as far as possible because if you don’t do that you might just get something that you don’t want that’s another thing it’s a little bit difficult you know. People tend to get attached to you, like a leech...” (P4)

4.4.4.6 *Volunteers perceive the work as difficult*

Three respondents voluntarily noted that they found their VEP work difficult. This perception may indicate that these three participants are grappling with the nature of their volunteer work. All of the three volunteers displayed STS and/or vicarious trauma-like symptoms. Interestingly, all three respondents also volunteered at the same station, where although they had monthly meetings where they could draw support from one another, there was an absence of mental health professionals to assist with supervision. The three respondents were on call between two and seven days per week whereas most of the volunteers at the other police stations are available for shifts one day per week or once a fortnight. It would seem that the three respondents in question are all on call very often when compared to the rest of the sample. As previously noted trauma workers with larger case loads may present with more negative sequelae than those with lighter case loads (Chrestman, 1999; Kassam-Adams, 1999). Furthermore, Maslach (2003a) cautions that for human service providers it is not just

the number of cases that impacts on their level of functioning, but the nature of cases that make up that caseload. Working with clients who show little to no improvement, or who repeatedly return with the same problems, can have a negative impact on a service provider's stress levels, placing them at risk of developing burnout. In addition, two of the three were experiencing difficulties in their personal lives (Figley, 2002) at the time of the interviews. All these cumulative factors place these individuals at a greater risk of developing negative outcomes as a result of their engagement with traumatised populations.

4.5 Summary

In conclusion the findings of this study show that supporting survivors of crime has both pathogenic and salutogenic consequences for the victim support volunteers. The themes that emerged from the data describing these consequences largely agree with the existing literature surrounding the positive and negative psychological impacts for therapists who engage with traumatised populations. These themes included: sleep disturbances; feelings of despondency in relation to the work; avoidant behaviours; difficulty regulating emotions; reduced empathy and tolerance for certain types of crime survivors; witnessing benefits to crime survivors; volunteers' experience of the work as rewarding and fulfilling; personal growth and development; and an increased awareness of safety and security needs. An additional theme, continued concern for, or unwanted thoughts about, past clients and cases also described a negative psychological impact but was found to be specific to this research context, and was not accounted for in the existing literature. Participants also reported factors that were considered to have an impact on their negative and positive psychological responses to their support work. These factors included: their ability to maintain boundaries between their work with crime survivors and their personal lives, the level of support received from friends and family, their own personal experiences of crime or other trauma, their level of self care, trying personal circumstances and finally their perception of the work as difficult. Aspects of these factors that were found to be specific to this particular sample group and research context were: limited access to, or an absence of professional supervision; a somewhat challenging relationship with SAPS; and limited availability of referral agencies, all of which could possibly enhance the negative consequences of working with traumatised individuals for volunteers.

CHAPTER FIVE: CONCLUSION

The concluding chapter will provide a synopsis of these findings, and recommendations to further protect victim support volunteers from the potential negative psychological impacts of their support role and to promote the possible positive outcomes of their volunteering experience. The limitations of the study will be considered as well as the relevance of these findings for victim support branches included in the study and branches throughout the country. Suggestions for further research surrounding this topic in a South African context will also be offered.

5.1 Summary of findings and recommendations for VEP service

The purpose of this study was to explore the impact of counselling survivors of crime on victim support volunteers. Although almost all of the participants reported some negative psychological impacts experienced as a result of the work, these impacts were transient for the majority of the sample. The fact that volunteers support crime survivors on a part-time basis and so are therefore not exposed to indirect trauma daily may contribute to their low level of secondary traumatisation. The negative impacts described by the research participants were accounted for in the existing literature on vicarious traumatisation (Figley, 1995; Maslach et al., 2001; McCann & Pearlman, 1990; Wilson & Lindy, 1994) and include: sleep disturbances; feelings of despondency in relation to the work; avoidant behaviours; difficulty regulating emotions; and reduced empathy and tolerance for certain types of crime survivors. However, the theme of continued concern for, or unwanted thoughts about, past clients and cases was unique to this sample, and is not encapsulated within existing constructs of negative impacts of trauma counselling. It is possible that preoccupation with the well-being of former clients is a result of contextual factors such as the limited number of sessions volunteers have with clients and the absence of referral agencies.

However, the overriding feeling of the respondents regarding their volunteer work was positive. While limited research exists regarding the salutary benefits for those who support traumatised populations, the outcomes of this study are consistent with those of research that has been conducted thus far (Arnold et al., 2005; Figley, 2002; Hernández et al., 2010; Kassam Adams, 1999; Schauben & Frazier, 1995). The positive outcomes experienced by the research participants were as follows: the witnessing of benefits to crime survivors; their

experience of the work as rewarding and fulfilling; and personal reports of growth and development. Participants also noted their increased awareness of safety and security needs which some considered a positive consequence of the work, but others considered to have both positive and negative aspects. That therapists and counsellors can experience both pathogenic and salutogenic outcomes, as a consequence of working with traumatised clients, is supported by existing research (Arnold et al., 2005; Mason & Nel, 2009).

Factors raised by the participants that were thought to impact on their negative and positive psychological responses to the work were: training and education; organisational processes and support; partnerships with other organisations; and individual factors which included their ability to maintain boundaries between their work with crime survivors and their personal lives, the level of support received from friends and family, their own personal experiences of crime or other trauma, their level of self care, trying personal circumstances and finally their perception of the work as difficult. The role of these factors is largely accounted for in the existing research (Figley, 2002; Linley & Joseph, 2007; Maslach et al. 2001; McCann & Pearlman, 1990; Wilson & Lindy, 1994). However, there were aspects of some of the abovementioned factors that were specific to the research context: limited access to professional supervision; a challenging relationship with SAPS; and limited availability of referral agencies to provide further practical and emotional assistance to survivors of crime

The three participants who had been directly exposed to crime scene trauma all felt the negative impacts they experienced as a result of this exposure to be far more severe than any effects experienced as a result of vicarious exposure to the traumatic accounts of crime survivors. It is noted that participants of the branches included in this study are seldom called out to crime scenes, unless a particularly serious crime has been committed. However, it may be advisable to do away with this practice entirely so as to protect volunteers from the possibility of being directly exposed to traumatic images and the more intense negative responses that may ensue, which may limit their capacity to effectively counsel survivors.

In relation to the respondent who experienced negative symptoms as a result of her involvement in four traumatic cases one after the other, it may be advisable for victim support branches to implement a procedural rule restricting the number of cases any one volunteer can work on within a particular time period. At one of the victim support branches included in the study, all cases are first reported to the co-ordinator who then allocates the case to an available volunteer, in this way controlling the distribution of traumatic cases amongst the

team. This measure may prove difficult to institute when a branch has a shortage of volunteers and so it is suggested that regular recruitment drives be conducted to try and prevent these shortages as much as possible.

It is also recommended that volunteers have access to a mental health professional for group supervision. This recommendation is made after consideration of the findings of existing research studies (Linley & Joseph, 2007; Neumann & Gamble, 2010), comments made by some of the participants in this study, and in light of the fact that the participants who currently appeared most negatively impacted by their support work volunteered at a station where they had no access to professional supervision.

While the researcher perceived the majority of participants to have a good to excellent level of trauma-specific training, a number of the respondents noted the importance of access to on-going training to improve or refresh their existing level of knowledge and skill. Two participants specifically noted that they were ill-equipped to deal with child victims. Participants also reported that the cases they continued to be concerned about long after their completion were those involving children. Perhaps more extensive training in this area would better prepare volunteers to deal with the emotional and practical aspects of such cases. It is also recommended that training about domestic violence and substance abuse be included in the basic preparation for VEP volunteers as cases involving these issues seemed to evoke strong reactions in some of the participants.

A fairly consistent response across the sample, regarding frustrations experienced in their volunteer work, involved the challenging and somewhat difficult relationship the victim support volunteers have with SAPS personnel. The participants perceived the major issues as being a lack of communication between SAPS and the victim support team, a lack of understanding among SAPS personnel as to the role victim support plays, and a general negative or indifferent attitude amongst the police regarding the service the volunteers provide. One of the respondents suggested that having a SAPS representative at the monthly supervision meetings may assist in improving communication between the two groups as well as providing the police with a clearer understanding as to the purpose and value of victim support. In addition to this the researcher also recommends that the victim support teams develop a presentation for SAPS personnel at their branch in order to provide greater clarity as to their role, in the hope of changing the negative perceptions that some SAPS staff have regarding victim support.

5.2 Limitations of study and recommendations for future research

While a multiple case study design enhances the generalisability of results to existing theory, the small sample size can limit the transferability of the research findings to larger populations. Therefore, it may be necessary for a larger survey style research study involving victim support volunteers throughout the country to be conducted in order to confirm the results of this study. Furthermore, the representativeness of the sample was limited by the branch co-ordinators who responded affirmatively to my request to include their teams in the study, as well as by the fact that the researcher was unable to control for the propensity of some volunteers to choose to participate, and for others not to. It is thought that some respondents would choose to participate due to their positive experiences of being victim support volunteers, or possibly because they felt they were experiencing symptoms of secondary traumatisation, whereas others may have chosen not to participate for the same reason. Potential respondent bias suggests that the sample under investigation may not be representative of all victim support volunteers in South Africa. Also due to the sensitive nature of some of the subject matter, interviewing participants over just one session may have impacted on their willingness to share details of their more personal and distressing experiences. Due to the fact that the majority of the sample were not professionally trained counsellors, the intensity and quality of the responses were somewhat influenced by the respondents degree of understanding regarding psychological concepts and ways of thinking. Finally the largest limitation of the study was the exclusion of volunteers who had left the victim support programme. It is possible that their experience of negative psychological impacts prompted their departure from the victim support programme. Future research could attempt to make contact with ex-volunteers to extend on and strengthen the findings of this study.

In conclusion, victim support volunteers, and especially the branch co-ordinators, must be commended on the volunteering of their time and emotional energy in order to maintain this valuable service of support to the survivors of crime in their communities. It is hoped that this research will be of use to further protect these volunteers from the possibility of experiencing negative impacts as a result of their engagement with crime survivors, and will serve to rather enhance the potential positive outcomes.

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Appendix A: Interview Schedule

Section A: Contextual information

How long have you been volunteering as a counsellor at the police station?

Why did you decide to volunteer as a counsellor at the police station?

How does the programme at this police station run?

What training have you received for your role as counsellor at the police station?

Do you have any previous counselling experience?

How often do you volunteer in an average month?

What crimes are you most often exposed to in this work?

Section B: What has it been like doing this counselling work? Tell me about it.

Specific probes as needed:

How do you feel that your experiences of counselling survivors of crime have affected you or changed you?

How does your work affect you emotionally? What have you noticed about the feelings that your volunteer work brings up for you?

Have you noticed any physical changes in yourself since you started volunteering as a counsellor?

Do the stories that your clients tell you come back to you in any way outside of sessions? Tell me about this.

Do you feel that there have been any changes in the way that you view the world as a result of your counselling work?

Do you feel that your experiences have impacted on your relationships with others, either in your close relationships or with people you don't know well? If so, in what way?

Have you noticed any changes in your behaviour while volunteering as a counsellor? When did these behaviours develop?

Do you experience any frustrations in your volunteer work? Tell me about them.

What or who supports you in your volunteer work?

Trauma counselling can be hard. What keeps you doing this work?

What personal characteristics do you think are necessary to be able to do this work well?

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Appendix B: Informed Consent Form



Consent form

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Consent to participate in a research study:

Counselling survivors of crime: The psychological impact on volunteers

Dear volunteer,

You are invited to participate in a research study about the psychological impact of counselling survivors of crime. The research will be conducted by myself, a Clinical Psychology Masters student from the University of Cape Town.

If you do agree to participate in this study, you will be asked to take part in an interview. The interview will last approximately 1 to 1½ hours and will take place at a time and place that is convenient for you.

Participation in this study is voluntary. You may choose to discontinue your participation in the study at any time, with no consequence. You may also refuse to answer any question you feel uncomfortable with.

The information obtained from the interview will be anonymised. Your name and any other identifying information will be removed from the interview transcript. The interview transcript will only be seen by the researcher and the research supervisor, and will be kept in a locked filing cabinet only accessible by the researcher. The audio recordings will be stored on password protected computer. Once the thesis has been marked the recordings and copies of the interview transcript will be destroyed.

There is a low risk that the study will have any negative impact on you, and the interviews may provide you with an opportunity to reflect on and consolidate your experiences as a counsellor of survivors of crime. However, should you feel distressed by the interview process, the interview can be terminated. The possibility of a referral for counselling will be discussed with you, and contact details provided if required.

