INDIGENOUS TRAUMA VOLUNTEERS:

SURVIVORS WITH A MISSION

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Dissertation submitted in partial fulfilment of the requirements
for the degree of Master of Social Science (Clinical Psychology).

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January, 2004

ABSTRACT

There is a growing body of literature on the risk for secondary trauma amongst professional trauma workers. Nonetheless, there is scant published literature on the impact of trauma work on volunteers; particularly when such volunteers are indigenous to the highly traumatized communities which they serve. The study examined a group of parents (N=16) who volunteered in a school-based trauma support project in an impoverished, gang-ridden South African urban community in which they themselves reside. Aims were to 1) Explore the psychological impact of indigenous trauma volunteerism; 2) Explore volunteers' perceptions of costs and benefits of volunteerism.

Data collection was chiefly qualitative, using focus group and individual interviews. The Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales (Stamm, 2002) were administered in order to determine risk for burnout, risk for compassion fatigue and potential for compassion satisfaction. The Stressful Life Experiences Screening Short Form (Stamm, 1997) was administered in order to gather descriptive information regarding personal trauma histories. Project documentation was reviewed. Analysis and interpretation of qualitative data involved a combination of both etic (theory-based) and emic (data and context-based) techniques.

The volunteers' experiences were co-constructed in interaction with three settings: 1) Experiences of training and supervision were affirming and empowering; 2) Experiences of the school context were mediated by the degree of access and integration into the school environment; 3) Experiences of the community context were mediated by the dynamics of identification, role fluidity and inter-setting negotiation.

The primary cost of involvement was distress relating to limitations on capacity to help fellow community members with whom they strongly identified, and whom they felt intrapsychically, interpersonally and socially pressured to assist. These limitations included limited client resources, limited personal resources, limited occupational resources and limited systemic resources. Other sources of distress included context-related boundary management difficulties, institutional (school-related) stressors, difficulties in persuading children to disclose abuse and material costs of volunteering. Coping was facilitated by empowering training, supervision, peer support, and self-care practices. Benefits included acquisition of psychological, interpersonal and occupational skills, improved personal relationships, social support, validation, personal healing and role satisfaction.

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ACKNOWLEDGEMENTS

I am deeply grateful to Dr. Cathy Ward, my Cape Town supervisor, for her unfailing support and enthusiasm.

Many thanks to Mr Jan Knoetze, my Grahamstown supervisor, for his support and advice.

An enormous vote of thanks to principals, staff, learners and especially trauma support workers of schools in the Hanover Park/ Lansdowne Safe Schools cluster for agreeing to share their valuable experience and ideas.

I am grateful to all the trainers involved in the trauma support project, including Ms Nokuzola Mkontwana, Ms Thabile Mkhonza and Ms Emma Oliver of The Trauma Centre for Survivors of Violence and Torture (the Trauma Centre); Mr James Eckley (formerly of the Family and Marriage Society of South Africa (FAMSA) and now at the Trauma Centre), Mr Victor Daniels of FAMSA; Ms Diane Fine and Mr Toni Sylvester (private practitioners).

Special thanks to Ms Lane Benjamin of Community Action for a Safer Environment (CASE), the project coordinator and supervisor, and Mr Dave Pinchuck of the Athlone School Clinic for their generosity in allowing me to attend their supervision sessions.

Thank you to Ms Kim Foster for taking notes and tending the tape recorder in focus group interviews.

I am grateful to the Western Cape Education Department and to the principals of all the schools involved for allowing me to conduct this research.

My gratitude to Ms Margaret Anema, Mrs Joan Brokensha, Ms Michel Friedman, Ms Jan Webster and especially to Mr Dain Peters for their moral support during the writing of this thesis.

I am grateful to Themba Lesizwe, the South African Network of Trauma Service Providers, for financial assistance. Responsibility for views expressed in this thesis is mine and they are not necessarily shared by Themba Lesizwe. Themba Lesizwe is funded by the European Union under the European Project for Reconstruction and Development (EPRD).

CHAPTER ONE: INTRODUCTION AND BACKGROUND

"In Hanover Park, living is expensive and life is cheap."
(comment recorded at the District Six Museum and quoted by Abrahams, 2002)

1. INTRODUCTION

In a country so challenged historically and currently by violence, mental health service providers cannot meet the needs for trauma services. South African volunteers from under-resourced communities are increasingly involving themselves in supporting traumatized members of their own communities. This is valuable work, but there is growing concern, particularly in the international literature of traumatology and the local literature of community psychology, that such involvement may not be without its costs. The question thus arises as to what the costs may be to these volunteers. There is also some evidence in the international literatures of both traumatology and community psychology to support the possibility that there may be some benefits to such volunteers, but there is scant published research regarding *indigenous* volunteers' experiences of their involvement in community-based trauma work, or of their perceptions of their volunteer experiences and its benefits and burdens. This dissertation undertakes to explore the psychological impact of indigenous trauma volunteerism on the volunteers themselves, in order to gain a better sense of how they may be protected in their work and how their experiences may be enhanced.

2. A SCHOOL-BASED TRAUMA SUPPORT PROJECT IN THE CAPE FLATS GANGLANDS

Hanover Park is a coloured township[1] on the Cape Flats with a population of about 40 000 people (Goedgedacht Forum for Social Reflection, 1997). It is composed of a mix of large, derelict public housing units, small free-standing formal dwellings and informal shacks. 78% of household heads earn less than the household subsistence level of R10 000 per annum (Cape Metropolitan Council, 1997). 43% of adults have less than a Standard Six education, there is a

[1] By "township" I mean a neighbourhood that was created by apartheid, and was an area designated for black people (by which I mean all those formerly designated non-white under apartheid; this is descriptive terminology, and in no way implies my acceptance of these racial categories).

23% unemployment rate and 57% of households are overcrowded, with some houses holding up to 40 people (ibid.). According to residents and school staff interviewed (Moultrie & Ward, 2003) there are high rates of alcohol and drug abuse and sexual and physical violence and abuse, including domestic violence and child abuse and neglect. Hanover Park is one of the most violent parts of Cape Town (Cape Town, 2003), and at one recent estimate, 37 gangs were operating in the area (Goedgedacht Forum for Social Reflection, 1997). The township forms part of a group of police districts where the murder rate in 1999 was 8-25 per 100 000 (Cape Town, 2003). At Hanover Park clinic, there are new TB cases at the rate of 870 per 100 000, one of the highest figures for any area in Cape Town (Cape Town, 2001).

In early 2001, Hanover Park was caught up in an unprecedented wave of gang violence. Local schools were overwhelmed by the direct and indirect effects of this on the learners and on the institutions themselves, but support for schools and learners to deal with this trauma was inaccessible. The principals were organized in a cluster (together with a few schools in Lansdowne) through the Safe Schools project (an initiative of the Western Cape Education Department). They requested help from a group of non-governmental organizations (NGOs) regarding their needs for trauma support.

The NGOs offered to train a group of parents to provide support to learners on-site at the schools. Twenty-one volunteer parents were selected by the NGOs from a larger number recruited by the fourteen schools involved. The majority of those selected were serving on their school governing body. All had some prior or current community volunteering involvement, and many of them had some prior experience and training in counselling.

The volunteers received 62 hours of training over several months. This covered assessment of trauma in children, basic counselling, debriefing, referral and self-care. An experiential facilitation approach was used, and volunteers had much opportunity to process their own trauma in role plays. After the training, the volunteers were deployed in the fourteen schools in the Safe Schools cluster, most of which are in Hanover Park. They received monthly supervision and had access to the trainers and their supervisor for telephonic support when necessary.

The Centre for the Study of Violence and Mental Health in the Department of Psychiatry and Mental Health at Groote Schuur Hospital was requested to undertake an evaluation of this

school-based trauma project, and I was recruited to do it. The current study was a by-product of that research involvement. Given the volunteers' challenging task of offering trauma support in an extremely under-resourced, highly violent and frequently chaotic environment, it became evident that their own mental health might warrant attention.

3. STRUCTURE OF THE DISSERTATION

Chapter two is a review of literature regarding the potential psychological sequelae of the trauma volunteers' life and work circumstances, and the potential interaction between them. The aim of the study is presented at the end of chapter two. Chapter three presents the method. Chapter four presents a thematic analysis of the results. Chapter five consists of a discussion of the results and a conclusion to the study.

CHAPTER TWO: LITERATURE REVIEW

1. INTRODUCTION

This review touches on several bodies of literature relevant to indigenous lay trauma volunteers in South African township settings who themselves have been traumatised. As there is very little literature directly relevant to such volunteers in these settings, it is necessary to examine several different but related and clearly relevant bodies of literature. These address a range of questions: 1) How does trauma present in the South African context? 2) What is the psychological impact of trauma? 3) What is the psychological impact of trauma work on trauma workers? 4) Are there any benefits of involvement in trauma work, or in lay volunteerism? and 5) What is known about specific stressors that may be encountered by indigenous lay trauma volunteers in South African township settings?

I will argue that in order to gain a nuanced understanding of the impact of trauma on the lay trauma volunteers studied here, it is important to understand their experience of trauma in social context, and to acknowledge the link between trauma and oppression in their lives. Especially in the context of poverty, trauma and psychological disempowerment appear to be linked, involving disruption to similar schemas, and impacting on similar aspects of the self. Similarly, there are indications in the literature that trauma recovery and empowerment are linked. It appears that both trauma recovery and empowerment may be facilitated through community participation. Helping other victims as a lay trauma worker may form part of a healing "survivor mission" (Herman, 1992). However, the literature suggests that trauma work has its own risks. Simply by residing where they do, South African indigenous paraprofessionals are at high risk for primary traumatization, as are their clients. This has implications for their role as helpers and both their and their clients' approach to their work. Furthermore, due to their close proximity and accessibility to their clients, they face challenges in maintaining boundaries ordinarily maintained by mental health workers. The literature argues that for survivor trauma workers, there are particular risks in the area of over-identification with clients' trauma. This may potentially result in over-extending assistance at the expense of self. It appears that this may particularly be the case for indigenous trauma professionals in communities with a strong culture of collectivism. But even here, the literature suggests that potentially negative sequelae may be mitigated by "optimistic perseverance" in doing what the trauma worker believes to be right, and through supervision, peer support and self-care.

2. THE PSYCHOLOGICAL IMPACT OF TRAUMA

2.1. Trauma in the South African context

The classical view of trauma is summarised in Figley's (1985) definition: "An emotional state of discomfort and stress resulting from memories of an extraordinary, catastrophic experience which shattered the survivor's sense of invulnerability to harm" (p. xviii). This view is mirrored in the DSM-III-R diagnosis (revised in the later edition) of post-traumatic stress disorder (American Psychiatric Association, 1987). Criterion A requires that in order to qualify for the diagnosis an individual has to have experienced

> an event that is outside the range of usual human experience and would be markedly distressing to almost anyone, e.g., serious threat to the life or physical integrity of oneself, one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing a person who has recently been, or is being, seriously injured or killed as a result of an accident or physical violence.

This view of trauma assumes 1) an environment where traumatic events are extraordinary and "outside the range of usual human experience" (ibid.); 2) that traumatic experiences usually result from a single, discrete traumatic event; and 3) that traumatic experiences are unexpected. In South African township contexts (as in many other countries and social contexts), these assumptions tend not to hold. Epidemiological data about the prevalence of certain stressors, including rape, childhood sexual abuse, assault and battery, consistently indicate that they commonly occur in many societies (World Health Organisation, 2003). This is certainly the case in South Africa, where violence is normative rather than extraordinary (Evans & Swartz, 2000; Hamber & Lewis, 1997). Approximately 60 South African deaths per 100 000 are due to homicide. This is ten times the US rate (Peden & Butchart, 1999). Rates of general interpersonal violence, particularly in the Western Cape, are extremely high (Butchart, Hamber, TerreBlanche & Seedat, 1997; Masuku, 2003; Skinner 1998), and increase in proportion to poverty levels (Evans & Swartz, 2000). During 2000, 1876 violent crimes were recorded in South Africa per 100 000 of the population. The figure for the Western Cape (where this study was based) was 2942 per 100 000 of the population (Institute for Security Studies, 2001). Within the Western Cape, Hanover Park is one of the epicentres of violence (Cape Town, 2003).

South African traumatologists have highlighted the cumulative trauma experienced by many South Africans (Evans & Swartz, 2000; Straker & Moosa, 1994; Straker & The Sanctuaries Counselling

Team, 1987; Swartz, 1998). Here, the impact of trauma is compounded through the experience of numerous traumatic events. Widespread exposure to multiple traumas is partially a function of the country's recent history of political oppression and violence, but is also a manifestation of the high levels of criminal violence reported above. Particularly in this situation, traumatic stimuli are seldom limited to discrete events. Many township residents live in environments where violence is ubiquitous and ongoing (Evans & Swartz, 2000; Skinner, 1998). This is frequently the case in the township where the current study was conducted. Residents reported that during a particularly severe spate of gang violence in 2001, they slept on the floor for weeks on end in order to avoid stray bullets flying through the window (Moultrie & Ward, 2003). For this group, violence has thus been experienced continuously for certain periods of time. According to principals at schools involved in the current study, the vast majority of learners had been directly or indirectly exposed to violence and abuse (ibid.). Trauma in this environment is expected, and is the norm (Evans & Swartz, 2000). An assumption of "personal invulnerability" (Janoff-Bulman, 1985) would seem not to be an option for the survivor. In fact the reality of the situation requires a certain amount of vigilance. How does this impact on the (development of) the self? What internal adjustments are necessitated by this external reality?

2.2. The impact of trauma on the self

Over the past decade or so, conceptualizations of trauma have shifted from focusing on an objective traumatic event to focusing on individuals' subjective understanding of the event. This cognitivist shift is reflected in the revised diagnosis for posttraumatic stress disorder (PTSD) in the DSM-IV (American Psychiatric Association, 1994). Criterion A stipulates that the:

> [p]erson has been exposed to a traumatic event in which both of the following were present:
> (1) person experienced, witnessed, or was confronted with an event or events involving actual or threatened death or serious injury, or a threat to the physical integrity of self or others; (2) response involved intense fear, helplessness, or horror.

Here, in order to qualify for the diagnosis it is no longer sufficient to confront a threatening situation; one also needs to experience the emotions of fear, horror, or helplessness. The relevance of the subjective experience of trauma has been affirmed by much of the recent literature. The particular subjective experience which is considered to define trauma is that of being affectively overwhelmed, and of being unable to integrate this experience. Trauma is thus commonly understood as a function of the interaction between an objective event or set of events and the individual's subjective experience of these.

The symptoms of PTSD which are listed in the DSM-IV reflect manifestations of unintegrated affect. These include reexperiencing of the initial stimulus, avoidance of associated stimuli and increased arousal. However, much of recent literature suggests that this is a rather limited view of the effects of trauma. The proponents of constructivist self development theory (CSDT, see Table 1, Appendix A) posit that traumatic events may impair fundamental aspects of an individual's self, affecting her personality and its development (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Saakvitne & Pearlman, 1996).

CSDT proponents assert that trauma damages an individual's capacities to meet her central psychological needs (Pearlman & Saakvitne, 1995; Saakvitne & Pearlman 1996). The degree to which this is the case is reflected in the maintenance or disruption of cognitive schemas about safety, esteem, trust/dependency, control and intimacy (ibid.). Aspects of the self affected by trauma include (1) an individual's frame of reference (the way she usually understands herself and the world, including her spirituality); (2) her capacity to modulate affect and to maintain benevolent inner connection with self and others; (3) her ability to meet her psychological needs by mature means (this would include her self-awareness and interpersonal and self-protective skills); and (4) her memory system (including memories and effects of the trauma as experienced verbally, through imagery, affectively, somatically and through the patterns of her interpersonal relationships).

CSDT's conceptualization of the effects of trauma was informed by the work of Janoff-Bulman (1985), who argued that trauma shatters individuals' basic assumptions about life. Specific assumptions affected include "the belief in personal invulnerability, the perception of the world as meaningful and the perception of oneself as positive" (ibid., p. 15). These assumptions are what Pearlman and Saakvitne (1995) refer to as the individual's frame of reference. Herman (1992) made an important contribution in reminding traumatologists that the most central basic human assumptions (through which the self is constructed and sustained) relate to one's basic human relationships. Herman (ibid.) contends that trauma calls human relationships into question at a fundamental level, and that victims react by withdrawing and disconnecting from others and from the world, resulting in isolation and deprivation of essential relational experiences and social support. At the same time Herman (ibid.) also emphasizes that interpersonal aggression violates the dignity and removes the agency of the victim, creating the experience of helplessness. She argues that this inherently disempowering aspect of the traumatic experience is reflected in consequent

damage to the victim's sense of control of herself and her surroundings. The image created is that of an isolated person withdrawing *and* feeling helpless. According to Herman, trauma affects the survivor's basic capacities for "trust, autonomy, initiative, competence, identity and intimacy" (1997, p. 132).

Whereas Pearlman and Saakvitne (1995) acknowledge that an individual's experience of trauma is mediated by her context, Herman (1992) particularly emphasizes the social dimensions of trauma, and the role of the victim's social milieu in framing the meaning of the event and in assisting or obstructing healing. Herman's focus on the oppressive and disempowering aspects of interpersonal violence is congruent with a broadly ecological-transactional emphasis on social context. Contextually-orientated theorists of human suffering (e.g. Bracken, Giller & Summerfield, 1995; Kleinman, Das & Lock, 1997; Swartz, 1998) have argued that violence is socially embedded, and is influenced and mediated at every level by social contexts, and by the unequal power relations that are embedded in those contexts. Such theorists would reason that the marginalised poverty-, race- and gender- related social positionings and attendant social and political oppression of many South African township residents are a prime cause of numerous life stressors, difficulties and deprivations. These include scarcity of food and clean water; overcrowded living conditions; inferior education; limited employment opportunities; insufficient access to basic state services including policing, justice and health; lifetime (pre-1994 and to some extent post-1994) experiences of racism and racial oppression and high risks for physical and health problems, including those resulting from high levels of interpersonal violence.

Swartz (1998), in discussing the analyses of responses and resistances to oppression by Fanon (1970), Biko (1978) and Manganyi (1973) has remarked that "responses are not always, or even primarily in the area of symptoms, but rather in the way that people feel about themselves ... what they feel they can aspire to, what they deserve in life" (p. 180, my ellipsis). Thus it appears that the effects of oppression (in terms of feelings of helplessness and resulting damage to what Janoff-Bulman (1985), Pearlman and Saakvitne (1995) and Herman (1992) regard as basic assumptions and schemas) may overlap with the effects of interpersonal violence and its traumatic sequelae. Further, as trauma and oppression are frequently experienced simultaneously, the effects of each may mediate the individual's experience of the other. Herman (1992) asserts that psychological trauma particularly afflicts those who are powerless and oppressed. While Farmer (1997) highlights the primacy of poverty (rather than culture) as a cause of social suffering, Bracken *et al.*

(1995) emphasise that social, political and cultural realities structure individuals' responses to violence and its subjective meanings.

Within a social context in which such violence is so ubiquitous and the consequences so deeply internalized, what are the costs of hoping to make a difference? What are the costs of caring?

3. THE COSTS OF CARING

3.1. Work-related secondary trauma

With the publication of the DSM-IV (American Psychiatric Association, 1994), the definition of a PTSD-qualifying stressor broadened from the prior definition in DSM-III-R (American Psychiatric Association, 1987). To qualify as having been exposed to trauma, it was no longer necessary to personally and directly experience the traumatic stimulus. It was sufficient to be confronted with (for example, by hearing about) a situation involving threat to the physical integrity of others. Thus the definition broadened to include both primary and secondary trauma (Figley, 1995a; McNally, Bryant & Ehlers, 2003). Concerns about secondary trauma have been raised with regard to those who work with the trauma of others. Proponents of the construct of vicarious traumatization (VT) (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Saakvitne & Pearlman, 1996) and the related construct of compassion fatigue (Figley, 1995a; Figley, 2002a; Stamm, 1999) contend that those whose work (professional or otherwise) includes repeated and empathic engagement with their clients' trauma are at risk for negative sequelae.

VT is conceptualised as an impairment of the self resulting from helping others who are traumatized (Pearlman & Saakvitne, 1995). Its proponents assert that it is experienced as a significant disruption in one's sense of meaning, connection, identity and world view (ibid.). Thus they understand VT's impact to be similar to that of primary trauma, as outlined in CSDT (see p. 7 above, and Table 1 in Appendix A), in that it affects the same aspects of self. Compassion fatigue (CF) is a closely related construct, which is also understood to result from empathic exposure to trauma (Figley, 1995b). It consists of symptoms of work-related PTSD (Stamm, 2002a), which may parallel those of clients (Gentry, Baranowsky & Dunning, 1997). Its effects are similar to those ascribed to VT, in that it impairs identity, purpose, empowerment and sense of well-being (ibid.).

According to Gentry, Baranowsky and Dunning (2002, p. 124), "[c]ompassion fatigue (CF) (Figley, 1995) is the convergence of primary traumatic stress, secondary traumatic stress (STS, Landry, 1999; Stamm, 1995) and cumulative stress/burnout (Maslach, 1982) in the lives of helping professionals and other care providers". Burnout is understood by CF theorists to be a "state of physical, emotional, and mental exhaustion caused by a depletion of ability to cope with one's everyday environment" (Gentry, Baranowsky & Dunning, 2002, p. 124). Stamm (1997a) advocates the interchangeable use of CF/STS/VT to denote a syndrome of trait-like negative changes to values, beliefs and behaviours in trauma workers.

Indigenous trauma care providers in highly traumatised South African townships are likely to qualify for exposure to primary traumatic stressors. Furthermore, according to the conceptualisations outlined above, they are also likely to qualify for exposure to secondary traumatic stress through confronting the trauma of those in their immediate environment, whose fate they share. Additionally, they are at risk for CF/STS/VT through their empathic engagement with their clients. Moreover, they may be at risk for burnout due to the accumulation of stressors that they face in their specific work contexts. Thus they are exposed to a number of risk factors that are aggravated by their primary experiences.

3.2. Empirical support and risk factors for secondary trauma in trauma workers

Empirical studies may shed light on specific risks for secondary stressors for the indigenous trauma volunteers in the current study. CF/STS/VT have been researched concurrently in several studies. Empirical support for the syndrome has been found in professionals working in fields relevant to this study's population, such as child protective services (Cornille & Meyers, 1999, Meyers & Cornille, 2002), where the workers are exposed continually to child trauma, as are the trauma volunteers studied here. According to Figley (1995a), childhood trauma is particularly provocative of CF. CF/STS/VT has been found in volunteer trauma counsellors in a South African corporate setting (Ortlepp & Friedman, 2002). This suggests that the concept applies to volunteers as well as to professionals. In reviewing the literature, however, no studies were found directly examining the existence or otherwise of VT in indigenous lay trauma volunteers in highly traumatised and under-resourced communities.

Saakvitne and Pearlman (1996) provide some guidance in considering risk factors:

> The specific impact of vicarious traumatization will be determined by the unique interaction between the situation (i.e., your work setting, type and number of clients and their traumas, nature

> of exposure to trauma, and the social, political, cultural contexts of both the original trauma[s] and the current work) and the person of the helper (i.e., your professional identity, resources, support, personal history, current life circumstances, coping style). (Saakvitne & Pearlman, 1996, p. 26)

VT may be mediated by the multiplicity of clients' problems and the limitations in their resources, both material and psychological (Saakvitne & Pearlman, 1996). Hendricks (1998) reported that the lack of social resources available to their low-income clients was significantly stressful to Rape Crisis volunteers in the Cape Town township of Khayelitsha.

Saakvitne and Pearlman (1996) assert that an organizational context can affect VT, especially if clients are treated disrespectfully or if staff are not provided with the resources that they need to do their work. Acute work stressors such as work overload and being on call are also potential contributing factors.

In Kassam-Adam's (1999) survey of 100 psychotherapists, she found that being female significantly predicted PTSD symptoms. Pearlman and Saakvitne (1995) contend that members of marginalized groups are more vulnerable to VT due to their tendency to identify with others who are also marginalized or victimized. Chronic life stressors such as poverty or living in an unsafe environment may also result in over-identification with trauma clients (ibid.). The degree of personal stress experienced by trauma workers can also mediate their experience of secondary stress (Chrestman, 1999; Pearlman & Saakvitne, 1995; Saakvitne & Pearlman, 1996). Limitations on trauma workers' material resources may be an additional mediating factor (Pearlman & Saakvitne, 1995). The above factors are all of relevance to this study's population.

3.3. Survivor therapists and unresolved issues

Survivors of childhood sexual abuse are disproportionately well-represented amongst therapists in comparison to the general population (Pearlman & Saakvitne, 1995), with reports ranging from "13 percent for male psychologists (Pope & Feldman-Summers, 1992) to 26 to 43 percent for female therapists (Elliott & Guy, 1993; Schauben & Frazier, in press)" (Pearlman & Saakvitne, 1995, p. 174). Meyers and Cornille (2002) found that the majority (82%) of the child protection services (CPS) workers in their sample had been traumatized prior to working in the CPS field. In the current sample, 43% of the female volunteers (but no male volunteers) had been sexually abused as children. 50% of the sample as a whole had been physically abused as children. All volunteers had experienced at least five stressful life experiences as measured by the Stressful Life Experiences –

Short Form. The group mean for number of items on the scale each person experienced was 10, indicating an extremely high level of cumulative trauma. This suggests that all the volunteers in the sample might be regarded as "survivor therapists", and may thus be vulnerable not only to VT/CF/STS but also to all the pitfalls of working vicariously with their own issues.

Pearlman and Saakvitne (1995, p. 175) warn that for some adult survivors of childhood sexual abuse, "the role of therapist can become an extension of a self-defeating pattern of overextending oneself in relationships at one's own expense". They also warn that this group faces particular countertransference issues. Both VT and CF theorists (Figley, 1995b; Pearlman & Saakvitne, 1995) warn of the re-activation of unresolved trauma in the worker by similar trauma in their clients. In the light of such challenges, what coping practices have trauma workers found to be useful?

3.4. Mitigating factors and coping strategies

Amongst 302 therapists working with abused children, Young (2000) found that coping ability was the most significant mediator of VT. He concluded that VT was predicted by the relative absence of protective factors rather than by the presence of risk factors. Thus the coping strategies of trauma volunteers are likely to be of critical importance to their experience of the work and to their well-being.

Schauben and Frazier (1995) found that therapists' social and emotional support was a significant correlate of VT. Several authors (Cerney, 2002; Pearlman & Saakvitne, 1995; Saakvitne & Pearlman, 1996) are of the clinical opinion that both supervision and collegial support can mitigate against VT:

> Supervision is also a forum for developing strategies to address and ameliorate the effects of vicarious traumatization. A supervisor may suggest that the therapist explore professional, organizational, and personal strategies for self-care and self-protection. She may observe vulnerabilities for the therapist and encourage him to notice potential blind spots, emotional vulnerabilities, or failures to be self-protective. (Pearlman & Saakvitne, 1995, p. 365).

According to Pearlman and Saakvitne (1995), supervisory support is particularly needed by new therapists in order to provide a framework (in the absence of experience) to help them to contextualize the powerful affect generated by the work. This appears to be applicable to the trauma volunteers in the current study, who as lay staff are also relatively new "therapists". Saakvitne and Pearlman (1996) assert that insufficient training can contribute to VT. This was

supported by Gentry, Baranowsky & Dunning (2002), who linked inadequate training and supervision to feelings of inadequacy and low self-esteem. These may be indicators of VT as related to CSDT (see Table 1). Conversely, Chrestman (1999) found that further training was a mitigating factor.

Pearlman (1999) highlights the value of leisure practices that reinforce aspects of the identity beyond the helper identity, thus restoring the helper's frame of reference and self capacities. Coping activities recommended on the basis of research and/or clinical experience include self-nurturance; relaxation and leisure activities (e.g. movies, reading), activities promoting physical health and well-being such as physical activities; exercising and reconnecting with one's body; spiritually-oriented and creative activities; socializing with friends and families; humour; engaging in activities where one is in a different role; and nurturing hope and optimism (Cerney, 2002; McCann & Pearlman, 1990; Pearlman, 1999; Pearlman & Saakvitne, 1995; Saakvitne & Pearlman, 1996; Schauben & Frazier, 1995).

4. BENEFITS OF CARING

4.1. Compassion satisfaction

Within the trauma literature, benefits to carers have been recently been conceptualised as "compassion satisfaction" (CS, Stamm, 2002a). The concept originated from the observation that many trauma workers are not negatively affected by helping others, but in fact display high levels of resilience. Whereas burnout is characterized by exhaustion and lack of efficacy, compassion satisfaction is conceived as "the portrayal of efficacy: Indeed, CS may be happiness with what one can do to make the world in which one lives a reflection of what one thinks it should be" (Stamm, 2002a, pp. 113-114).

Stamm hypothesises that helpers' satisfaction in doing what they believe is right may enhance their resiliency, thus protecting against compassion fatigue, providing that the level of burnout is not overly high (ibid.) This may contribute to what Medeiros and Prochaska (1988) refer to as "optimistic perseverance", an adaptive coping strategy in the face of tragedy.

There has been little empirical work on compassion satisfaction. However, in their study of 130 South African volunteer trauma counsellors working in a corporate setting, Ortlepp and Friedman (2002) found that they experienced high role satisfaction. Counsellors also experienced increased

esteem, personal growth, deeper connections with other people, hope, respect for human resilience, and a greater awareness of all aspects of life (Ortlepp & Friedman, 2002).

Pearlman and Saakvitne (1995) also list many benefits of trauma work. These include the following:

> For some of us, an outcome of our enhanced awareness of social and political conditions that lead to violence has been greater social activism. Other positive effects include a heightened sensitivity and enhanced empathy for the suffering of victims, resulting in a deeper sense of connection with others; increased feelings of self-esteem from helping trauma victims regain a sense of wholeness and meaning in their lives; a deep sense of hopefulness about the capacity of human beings to endure, overcome, and even transform their traumatic experiences; and a more realistic view of the world, through the integration of the dark sides of humanity with healing images. (McCann & Pearlman, 1990, p. 146-147)

Other rewards include "opportunities for learning, human connection, personal growth, inspiration, … the creation of meaning in our lives" and spiritual growth (Pearlman & Saakvitne, 1995, p. xvii).

4.2. Survivor missions and lay volunteerism

Herman (1997), in line with her emphasis on the damaging effects of trauma on a victim's capacity for relationship and empathy, emphasizes that connection with others can facilitate the process of trauma recovery. Herman (1997) posits three stages of recovery: (1) the establishment of safety; (2) remembrance and mourning (or reconstructing the trauma story and processing the trauma); and (3) reconnection with ordinary life. An important aspect of the third stage involves the deepening of relationships with others. In this stage, involvement in groups can be particularly valuable:

> Traumatic events destroy the sustaining bonds between individual and community. Those who have survived learn that their sense of self, of worth, of humanity, depends upon a feeling of connection to others. The solidarity of a group provides the strongest protection against terror and despair, and the strongest antidote to traumatic experience. Trauma isolates; the group re-creates a sense of belonging. Trauma shames and stigmatizes; the group bears witness and affirms. Trauma degrades the victim; the group exalts her. Trauma dehumanizes the victim; the group restores her humanity (Herman, 1997, p. 214).

Herman asserts that the third stage of trauma recovery includes the survivor's reclamation of power. This may involve confronting others. Through such activities, the survivor regains

possession of herself; becoming the person she wants to be and creating a new identity based on survival rather than on victimhood. Herman argues that whereas

> most survivors seek the resolution of their traumatic experience within the confines of their personal lives… a significant minority, as a result of the trauma, feel called upon to engage in a wider world. These survivors recognize a political or religious dimension in their misfortune and discover that they can transform the meaning of their personal tragedy by making it the basis for social action. While there is no way to compensate for an atrocity, there is a way to transcend it, by making it a gift to others. The trauma is redeemed only when it becomes the source of a survivor mission. (Herman, 1997, p. 207).

Social action connects the survivor both with her own power and with others. According to Herman, providing assistance to other victims is a form of social action. The act of caring for others can be very healing for the carer:

> Although giving to others is the essence of the survivor mission, those who practice it recognize that they do so for their own healing. In taking care of others, survivors feel recognized, loved, and cared for themselves. (Herman, 1997, p. 209).

Similarly, Pearlman and MacIan (1995) argue that survivor therapists may be healed by their work through finding meaning in their own trauma or by contributing to the healing of others, resulting in less disrupted schemas (Pearlman & Mac Ian, 1995).

Helper therapy (Riessman, 1965) is a construct which has been applied to the specific arena of lay volunteerism, and highlights the personal growth that non-professional helpers often experience through their training and service to others (Roman, Lindsay, Moore & Shoemaker, 1999). Empirical investigations of volunteers who share similar characteristics with their clients identified the following benefits:

> energizing effects of visiting; a sense of belonging with others; status and importance associated with this role in the health system; increased self-confidence; maintenance of general level of well-being; greater social support; increased self-knowledge; learning through teaching; and improved personal effectiveness (Bond, 1979; Guianan, McCallum, Painter, Dykes, & Gold, 1991; Kahn & Fua, 1992; Wallston, McMinn, Kafahn, & Pleas, 1983). (Roman *et al.*, 1999).

Thus the literature suggests that lay volunteerism may be empowering, and may result in a number of additional benefits. In the case of indigenous trauma work "the others" are more immediately connected with the self, being neighbours, family friends, community resources, perpetrators etcetera. Both the trauma worker and their clients have an investment in each others' healing and

well-being. The healing of self and other has protective and preventative potential which includes aspects of agency and empowerment.

4.3. Empowerment through community participation

In the community psychology literature of the past two decades (Foster-Fishman, Salem, Chibnall, Legler & Yapchai, 1998; Rappaport, 1981; Rappaport, 1987; Zimmerman, 1995; Zimmerman, 2000), there has been much attention to the related constructs of empowerment and participation. "By empowerment, I mean that our aim should be to enhance the possibilities for people to control their own lives" (Rappaport, 1981, p. 15, cited in Revenson & Seidman, 2002, p. 10). According to empowerment theory, community involvement and participation lead to empowerment. There is a strong focus on settings such as voluntary organizations as vehicles or niches for empowerment (Revenson & Seidman, 2002). Zimmerman (1995, p. 588) defines empowering processes as those where

> people create or are given opportunities to control their own destiny and influence the decisions that affect their lives. They are a series of experiences in which individuals learn to see a closer correspondence between their goals and a sense of how to achieve them, gain greater access to and control over resources, and where people, organizations, and communities gain mastery over their lives (Cornell Empowerment Group, 1989; Mechanic, 1991; Zimmerman, 1990a). Efforts to gain control, access to resources, and a critical understanding of one's sociopolitical context are fundamental aspects of empowering processes.

Elsewhere Zimmerman describes psychological empowerment as including "beliefs about one's competence and efficacy, and a willingness to become involved in activities to exert control in the social and political environment. . . . Psychological empowerment is a construct that integrates perceptions of personal control with behaviors to exert control". (Zimmerman, nd., quoted in Riger, 1993, p. 280). Thus it appears that there are similarities between the benefits of community involvement and participation (i.e. control, efficacy and mastery), and the adaptive coping behaviour adopted by those who have healed from trauma (cf. e.g. Pearlman & MacIan, 1995 and Herman, 1997, cited on pp. 14-15). In fact, although the term 'empowerment' was introduced in the early 1980s through the community psychology literature (Rappaport, 1981), it has also been widely taken up by the trauma literature, where it is often used as a close synonym for mastery. In the community psychology literature, empowerment, like the conceptualizations of trauma that have been discussed above, is a contextually-based construct (Foster-Fishman *et al.*, 1998). It implies that

> "many competencies are already present or at least possible, given niches and opportunities. …[and] that what you see as poor functioning is a result of social structure and lack of resources which make it impossible for the existing competencies to operate." (Rappaport, 2002, p. 136)

This suggests that given the right conditions, opportunities and settings to scaffold their behaviours and exercise their competencies, those who might previously have been functioning at a low level might be induced to flourish. Thus it appears that appropriate niches and opportunities may facilitate empowerment in much the same way that social activism and the survivor mission seem to facilitate the healing of trauma survivors (cf. Herman, 1997, cited above on pp. 14-15). In providing opportunities to help others heal their trauma, the trauma support project studied here may thus be serving both of these closely related purposes.

5. WORK-RELATED STRESS AND BURNOUT IN VOLUNTEERS AND SOUTH AFRICAN INDIGENOUS PARAPROFESSIONALS

Burnout is frequently related to workload, autonomy, control, institutional power, immediate work community and reward (particularly recognition) (Maslach & Leiter, 1997). Other factors include role ambiguity and role conflict (Maslach, Schaufeli & Leiter, 2001). According to Swartz and Gibson (2001), work overload and interrelated care role confusion and consequent expansion in the context of scarce resources are significant causes of attrition among indigenous paraprofessionals. Richter, Durrheim, Griesel and Solomon (1996) associated burnout in South African lay HIV/AIDS counsellors with inadequate training, lack of appropriate institutional support and insufficient referral networks. Nesbitt, Ross, Sunderland and Shelp (1996) studied HIV/AIDS volunteers and posit that burnout in this population may differ from that in health care professionals. Reasons for this may include: 1) the volunteers' choice to do HIV/AIDS work; 2) their greater control over the time they spend volunteering; 3) their internal motivation to work in the HIV/AIDS area; and 4) their relative freedom to discontinue their involvement. Thus relative autonomy regarding workload adjustments may be a protective factor for volunteer burnout in some settings.

Riger (1993) compares and contrasts autonomy with relatedness, asserting that "whether individuals act in an autonomous manner or operate in a communal mode reflects their relative position in the social structure" (p. 288). She argues that "community may exist most cohesively when people experience a shared externally generated fate such as a crisis or disaster, or a condition of poverty or oppression" (1993, p. 288), and that "those not in a position of autonomy

and choice must focus on connection and communal goals to survive". Thus she suggests that poor communities tend to exert pressure on their members to behave in a collectivist fashion by sharing their resources with others. This phenomenon is apparently confirmed by the work of Swartz and Gibson (2001), Henderson (2003) and Hendricks (1998) on indigenous community workers, paraprofessionals and volunteers living and working in South African township settings. They suggest that these indigenous workers face many pressures to share material resources and to relax boundaries (such as fixed working hours) that are commonly maintained by professional mental health workers. This may lead to burnout. As connectedness may be a particularly valued quality in such settings, these pressures may be both intrapersonal and interpersonal. Furthermore, as connection may serve a more important function relative to autonomy than it does in more resourced settings (Riger, 1993), it may be valuable to bear this in mind when evaluating the contextual meaning and psychological impact of such boundary infractions.

6. SUMMARY

Given the specific South African context and history, which challenges traditional definitions of and interventions for trauma, the involvement of indigenous trauma volunteers presents at once heightened risk for the trauma worker and great potential for sustainable healing. The question remains: What is the net result of the collision of such risk and potential? How can we, by defining more clearly the dangers and the benefits, maximise the results of such work in a way which is supportive and helpful?

7. AIMS OF THE STUDY

This study has focused on a group of adults who live in a traumatised, disenfranchised, impoverished and gang-ridden coloured Cape Flats community, and who, by virtue of past and present South African political and social realities, have been at high risk throughout their lives for the negative psychological sequelae of a series of adversities, deprivations, life stressors and discrete and continuous traumas at societal, community and personal levels. They were recruited by a school-based trauma support project to provide support to traumatised children. This involvement potentially placed them at risk for further negative sequelae of work-related stressors. However, in their training and supervision, conducted by mental health professionals, there has been great emphasis on empowerment (in the senses that the term is understood both by traumatologists and by community psychologists), and on building the volunteers' capacity

to address and alleviate the potential mental health risks of their work. The study explored their experiences of their involvement in this project. This dissertation aims to present a rich picture of the personal meaning and impact (both the benefits and the burdens) of the volunteers' training, volunteer work and role, and to provide insights into the ways in which they have coped with the challenges presented by their involvement. In this way, it aims to address some of the questions raised by the examination of the literature.

CHAPTER THREE: METHODOLOGY

1. RESEARCH DESIGN AND DATA COLLECTION

The current study was conducted as part of a larger study, which evaluated the trauma support project on a range of dimensions. This provided useful additional insights into the context of the current study.

Both qualitative and quantitative methods were used. Qualitative methodology was used to obtain a rich picture of volunteers' and trainers' experiences of their involvement with the project. Focus group interviews were used to "provide direct evidence about similarities and differences in participants' opinions and experiences" (Morgan, 1997, p. 10). Quantitative methodology was used in order to obtain descriptive information about participants' compassion fatigue, burnout, compassion satisfaction, personal lifetime trauma histories, volunteer histories and demographic details.

All of the volunteer trauma support workers were invited to participate in the research, with the aim of producing a comprehensive sample. Nevertheless, four volunteers did not participate. All of these were employed and cited work commitments as the reason, and all had become inactive as volunteers. All six trainers residing in Cape Town at the time of the research (two further trainers were residing elsewhere at the time the research was conducted) were invited to participate in the research. Here again, the aim was to produce as comprehensive a sample as possible.

Ethical clearance for the study was obtained both from the Department of Psychology at Rhodes University under the auspices of the Rhodes University Ethical Standards Committee, and from the Research Ethics Committee of the Faculty of Health Sciences at the University of Cape Town. Informed consent was obtained from all participants.

Collection of data from each volunteer involved a research session during which s/he completed two self-report scales, participated in a semi-structured focus group interview and completed a self-report questionnaire. I administered the self-report scales immediately before the focus group in the hope that the content of the scales would provide added stimulus to the focus group discussion. The self-report questionnaire was administered after the discussion. Four research sessions were conducted in December 2002 at venues in Hanover Park and Lansdowne. They ranged in duration

from 110 to 130 minutes, and the size of the groups participating ranged from three to five. A research assistant was present at all interviews. She took notes and was responsible for tape recording the sessions. Participants later completed a self-report questionnaire providing demographic information.

The primary data-gathering instrument was the focus group interview protocol, which was designed to surface a rich picture of volunteers' perceptions of their volunteering experience and (as far as possible) the effects of their participation. (See Appendix B.) It covered their prior volunteer histories; motivations for their initial, ongoing and future involvement in the project; the nature of the volunteer work; their self-efficacy and confidence with regard to the work; the positive and negative personal impact of the work; the difficulties and challenges that they faced; the coping resources and strategies they used to either prevent or manage any adverse effects of trauma support work, the potentially protective effects of their training and of their supervisory and peer support; the effects of their relationships with school staff; and the effects of the work on their family life. The areas explored were selected from a review of the literature of the positive and negative impact of similar work (i.e. trauma counselling and volunteering) on similar populations (i.e. trauma counsellors and volunteers, particularly those who are indigenous to their communities).

In order to gather further descriptive data regarding burnout, compassion fatigue and compassion satisfaction, a modified version of the Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales (ProQOL, Stamm, 2002b) was administered. Each subscale is a Likert-type scale with ten items, with a potential range of scores between nought and five, and taps participants' experiences in the past month. Stamm (2002a, 2003) acknowledges that the construct validity for the ProQOL has not yet been established, although the scales and individual items are based on current theoretical understandings of the constructs measured. Cronbach's alphas for internal consistency of the subscales are as follows: 0.87 (Potential for Compassion Satisfaction), 0.72 (Risk for Burnout), 0.8 (Risk for Compassion Fatigue).

In order to gather data regarding volunteers' personal lifetime trauma histories, a modified version of the Stressful Life Experiences Screening - Short Form (SLES-SF) (Stamm, 1997b) was administered.

I piloted the both the ProQOL and the SLES-SF in order to assess the appropriateness of the language and the content in the specific South African context in which it was to be used. Piloting was done with five trauma counselling volunteers working with children in non-governmental organizations. Their language usage, educational level, socio-economic background and trauma volunteering experience were similar to that of the research participants. The pilot participants completed both measures and then participated in a focus group where they discussed their understanding of the meaning of the questionnaire items. In the case of the ProQOL, the language of seven items was modified in order to enhance comprehension. See Appendix C for an item comparison of the two versions. In the case of the SLES-SF, the language of two items was modified in order to enhance comprehension. In both items, the word "teen" was replaced by "teenager". Four items (related to political, gang, taxi and train violence) were added in order to render the scale more relevant to the participants' likely experience. See Appendix D for an item comparison of the two versions. There are no available norms for the Stressful Life Experiences Screening Short Form. Data gathered from both measures has been used descriptively.

An evaluation questionnaire (which was also used for the related evaluation study of the trauma support project) collected a range of data including the number and types of cases seen; difficulties with incoming and outgoing referrals; relationships with school staff; other prior and ongoing volunteer involvement; goals for the following year and motivations for continuing counselling (see Appendix E). The volunteers were permitted to take these away with them to complete with reference to their records, and the forms were collected one week later. However, as the majority of the volunteers had not kept detailed formal records of their activities, most of the quantitative responses were based on estimates. Thus, although trends were noted, frequency counts and averages were not produced. Rather, this data was viewed as descriptive and with caution.

A range of demographic data was collected from a self-report demographic questionnaire (see Appendix F). Frequency counts (and averages, where applicable) were produced for participants' age, marital status, number of children, number of children living at home, educational level, additional training courses undertaken and qualifications received, employment status, religious attendance, and area of residence.

Four trainers who had been involved in training the TSWs attended a semi-structured focus group interview of ninety-minute duration. The aim of the focus group was to explore their rationale for the design of the training programme and their assessment of the results (see Appendix G). Some

of the topics covered were primarily of relevance to the related project evaluation study. Topics relevant to this current study included participant selection, training methodology and course content. One trainer who had designed and taught the self-care module of the training course was interviewed individually. The interview focused on discovering the content taught in the module, the rationale for the course content design and the trainer's perception of trainees' responses to the material (see Appendix H). The volunteers' clinical supervisor, who had also performed a central liaison function between the schools and the training team, and who had written the initial funding proposal, was also interviewed individually in a loosely structured format. Although the interview was conducted primarily to collect data for the related project evaluation study, the topic of volunteer self-care, relevant to the current study, was covered.

In order to gain background knowledge of the project, I reviewed project documentation, including minutes of planning meetings and training materials. I observed six sessions of a training course where the trainers taught the same material in the same format that was taught to the volunteers in the current study to a similar group of volunteers from another area. Between September 2002 and December 2003 I also attended and observed seven monthly supervision sessions and one ad hoc supervision session with the volunteers in the current study. Furthermore, in December 2002 and January 2003 I attended and observed two extra one-off training sessions with the volunteers. The first of these focused on self-care, and was designed to be a refresher course following their original self-care training, and the second covered bereavement.

As qualitative research is a dialogical process, it is perhaps valuable to give an idea of how participants interacted with the research frame. Most volunteers were prepared to discuss all the topics of interest and interacted and self-disclosed actively in the focus group discussions. This is an indicator of the appropriateness of the use of focus group methodology for the research (Morgan, 1997). Even potentially sensitive self-disclosures, regarding such topics as having been sexually abused as children, occurred. Although many found the research participation experience (and especially the completion of the SLES) emotionally demanding, many expressed appreciation of the opportunity to talk about their experiences. As one commented, "as I told you the other day it will most probably help me also, talking to you to get this off my chest, what I feel, how I feel about that". The level of openness in the groups may in part be attributed to the strong bonds evident between the volunteers, whose training and supervision have encouraged self-disclosure. The trainers were also co-operative and shared their experiences freely.

2. PROFILE OF PARTICIPANTS

Of the 21 selected volunteers who completed the training, one volunteer passed away before the research took place, and four volunteers were unable to participate in the research. In all four cases, the reason given was work commitments. All four were in full-time employment. Three of the four had ceased their involvement as trauma support volunteers, whereas the fourth had continued her involvement at a minimal level. Only thirteen of the sixteen who attended the focus groups were currently active as volunteers. Three had become inactive due to lack of interest in their services by the schools where they had been placed. Another had become a paid counsellor with a local state service provider. Although these inactive volunteers were included in the focus groups because they were able to contribute information about their past volunteering experiences, their scores on quantitative measures were removed because they had not counselled as trauma volunteers on the project studied within the past month, as required by the scales. A further volunteer was excluded from the quantitative results due to high levels of work-(as opposed to volunteer-)related trauma exposure. It was felt that this participant's unusual work-related experiences would bias the sample.

Of the sixteen volunteers who participated in the research sessions, all were coloured and twelve lived in Hanover Park and four in Lansdowne. Fourteen were female and two were male. Only three had completed twelve years of schooling. One of these was trained as a paramedic, the second was trained as a junior class teacher and the third had a Higher Diploma in Education. None of the other volunteers had a formal post-secondary qualification. The majority had prior volunteering experience. See Appendix I for further demographic information.

Responses to the modified version of the SLES-SF (see Appendix J) indicated that as a group the volunteers had experienced high levels of trauma. In terms of lifetime prevalence, 56% of the volunteers had experienced at least one incident involving unwanted sexual contact (either as a child/adolescent or as an adult). 64% of the women had had unwanted sexual contact. 69% had been hit, choked or pushed hard enough to cause injury. 44% had witnessed an attack with a weapon or themselves been attacked with a weapon. 81% had experienced one of the above. 43% of the female volunteers (but no male volunteers) had been sexually abused as children. All had experienced at least five stressful life experiences on the scale. The group mean for number of items experienced was 10, indicating an extremely high level of cumulative trauma.

Thus the participants were predominantly poor women living in an economically and politically marginalized community where they had been subjected to high levels of gender-based violence, physical assault, community (gang) violence and political violence.

3. DATA ANALYSIS

The interview and focus group data, which had been tape-recorded, was transcribed. The data was initially coded and analysed using etic conceptual content analytical techniques, as articulated by Babbie and Mouton (2001). Concepts and themes coded for were drawn from a prior review of the literature about the costs and benefits of trauma and volunteer work and coping mechanisms in relevant populations. However, in keeping with the exploratory intent of the research, the analysis depended on sensitive and reflective openness to new themes and concepts, and the analytic process became increasingly more emic as it progressed, and the particularities of the data revealed themselves. Thus grounded theory techniques, as articulated by Strauss and Corbin (1997), were used. I drew on my training in clinical psychology in the design and administration of the research, and in the interpretation of the data. The transcripts were read and coded by another researcher (a clinical-community psychologist) and differences in coding approaches were resolved by consensus through discussion.

In the final data analysis, the approach described by Rubin and Rubin (1995: 226-227; cited in Mouton, 2001, pp. 198-199) was used. This is described as follows: “To begin the final data analysis, put into one category all the material from all your interviews that speaks to one theme or concept. Compare material within the categories to look for variations and nuances in meanings. Compare across the categories to discover connections between themes. The goal is to integrate the themes and concepts into a theory that offers an accurate, detailed, yet subtle interpretation of your research arena. The analysis is complete when you feel that you can share with others what your interpretation means for policymaking, for theory, and for understanding the social and political world."

Morgan comments that in interpreting focus group data, “consideration should be given to which topics should receive the most emphasis in the final report” (Morgan, 1997, p. 63). I have followed his guidelines in emphasizing topics where there is “group-to-group validation”. This “means that whenever a topic comes up, it generates a consistent level of energy among a consistent proportion of the participants across nearly all the groups” (Morgan, 1997, p. 63). However, a strength of

qualitative research is its capacity to detect 'quiet' or marginalised voices. With this in mind, I have reported on issues raised in only one or two instances where I felt that they added to the depth of comprehension of the subjects studied. Quotes are used in this report to enrich the texture of the description, and to reduce the remoteness between the reader and the original participants (Morgan, 1997).

Quantitative data were used descriptively, and their analysis and interpretation was integrated with that of the qualitative data. Frequency and means of variables were calculated where appropriate.

I have been keenly concerned about the degree of my personal (in)adequacy to the tasks of the research. South Africa constitutes a highly complex, layered society. There is a wide range of contextual variation in racial, linguistic and social positionings and life experience. Apartheid has profoundly shaped social identities and maintained social divisions. Varying identities criss-cross social worlds. Very few individuals are likely to have developed nuanced social competence across more than a couple of these many co-existing social worlds. As a white, female, privileged postgraduate clinical psychology student who is an outsider to the social world occupied by the study's participants, the issues and experiences raised in the interviews by these (mainly female) participants from a working-class and coloured racial background were largely foreign to my own. As they talked of the details of their lives in a country where our varied experiences are all saliently shaped by class and race, I became aware of some of the ways in which my own social and racial positioning impacted on the relational possibilities of our dialogues. There were, no doubt, barriers to communication of which I am not even conscious, including vestiges of my own unconscious racism. Privilege produces powerful blinkers. What was said and not said is related to whom I am and am not, and what I could and could not hear. I thus acknowledge my own presence in this work, and the limited, uneven comprehension and interpretation that I bring to it. I have included my own words in some quotations to highlight that participants' comments were produced in interchanges for which I share some responsibility.

CHAPTER FOUR: THEMATIC ANALYSIS OF RESULTS

1. INTRODUCTION

In this chapter, the findings are discussed thematically. I found that the settings in which the volunteers operated were the most powerful mediators of their experiences. Thus, the findings are initially arranged in terms of settings. Thereafter, the findings are explored in terms of the volunteers' perceptions of the costs of volunteering, of their coping strategies, and of the benefits they experienced.

2. SETTINGS

Volunteers were both the recipients of an intervention (i.e. training and supervision), and the providers of interventions to others. These roles were enacted across three spatially overlapping but culturally distinct settings:

1) The first setting revolved around the volunteers' training, supervision, relationships with their trainers, supervisors and each other, and the impact of this on their private lives, both intrapersonal and interpersonal. The discussion of this setting includes some of the volunteers' coping experiences, as it was found that the majority of coping skills learned through the project were acquired through their training and supervision, which operated at both the personal (life skills, relational skills and healing) level and at the occupational (i.e. trauma management skills) level. The central dynamic that operated in this setting was the volunteers' experience of affirmation.

2) The second setting was the school environment, a relatively formal institutional system into which the volunteers were required to integrate themselves in order to perform their trauma support function. For the volunteers, the organizing dynamic in this setting was that of hierarchy.

3) The third setting was the community, a social and physical environment in which the volunteers were deeply embedded, whose concerns they shared, and on whose behalf they negotiated with state service providers for access to resources. Here the most salient dynamics were those of identification, role fluidity and inter-setting negotiation.

2.1. Experiences of training and supervision

2.1.1. *Acquisition of psychological and interpersonal skills, and personal healing*

The participants' experience of the training and supervision seemed overwhelmingly positive. In the language of CSDT (refer to Table 1, Appendix A), it had particularly marked impact with regard to their psychological needs and cognitive schemas relating to (1) control (which had spin-off effects for their experiences of trust and esteem) and (2) intimacy/ connection. The participants alluded to benefits which related to positive changes in their identity, world view and spirituality (frame of reference), their self-awareness and interpersonal and protective skills (ego resources) and their self capacities.

Participants' reflexivity was developed and enhanced by the training and through involvement with the programme, and was strongly related to self-efficacy (control) and confidence in their own judgement (trust). The skill of reflexivity seemed to have an impact on participants' sense of themselves and identity. Some felt that they had accessed new ways of looking at the world:

> I think it's changed my whole life. Before you didn't think about that is a problem, now you can think. You know? And you feel that you can handle things that you couldn't before. And you also feel that here you can go into a thing (…) [and] look behind a thing. … A more perceptive person.

As is clear from the results of the SLES-SF (see Appendix K), all the volunteers had experienced multiple traumas prior to their involvement with the trauma support project. No volunteer mentioned having accessed mental health services to deal with their trauma, and several commented that such services had not been available, especially with regard to childhood trauma experienced. Neither had they been able to talk to their parents about such experiences. It appeared from their comments that many, if not most, volunteers had unresolved traumatic issues prior to commencing the training. Volunteers reported that their involvement had improved their mental health. Personal resources for coping and resilience were developed or surfaced and reinforced during involvement with the project. The training provided opportunities for volunteers to process and master their own trauma history through participating in role-plays. For the majority of the participants, the opportunity to reflect on and integrate prior trauma was experienced as empowering.

> What stood out for me in that [training] programme was the debriefing. Before this programme I have had my trauma, traumatic um things years ago. … It came back and I faced it and then afterwards I felt better and I could face everything that is supposed to come in the future. I'm willing to face it. And I feel more empowered and I feel more secure about everything now.

For many participants, the training had highlighted the value of "speaking out" as a way of regaining mastery. The training setting provided a sufficiently safe venue to verbalise traumatic narratives, many of which had not been aired before. One reported that her guilt about having been abused as a child had been alleviated. Like many others, she felt that the training had strengthened her. Another described the training as a "power tool – a tool I never had".

The trainers used volunteers' experiences of processing their own traumas to facilitate their learning about helping others. Several volunteers modelled their own supportive style and role on that of the trainers, who had shown genuine interest in their well-being (an unusual if not unprecedented experience for many, it appeared) and had created a sufficiently reliable safe space for them to process their trauma:

> The training really prepared me for my work and my myself. And, I discovered then, there is people out there who came out to give to us who really wanted that experience. Very confident and I can also go out and give it to other people. … I went through a bad experience but I could be there for another person.

From the participants' comments, it was clear that the training had assisted in reframing the survival and processing of prior trauma and the (consequent) ability to help others as experiences of mastery and as evidence of resilience. This was in clear contrast to Pearlman & Saakvitne's (1995) clinical observations of the tendency in many professional contexts to stigmatize survivor therapists. Rather, previous experiences of trauma were so effectively reframed in the training that a volunteer who claimed not to have experienced severe personal trauma appeared to feel at a disadvantage.

Many volunteers reported that they were more assertive and had learned boundary-setting skills. One volunteer appeared to see aspects of the training as useful tools to empower women in her community in their (often abusive) relationships with men (and perhaps with the larger society?):

> I became a very confident person. I'm also using this counselling training that we received. I'm using it on my children. I'm using it on my husband. Because why, I've had a very abusive husband but since I had this course he actually became more resp.. he respected me more now and

> I feel also very much empowered because I can stand up now and speak out if I see something is wrong … I actually did tell someone that if all our women in this community can receive this training then it would be of very great benefit for us and for our children and even for the future.

Three volunteers reported that the training and support received in the project had helped them to end abusive partnerships.

Many volunteers reported increased generalised self-esteem, confidence and self-efficacy as a result of their involvement with the programme. Their training featured centrally in this regard. For many, the course and the volunteer work were experienced as opportunities to challenge themselves and to demonstrate their capacities to themselves and their families. One participant said that the course had enabled her to become a role model for her children. Validation by the trainers had a powerful impact. The graduation from the course was experienced as an achievement. Certification boosted their confidence and increased their credibility in the community. Especially for those who had previously volunteered only in informal capacities, unrecognized by high status establishment figures such as mental health professionals, graduation signified a shift in identity:

> Excuse me, Alison. I left out the main important thing. When I was sixteen years of age, I wanted to become a social worker. I was still at school but financially we couldn't. I never knew I would become the person I wanted to be. Not on the same level, but you know at the age of 42, that is very confident for me. From 16 years of age to 42 years of age, I received it now but for me it is not too late. There's still some more that I want. That makes me confident.

Volunteers reported greater empathy and understanding of others. They reported that their communication, listening and conflict management skills had improved. Improved family and other relationships were reported, and parenting skills had improved. Spirituality was integrated into the training, especially in the self-care segments. One participant reported that she had grown spiritually through her involvement in the project. The participants' involvement with the course and contact with the trainers and the other participants also gave them access to added sources of personal and social support. In particular, the volunteer group that formed through the training took on a life of its own and became a vibrant nexus of supportive connections and friendships.

The trainers were greatly respectful of the trainees in their approach to the training. They aimed to build capacity by working from and through the volunteers' own direct experience in

communicating and reinforcing the course content. The experiences that the course engendered were clearly successful in connecting the volunteers with their own personal resources, and the facilitation modelled a communication style that the volunteers could then use to facilitate the empowerment of their clients. Volunteers displayed a high level of attention to their own process in their counselling, and were articulate about their own approaches to empowering their clients and to helping them reclaim a sense of self which may have been lost through the trauma:

> The big thing for me is to get whoever I'm counselling to accept that I'm going to be their counsellor. Once they acknowledge that they are … with me, you know once they accept me and I immediately get comfortable in there also, it brings a calm to me as well that somebody's accepted me now, and then I would then assure the person confidentiality. I would also make that person understand that it's important for what has happened to him, your parents need to know because if you don't have your parents know about this it means that whatever perpetrator whatever the situation is that happened it didn't take control over your life. So in order to take control over your life and gain back your freedom and who you are, we need to have people what is close to you that's important to you, they need to know what's happened. And by means of you giving me permission in the same case you're saying the perpetrator has no hold as such over you and will not take charge over your life. **Interviewer[1]: So what I'm hearing you say is that there are two important negotiations. One is to negotiate your acceptance as a counsellor and the other is the negotiation of the permission to tell the parents.** And at the same time also to gain back your what has been taken from you, your right to be who you really are. Where you are not allowing the person to change you to withhold to you from you the centre person who you are supposed to be … we're claiming back the right to say this is not who I am.

Both the above quotation and an earlier one about "the person I wanted to be" suggest that these (different) volunteers felt that disempowering trauma and disempowering lack of opportunity had prevented them from becoming their truer selves. Their involvement with the project and engagement with the opportunities it was providing were allowing them to reappraise these aspects in a manner which integrated their intrapersonal, interpersonal and social levels of being.

Volunteers reported that they had learned case management skills relevant to their work. The occupational skills learned through their involvement were applicable beyond the project, and had improved their employment prospects. Existing skills in community work were validated, extended and enhanced.

[1] In these transcript extracts, the interviewer's speech is formatted in bold.

2.1.2. *Supervision, support and coping strategies*

The volunteers experienced the supervisor as very supportive of them in their work. They reported that they drew comfort and confidence from being heard, witnessed and encouraged in clinical supervision. They reported that group supervision had helped to contain difficult feelings generated through their support work, and assisted in addressing these. They also continued to learn about themselves. Volunteers reported that through their training and supervision (both from their clinical supervisor and from peers) they learned strategies and techniques to cope with the challenges that they faced:

> With supervision I was able to learn to know my weaknesses and my strengths. I was able to ask my supervisor. I've passed my obstacles off to them and that also just helped to reinforce my approach to the learners. To me doing that that gave me a confidence boost that I was right and it just gave me a whole lot of energy for counselling … At the same time all the other case scenarios that one hears there, it also just equips one further, you know, so that when you do have similar situations, then you know the results, outcomes, and what people have done. It's very important.

Useful information about referral resources was also obtained through clinical and peer supervision. Trainers themselves provided access to referral resources, and were on hand to provide supervision and support when needed. The volunteers were making use of these resources. Volunteers provided support and peer supervision to each other. Several commented on their need for debriefing after counselling. It appeared that in most cases volunteers were able to access the necessary support in this regard from their supervisor or colleagues.

It appeared that most volunteers felt sufficiently confident to handle their case management, debriefing and counselling responsibilities, and were able to draw on support from supervisors and peers when required. However, self-efficacy anxieties were voiced, particularly by one volunteer who was less inclined to phone for support due to pressure from school staff to appear competent (see below), and appeared to rely more on her inner resources. Like others however, she used her notes and access to other sources of information to think things through. Several volunteers were resourceful in extending their education. However, there was also a strong demand for further training from most of the volunteers. This was partially related to the range of cases that they found themselves being expected to manage (such as those relating to bereavement and prior rather than recent trauma).

2.1.3. *Self-care*

Volunteers had integrated and applied much of the psychoeducation they had received concerning the importance of self-care in relieving work-related stress. Relaxation practices used included reading novels, aromatherapy, massage by family members, exercise, sitting in the sun, playing with small children, listening to relaxing music, taking a shower and sleeping.

2.2. Experiences of interfacing with the school setting

Although the school principals in the area had conceptualised and initiated the trauma support project, there were varying degrees of support for the project at various schools. Consequently, the volunteers' experiences of the school environments where they worked were mixed. The contracting between volunteers and schools about their role, the attitudes of school staff towards the volunteers and their work and the degree of integration of their trauma support services into internal referral structures were crucial both in mediating the volunteers' experiences and in determining the success of the trauma support project at school level (Moultrie & Ward, 2003).

2.2.1. *Institutional suspicion and role confusion*

Some volunteers reported frustrations resulting from lack of interest and cooperation from school staff. Conversely, a good relationship with the staff was experienced as motivating, and some staff members were experienced as supportive. In certain instances, volunteers' confidence was undermined by mistrust or judgemental expectations of competence on the part of school staff. For example, certain staff members felt that volunteers should not have to call on their supervisors or peers for assistance in case management. If they did so, this was interpreted as an indication of incompetence.

There were widespread differences of opinion (or even frank confusion) amongst many staff as to the volunteers' qualifications and role (Moultrie & Ward, 2003). The trainers had indicated that the volunteers were expected to contain learner-clients, spending up to three sessions on debriefing and counselling if necessary, and to refer if further intervention was required. They were also to conduct group debriefings after discrete traumatic incidents where required. They were not to be referred to as counsellors, but rather as trauma support workers, and were not to make home visits.

Unfortunately, these guidelines were not widely circulated, and perhaps required further negotiation with staff and volunteers. Many staff members appeared uncertain as to the appropriate nomenclature for the volunteers. In part because the volunteers were not referred to as counsellors, they were sceptical as to their level of competence. The scope and depth of the volunteers' training, which was in fact greater than many assumed, was not widely known. These uncertainties appear to have been exacerbated by class and rank distinctions between volunteers and school staff members, most of whom resided in more middle-class areas and thus did not consider themselves to be part of the school's local community. One staff member expressed doubts about the volunteers' capacity to speak 'our' (i.e. professional) language to other professionals, such as social workers. Volunteers in some schools were scarcely called on at all.

In other schools, volunteers were integrated into school life with a fluid portfolio of roles and were variously (and sometimes simultaneously) expected to function as (1) crisis managers who would be available on call at a moment's notice when required; (2) quasi-social workers who could encourage children to disclose abuse, thus setting social welfare procedures in motion, and could be expected to visit learners' houses if necessary; (3) quasi-professionals who could interface appropriately with the education, social services, justice and mental health systems; (4) members of the community who thus had insider knowledge and community contacts unavailable to school staff; (5) counsellors who could call parents (many of whom had ignored repeated summons from teachers) to the school to discuss their children's problems; (6) teacher assistants who would supervise classes while teachers were away; (7) life skills teachers; (8) sports teachers; (9) quasi-disciplinary figures to whom learners could be sent for behavioural infractions; (10) tutors for learning disabilities; and (11) surrogate parents who could socialise learners and provide comfort and support not otherwise available at home or at school. This plethora of roles, all of which were filled by volunteers at various times, is indicative of the many needs for containment and support experienced by schools, and the pressures on the volunteers to function as containers of many kinds of difficult emotions.

In schools where volunteers received few referrals, limited opportunities to develop confidence resulted in feelings of disempowerment. Conversely, where volunteers were entrusted with responsibility, they experienced this (in the main) as empowering. Although volunteers were valued, especially by school staff (Moultrie & Ward, 2003), for their capacity to encourage learner clients to disclose abuse for quasi-forensic purposes (as discussed above), this role was not

unproblematic, as it was not always seen as being in the learners' best interests. Further, a number of volunteers expressed concerns about the difficulties involved in negotiating and honouring the confidentiality concerns of their learner-clients. Some volunteers reported cases where they felt that teachers had not adequately respected their clients' confidentiality, and that this had compromised their credibility with their clients.

2.2.2. *Material demands*

The schools, most of which were severely under-resourced, were frequently unable to supply even the minimum material resources required for the work. Volunteers reported that they often bore the burden of telephone and transport costs. The work conflicted with their need to earn an income. They were not remunerated for their work. For some, their involvement as volunteers compromised their family and work time commitments. Two volunteers said that urgent trauma calls were disruptive of their daily routines.

2.3. Experiences of working in the community setting

2.3.1. *Role satisfaction*

Volunteers reported satisfaction with the opportunities afforded by their role as volunteers to meet a community need for trauma support, and thus to help others, give them hope, and 'make a difference'. Four volunteers were volunteering on an almost daily basis at their schools. They passionately articulated the personal benefits of their volunteering experiences in terms of the role opportunities provided (for example, conducting discussions with the children). For some, their work was experienced as a vocation. Volunteers derived self-esteem and satisfaction from motivating and encouraging others in their personal growth process, and "to take control of their lives and empower themselves". Volunteering was seen as a contribution at community, societal and even national levels. For one participant, a significant motive for volunteering was "to help heal the nation".

Volunteers reported that clients had expressed gratitude, and that they had received positive feedback both from clients and from the community. In one case, gratitude was expressed very tangibly:

> Ok the costs for me was nothing. If I speak about money it costs me nothing. Because I didn't pay for it. But the benefits the benefits out outweigh it. And um because I really feel because I did this voluntarily I didn't get any pay for it but I do believe that if you give good with the one hand you receive with the other hand. And I believe that I received a lot during the month of August and October before my son had to leave for Indonesia and I didn't have a cent to send him there. We had to pay all his airfare, which was about R8000, and I didn't have any money. But due to the because of me doing this work voluntarily I believe that God blessed me and sent other people to give me the money to send him. And I received about a R10 000. And I believe that if did work for money before that I wouldn't have because people would have said no this person is working she can pay for her own child's fare and but people did came along and said I know you not you were doing voluntary work but here's the envelope. [2nd participant]: Wonderful. [1st participant]: And I that's why believe it really was a lot of benefit in doing voluntary work. Even though I would like to be paid one day. LAUGHS

The volunteers appreciated the trust placed in them by clients. The esteem and respect of others also increased their own self-esteem and confidence. Although most of the volunteers were already active in community work, many commented that their involvement with the trauma support project had raised their community profile. They carried a certain situational authority:

> For myself … what makes me confident is that I've got the respect of the community actually. Um like the other day a policeman phoned me. He wanted help from me. The gangsters come and they wanted help from me. I go to church on a Sunday morning and they say Oh [name], man! Just the one I want to see. What must I do? This person needs to do this or that or where do I go to? Who do I call? Or can you do it for me? And you know that is the you, It's been built up now. You know. Here my face was in the Athlone News, Here our faces was in the Argus. Here we standing on TV, doing things like that. People know you now. And that is the thing. You need their respect. They need to know who you are, what you can do for us. And this is where your confidence comes from.

They were very visible protectors of children's rights, and appeared to see themselves as serving a preventative function:

> And because you are a trauma support worker you get a lot of respect and people know that they have to be very careful when see a trauma support worker or somebody else like Eye of the Child, or like [volunteer name] or myself. Then they know they need to be aware, we lurking around or looking if there is some problem with if the child is looking that way then you will actually go look what is happening there.

2.3.2. *Empowering niches in a disempowering context*

Most volunteers reported prior or parallel involvement in both formal and informal community work or activities through schools, NGOs, and their religious and family affiliations. Most were volunteering in multiple capacities. Thus their involvement in the school-based trauma project studied here was only one activity in the portfolio of community service roles that each had personally assembled. For example, several volunteers in the school-based trauma project were also working with a project called "Eye on the Child", which focused on child abuse. They assisted social workers in handling child abuse cases, and had gained legal rights to remove children from abusive situations where necessary. Other volunteers had been working more informally:

> I've been doing voluntary work but I didn't actually take notice of it I didn't actually knew that I'm doing voluntary work. In the community. But taking the children from the street when it was dangerous and took them in read books to them and keep them in a safe house. I kept my house as a safe house for the children. And we are having this soup kitchen all the time once a week. **From your house?** By my house yes. I've got help from other people too. And I belong to a street committee and I work on the street committee and I've been doing voluntary work as feeding children at school too. I've been doing this now for a long time but I never knew that I'm actually a voluntary worker for the community. Only now that I came to the schools that I realised that I've been doing it and and I enjoy it. Every day's a different day. And I'm giving abuse awareness programmes also there. **At the school?** Giving talks about the teenage pregnancies around there by us and Aids and this things now. Of what I've learned. I hope you don't mind I'm doing it around there in <u>our</u> community in our area. Because the people don't come out to the clinic and that. And I'm spending two hours at the old age home every Saturday. Just by being there as a friend. As a child. As a brother or sister to them. That is every Saturday morning two hours at the old age home.

Thus the volunteers brought a range of skills and competencies to their roles in the project which is the focus of this study, and were in fact selected on the basis of these criteria. One result of this was that few volunteers linked their volunteering role solely with the project. Rather, most had taken personal ownership of and responsibility for their volunteering role, and appeared to experience themselves as being firmly in control in this regard. They did not strongly distinguish between the different projects with which they were involved. For these volunteers, the school-based trauma support project appears to have functioned as a nexus of training, support, supervision, incoming and outgoing referral sources and credibility (both with the community and with state service

providers) on which to draw, and which they combined with other activities and resources to synergistically underwrite their personal missions to help their communities.

Riger (1993, p. 282) warns of confusing or conflating an individual's sense of power and willingness exert influence on their social and political environment ("power to") with their actual ability to influence the world so as to meet their needs ("power over"). She argues that "a sense of empowerment may be an illusion when so much of life is controlled by the politics and practices at a macro level" (ibid.). The project studied here has provided a niche for psychological empowerment, in that it has provided a setting and an outlet for the volunteers' productive use and expression of their skills and energies. Moreover it has also (to a limited extent) provided resources for 'actual' influence, in the sense that it has facilitated individual and collective mobilization of material social resources (i.e. for the volunteers, training and access to the resources described above; and for the community, access to counselling and trauma support services provided by the volunteers, and through them to state services) which could be used to facilitate community members gaining greater mastery over their lives (c.f. Zimmerman, 1995, reviewed on pp. 16-17 above).

> I suppose is one of the reasons that I want to be there for children and the people that's been raped because now they can get counselling and now they can go to their parents and they talk about it. We couldn't do it. That years back when this happened to you, you couldn't go to your parents and go say this is what happened to me. So those years back people doing it could walk away as if nothing happened. **Interviewer: So now there's from what you're saying it's also there's a wonderful sense of empowerment to be able to empower people in a way that you weren't.** Yes. Yes. Because here it is that I take that person I can say come I gonna take you to the police station. And I walk with that person to the police station, and I come there and nobody's gonna stop me now, and I gonna demand from them you are gonna take this person to hospital now. Here I can say Look here this person has been raped. She needs (like this one person also that I'm still working with), she needs to have treatment at hospital and they not gonna give it to her. Because of the AIDS and things going on now also. **Interviewer: And you're now in a position to demand that** Yes **and be respected** Yes **and listened to.** Yes. That's it. That's the big thing. They won't listen if that girl did go down there alone, they would say You a nuisance here. But now with me standing next to victim, they're not going to tell her she's a nuisance. They gonna do what I tell them to do. **Interviewer: Mmm. So your voice strengthens her voice for her to get** Ja. **her rights** Yes **and her needs seen to.** Yes. Yes. **Interviewer: ok, I understand now.** [2nd participant]: It's woman empowerment. [1st volunteer]: Because even that perpetrator, he was in jail and he escaped and I knew him and I knew where he was and I went to the police. I

> actually spoke to the police van outside I said you go to Hermanus you gonna find that chap there. They're gonna go pick him up. **Interviewer: So they actually listened to you.** Yes. **They went <u>all</u> the way to Hermanus on the basis of what you said and they caught the guy.** And they picked him up he is in Pollsmoor now again. **Interviewer: So that's another example of very concretely what you are able to do for other people and you weren't able to do for yourself when you needed it.** For myself. Yes. **Interviewer: It must be very very satisfying.** It is it does help now. [3rd participant]: it's like a counselling thing**. Interviewer: Ja. It's a very very useful way of going.** Ja.

In the above transcript extract, the inextricable interconnection between trauma and disempowerment is evident. Disempowerment, both in the sense of a material lack of access to essential resources (the likely refusal by the police to provide transport to hospital for a child who has been raped and needs to receive anti-retroviral medication) and of lack of efficacy (the incapacity of the child to stand up for her own rights, due to her socialization, her recent trauma and her low social rank) exacerbate trauma, by putting the victim at risk for retraumatization (such as disrespectful, inadequate treatment or abuse by the police or the hospital) or causing further trauma (the avoidable sequel of contracting the HIV virus). The volunteer's role in influencing the situation involves a number of elements: 1) her identification and empathy with the victim and her belief in standing for her (the victim's) rights; 2) her knowledge of the police and hospital systems, and the victim's rights within these systems, and her ability to advocate successfully for these; and 3) her intimate knowledge of and connection with the community, which meant that she actually knew the perpetrator (had in fact known him since he was a child) and knew where he was when he escaped from jail.

Despite successes such as those described above, many volunteers reported feeling overwhelmed by the sheer magnitude of the problems faced in many situations. Feelings of helplessness and frustration were related to the extent of problems in certain client families, to limited or inadequate referral resources, to the inaccessibility of or extreme backlogs in existing referral resources, to limited resources in client families to take up resources (for example, lack of money for transport to travel to consult a social worker), to limitations on the volunteers' own time and availability, and to their own limited power to access resources:

> And this is what really <u>gets</u> me about trauma counselling. Where you can't really do anything. **Interviewer: You were saying earlier that the best thing is the empowerment, but the worst thing is the disempowerment.** That's so true. That is <u>so</u> true.

This volunteer was sufficiently frustrated as to indicate her wish to pursue such concerns at higher levels, such with the Ministry of Justice:

> You get a child where you feel what do I do here? There comes that question I asked you about the justice system - How do I go about letting the people up there to listen to me? You know because we are here – we are only a few but here's such a lot of children that's being abused and we can't really do anything for them because when you come to the justice system, that case is not important for them – it's important for us. It's a child that got hurt there – it's important for us but it's not important enough for them. And this is actually how I feel – as I told you the other day it will most probably help me also, talking to you to get this off my chest, what I feel, how I feel about that, and things like that because now we are also debriefing here by you. **Interviewer: I remember you were saying the other day that most people that they were feeling quite angry. Very angry.** Yes, yes. We do. We do feel anger. When you can't – you're sitting there with a little one there that can't do anything and you yourself you want to and you can't really do - you feel so angry like this one case that I've got I feel like I can walk up to the minister, I can walk up to the president for that matter and go speak to him about it. You don't know what really happened and the principal can't even tell me look this is what I'm going to do to get the perpetrators. So it's it's you know you get the time when you feel you did something as I told you now that child will be coming in with tears in the eyes walking out with a smile you did something now, um positive for that child. And then you get this other child that I'm talking about now that I still feel pap after today and this has been going on for months but that child is never out of my mind. I'm forever thinking about that child. Because even the police haven't didn't do anything about it and we can get very cross about it.

The volunteer here implicitly likened her frustrations about the community's and her own disempowerment to trauma – something to be debriefed about, to speak up about and to take social action about. Although she apparently felt sufficiently motivated and confident (i.e. psychologically empowered) to raise her concerns at higher levels, neither she or her community were likely to influence the authorities to provide the essential resources required. Thus both she and her community (in this and many other instances) remained disempowered.

2.3.3. *The volunteers' relationship with the community*

From the above extracts it is clear that these lay volunteers had (over a period of time and prior to the current project) co-created helping relationships and frameworks with their clients (and with the community which forms their client base) which differed in important respects from the relationships and frames created and adhered to by mental health workers, and particularly by most

professional psychotherapists. It appeared that these relationships had emerged from the interaction between the community's needs and the volunteers' degree of willingness and capacity to meet these needs. However, the volunteers were also, at least to some extent, answerable to the requirements and strictures of the various organizations for which they volunteered (where this was the case) and to the various state agencies (welfare, justice, health etc.) with which they negotiated on their clients' (and community's) behalf. In a sense then, the volunteers functioned as go-betweens between worlds. Henderson (2003), in her study of Eye on the Child volunteers in two nearby Cape Flats communities, reported similar findings. They were embedded in the community but their behaviour and roles in various settings and situations were necessarily fluid in order to interface efficiently between realities which were in many ways contradictory. This situation gave rise to a set of issues which bear exploration. These relate to 1) understandings of the helper role in the community; 2) the volunteer's difficulty in creating and maintaining reliably safe spaces; and 3) the implications and consequences of volunteers' close identification with their clients. All of these issues speak to the (partially contextually specific) problematics of constructing and maintaining appropriate frameworks and boundaries for helping work at both structural (i.e. within schools and the community) and intrapsychic levels.

2.3.3.1. The helper role in the community

Many volunteers were acquainted with or had prior connections with a high proportion of the families of their learner-clients, many of whom who lived in close proximity in the same neighbourhood. This depth of community familiarity was experienced ambivalently. It was argued, especially by teachers and principals (Moultrie & Ward, 2003), that volunteers were uniquely equipped to gain the trust of learners and parents by virtue of their insider familiarity with the community. However, some volunteers contended that their lack of distance from the community undermined their credibility and credentials as support workers, due to confusion on the part of their clients as to their role as defined by the school-based project. Volunteers also highlighted concerns of parents in the community about potential breaches of confidentiality and invasion of family privacy through volunteer work with their children. Furthermore, some volunteers reported that their role as counsellors in schools attended by their own children had placed pressure on their relationships with their children.

On the other hand, volunteers reported instances where they felt that parents and other community members had unreasonably high expectations of their healing capacities, given their training:

> I think a lot of people doesn't really know what our what we mean what we can do. I think a lot of people look on us as being magicians. Um, we heal people, and everything just happens. I think if people are really informed that we basically go out to help people to help themselves, and that basically we help them to reconnect … with their emotions. We help to realign that. Then I think they understand that it could mean that they could go through three, four, five or more sessions before we can help them to realize that we basically don't do it. They do it themselves by means of our guidance. And I think that a lot of people out there, like you were saying, expect, that when we speak to the children, that they will be healed tomorrow or that we heal people. Like magic.

Whereas the volunteers appeared to be relatively successful in limiting the number of cases that they were prepared to see at the schools (which were institutions that were, in the main, geared to uphold such boundaries), many if not most of them reported instances of community members coming to their homes or approaching them on the street for assistance. There were varying and ambivalent sentiments about these practices. Some volunteers appeared to welcome this kind of approach (at least some of the time) as a sign of acknowledgement of their competence, and an opportunity to be of assistance, whereas others (or the same volunteers at other times) experienced it as intrusive and burdensome. Volunteers' comments highlight the distinction between what a professional might see as a problem and what they themselves may or may not have seen as problematic:

> I'm actually networking it - with Eye on the Child and the trauma counselling. What we do is Eye on the Child starts actually four o'clock in the afternoon until the next morning and weekends 24 hours. And with the trauma counselling we work in the morning at school. But the experience I have gained there is that I can also I'm not only working now with children because my house is like a welfare society – it's like an office – people come and knock on my door all hours of the day or at night.

From the above extract is clear that this volunteer's Eye on the Child work required a very different framework and set of boundary lines from those required by the school-based trauma support project. However, it appears that she viewed the maintenance of clear distinctions between these volunteer roles as impracticable and even undesirable, preferring rather to "network" them.

2.3.3.2. The difficulty of creating and maintaining reliable spaces

Many volunteers (as a result of their experiences during the training course) valued the opportunity to disclose and process their own traumata in a reliable, confidential space, and encouraged their learner clients to disclose to them in a similar fashion. However, a number of children were apparently reluctant to disclose their trauma. Further, volunteers were often unable to provide the requisite reliability to the children to ensure their safety in doing so, as they themselves were frequently compromised by the unreliability of others, including school staff (as mentioned earlier) and the scarcity of resources and slowness or absence of response from relevant service agencies in the educational, social welfare, mental health and justice systems. This often placed volunteers in a double-bind, causing them distress.

2.3.3.3. Identification, vicarious healing and vicarious trauma

As was argued in the literature review, all the volunteers studied were 'survivor therapists' in that they had all experienced multiple traumas. Most also identified strongly both with their clients and with the community itself (especially those volunteers resident in Hanover Park). Helping others appeared to function partly as a form of vicarious healing and empowerment, especially where volunteers who were themselves survivors of child abuse were able to give abused children "the love we never got". Such helping experiences appear to have created retrospective opportunities for efficacy, where in similar personal experiences the volunteers had previously been helpless.

Identification appears to have been a powerful motivator for the volunteers' very valuable work. This was reinforced by their training to some degree, in that their learning about trauma healing was in large part experiential, involving putting them in touch with their own trauma and using their own healing processes to access their empathy with others. However, their identification with their clients and consequent desire to help, combined with the community's seemingly insatiable demand for their services, appears to have put them at risk for extending themselves beyond their own perceptions of the limits of their resources, even given their high levels of resilience. They thus frequently colluded with their clients and the community in creating frameworks and expectations (both in themselves and in others) with regard to their availability and capacity which they were unable to fulfil or maintain on a consistent basis. They thus put themselves at risk for intrusive feelings of guilt and inadequacy (and potentially retraumatizing their clients):

> Sometimes when the client the child is so traumatized, then you feel you didn't do enough for that child. (sounds of agreement) You didn't do enough and when you go home you think the whole time about that. Somebody try to just take it out of your mind but is difficult sometimes.

However, for some volunteers, the guidelines provided by their trainers and supervisor appeared to be a useful resource in managing their boundaries and avoiding guilt feelings:

> Training, preparing us, it's a big task we've got here is that. Um, you know, going into a situation, and knowing, I mean you've also got to know your limits. And this is also a big thing, to know your limits. How far you can go. And when you know that look, this is not up my road. Here I've got to call in professionals. And this is a very big thing, because look we, the counsellors, we are lay counsellors, we not really counsellors. We can go that far. And then we've got to cut off there. But for instance when we did this training I'm sure for that [supervisor's name] said you can give counselling for just three times or four times to a person. After that, if that person needs more, you've got to refer that person. And I feel this is one of the big things. That you must know your limits. How far you can go. And after that, you've got to, go get professionals in.

The training also helped volunteers to gain greater awareness of their own unresolved issues. Moreover, they were sensitised as to how these may impact on those they counselled, and were warned about the risks to clients of overidentification:

> But the experience I went through really, here inside, I was glad I could open up. And they listen and show empathy with me. … Through the training and everything it made me stronger to handle certain kinds of things and say if there is somebody coming with that kind of problem, cut myself off because it is my thing and I can't put it on that person. The training I went through is where I can actually have timeout for myself and draw the line and what to do when I need to debrief that person. And where empathy and all that came in.

While supervision appeared to assist volunteers in avoiding therapeutically inappropriate behaviour and in managing countertransferential feelings, their situation raises a set of questions around how helpers can best manage their relationships with clients and protect themselves psychologically in a setting where they and their clients live in close physical and social proximity, where boundaries and roles are fluid and where the self is more collectively constituted than it is in more resourced settings, where people can afford to be more individualised. The volunteers' difficulty in protecting themselves from guilt in not fulfilling their own or clients' expectations may be partially related to the relative novelty of their services in the community, in the sense that appropriate indigenous checks and balances have yet to evolve.

3. COSTS AND BENEFITS OF VOLUNTEER INVOLVEMENT

3.1. Stressors, risks and costs

With regard to their experiences of their training and supervision and its impact, volunteers' experiences were overwhelmingly positive, and few if any stressors were reported.

With regard to their experiences in the schools, volunteers in certain schools found it extremely difficult to establish their credibility as legitimate sources of trauma support services in the context of minimal institutional or personal support or interest from principals and other school authority structures. This seriously hampered their work, and resulted in demotivation. Some volunteers reached the point of discontinuing their involvement with the schools with which they were originally placed, even though they continued to come for supervision and found other outlets for their trauma support skills. (This reinforces the suggestion made earlier that the work itself was a significant motivator, rather than the school setting.) Even in schools where volunteers and their work were valued, they frequently encountered difficulties in negotiating reciprocal roles, responsibilities and expectations with school staff members. Although such experiences frustrated volunteers' needs for esteem and control, the support they received from their supervisor and peers appeared to function as a protective factor.

Volunteers appeared to be affected on a more personal level by their interaction with the community setting, and especially with the degree of community poverty and helplessness and the lack of resources for assistance.

> **Interviewer: What was the hardest thing for you about being a trauma support worker?**
> The hardest thing, [deep breath] actually the people that's that can't help themselves and people that's got lots of problems and and poverty, poverty ja that was very much part of my experience. That experience. **Interviewer: Ok and how was that hard for you personally? How did you experience it when you dealt with people who couldn't - ?** [laugh] self, I could have put myself in that position and how do I felt? I didn't have food on my table and that rape cases it had to happened to me, how would I feel? How would I felt if had to happen to me? **Interviewer: Ok so you were feeling a lot of empathy in that experience and imagining yourself in that person's shoes?** In that person's shoes yes ja.

Volunteers' strong identification with the concerns and problems of their clients combined with the limitations on their capacity to help were experienced as very distressing, and resulted in intrusive thoughts in some cases, as illustrated earlier. This distress was the most significant form of distress that was identified, and was strongly frustrating of the need for control. Further, volunteers were confronted with a number of situations for which they felt they had not been adequately trained. This was reflected in their requests for further training, and was experienced as stressful, despite evidence of their high levels of resourcefulness in managing such situations through obtaining the support they required from supervisors and from peers. The fact that volunteers were frequently confronted with such situations is a reflection of lack of clarity about their role. They experienced both social and intrapersonal pressure to respond to the needs of the community as they were presented with them, and appeared to find it difficult to set limits in this regard. Further, although they made efforts to refer clients where they felt that cases required skills beyond the limits of their expertise, access to referral resources was limited, as discussed above. They had limited influence in mobilizing the resources that their clients required.

Volunteers also faced expectations from members of the community to be available on demand. This was exacerbated by their *de facto* physical availability as they moved around the community on foot. They were known to the community as helpers and could be (and frequently were) approached by people for help at any given time.

Other costs experienced related to material sacrifices of time (often at inconvenient times) and financial resources (such as the costs of phone calls and transport). A number of volunteers mentioned this. The wish to be paid for their work was strongly voiced in all groups.

3.1.1. *Compassion fatigue and burnout*

Data from the ProQOL subscales was interpreted descriptively, as construct validity has not yet been established, and the scales have not yet been normed on samples comparable to this study's population. However, from inspection of Table 9 (Appendix K), it appears that the volunteers' risk for compassion fatigue was high by comparison with professional samples. More than half the group's scores fell within the top quartile of norm scores. From Table 10 it is evident that the highest-ranking item related to thoughts (and potentially to anxiety) about clients. The second-ranking item related to the helper feeling as though they were experiencing a client's trauma, and

the fourth-ranking item related to the helper finding it difficult to separate their private life from their life as a helper. The high ranking of these items is congruent with qualitative findings, and supports an emerging sense of the volunteers' strong identification with clients, and the fluidity of movement between their work roles and private lives. Taken together, the high ranking of these items suggest that volunteers' identification with clients poses some risk for distress.

In contrast, results from the burnout subscale (Table 9) suggest that as a group the volunteers' risk for burnout was low by comparison with professionals. I will return to this point in chapter five.

3.2. Coping

Volunteers' ways of coping with their work were informed by the skills they had learned and the experiences that they had had of processing their primary trauma during the training. These were reinforced via supervision and support from the supervisor, trainers and peers. The strong group cohesion that had been developed during the training appears was maintained by the volunteers, both through monthly supervision meetings and through frequent informal contact and close friendships that developed. Volunteers had been sensitised to the importance of self-care during the training, and were following recommendations to engage in self-nurturing and relaxing activities.

A particular set of skills that many appreciated having developed related to assertiveness and boundary setting. It was clear that they were using these skills appropriately with the many gatekeepers (such as school authorities and social services providers and authorities) that they encountered during their trauma support activities. However, as mentioned above, they found it particularly challenging to apply these skills to clients, where there was frequently a strong level of identification, and where there was great social pressure to share their skills on demand. Nevertheless, they were sensitised to this issue, and received support in this regard in supervision.

3.3. Opportunities, rewards and benefits

Benefits to volunteers accruing from their training and supervision included the acquisition of psychological, interpersonal and occupational skills, improved personal relationships, greater social support, personal validation and personal healing. With regards to CSDT (Pearlman & Saakvitne, 1995), schemas regarding safety, esteem, trust/dependency, control and intimacy were

strengthened. Opportunities were created and used to process prior traumas. This had positive effects on internal traumatic narratives and imagery, on trauma-related affect and on trauma-related relational patterns and behaviours. Frame of reference was positively transformed in that volunteers' sense of themselves was enhanced, spirituality was strengthened, and their world view became more optimistic:

> **Interviewer: What has changed in your life since you became a trauma support worker?** I feel that I'm a totally different person, renewed through training that I went through – I'm able now to look at life differently. If I look at problems on TV, I can relate to that and say, it's not as bad as it looks because if I should counsel that person, I know what will be the outcome.

Aspects of self-awareness, including ability to be introspective, willpower and initiative, ability to strive for personal growth, awareness of psychological needs and ability to take perspective, were all facilitated and (in many cases) enhanced:

> I learnt to empathise. At times, I used to think if a person tells me something then I used to think I could sympathise I'm sympathising with this person now. but then they with the training I heard now that it's empathy that you show to that person, and I also learned … how to sit when you speak to a person, and how to listen. That was what prepared me. Because I didn't know that I had this listening skills. But with the training it came forth that I can listen very well, and I remember for a long time afterwards what the person told me and I think that is what prepared me even more. And I felt respect for myself. And nou I can look into myself before I can help another person first try and help myself. **Interviewer: Look into yourself before you help another person? Ja. Interesting. So I'm hearing two things, one is that you actually learned that you had skills already but you became more conscious of those** That's right. Yes [***general agreement on this point***] [2nd participant]: after the training. **Interviewer: Ja** [2nd participant]: within the training. The compassion, empathy, everything. **Interviewer: Ja. So one was becoming more conscious of skills you had already** Ja. **And the other is, something about self-reflection** ja. Mmm. [general agreement] becoming more self-aware. Ja. Because I learned there I learned that I need to face my problems first. [agreement from others] And I need to face my insufficiencies first. Before I could see another person's problem.

Aspects of interpersonal and protective skills, including abilities to establish interpersonal boundaries and mature relations with others and to make self-protective judgements, were enhanced. Thus the volunteers' ego resources, that is their abilities to meet their psychological needs and to relate to others, were enhanced. Furthermore, opportunities were created for volunteers to experience themselves as more viable, benign, positive and deserving of life and love. Thus self capacities were enhanced.

As the volunteers applied the interpersonal skills that they had learned in their personal lives, their intimate family and partnership relationships improved, thus providing them with a greater depth of social support than previously, and diluting a prior source of stress:

> How I deal with everyday family situations has improved and is more appropriate. Inter-family communication is much better now.

Where there had been sufficiently appropriate contracting and integration of volunteers into the schools, both socially and structurally, volunteers experienced appreciation and support from staff, strengthening schemas of esteem, trust, control and intimacy. (However, insufficient contracting and integration resulted in less positive outcomes regarding the same schemas – see above.)

Volunteers experienced high levels of role satisfaction in their working with clients in the community setting (even when the work was physically located in the schools). The role appeared to be meeting their needs for control, intimacy and esteem, and had positive effects on their sense of themselves in the world, thus positively affecting their frame of reference:

> It makes [me] very confident to know that I made a difference in someone's life and I can see that's why if I walk in street, then one of the learners follow me and then 'Hi Nurse!' He will come to me and before I can ask him 'how are you' then that person tells me already 'I'm ok now' and 'things are better now' and things like that and that's what's making me very confident.

3.3.1. *Compassion Satisfaction*

In comparison with the professionals with whom the ProQOL was normed, it appears from Table 12 (Appendix L) that volunteers experienced very high levels of compassion satisfaction. These results are concordant with the qualitative findings concerning high levels of role satisfaction, empowerment and esteem.

4. SUMMARY

The pervasiveness of violence, the depth of trauma, the multiplicity of problems and the scarcity of resources in Hanover Park are such that it is no wonder that many residents seem to feel overwhelmed and helpless, unable to access the scraps of help that may be available from extremely under resourced state services and NGOs. Yet it seems that a cadre of natural helpers has

emerged in this community, seen the needs of their neighbours and their children and responded as effectively as possible by equipping themselves with a patchwork array of skills and contacts gleaned from wherever they have been available.

The volunteers in this study are members of this group. Although they have had a strong sense of purpose, it appears that they have tended to apply their skills broadly, doing what they can here and there to improve their own lives and those of those around them. The fluidity and range of their helping behaviour has reflected the range of need in their community. They have watched over their neighbours' children as they played on the street, guarding them against abduction, rape and assault. They have visited the old and the sick, acted as midwives, run informal soup kitchens from their houses, organized with others in street committees and written and directed plays about drug abuse. They have gone out of their way and risked their safety to initiate communication with gangsters, making an effort to understand their point of view. They have assisted at their children's schools in a variety of capacities, from minding classrooms of children in the absence of teachers to serving on governing bodies.

As they have continued in their endeavours, they have been changed by them. They have come to acknowledge and appreciate their own resourcefulness, and their self-esteem has increased. They have read and treasured self-help books, sharing them with trusted friends. They have put themselves in the path of any available opportunity to develop and grow, including that of this project, and have flourished on sprinklings of affirmation and encouragement. They have had sparks of self-trust awoken in them by mentors, and they nurture hopes of playing that role for others, especially children.

Their interactions with mental health professionals and with psychological discourse have profoundly influenced them. They have taken these tools and made them their own, yet they have shared them with others wherever possible, organizing workshops to teach others skills that they themselves have only just learned.

Like other members of their community, they have experienced and witnessed their fair share of abuse, shootings, batterings, deprivations and dashed hopes. They are wounded and it shows. Their scars are evident in the passionate intensity of their efforts to make things right for those who have been victimised, especially children. They frequently give their time and energy at the expense of

their own needs, and sometimes at the expense of their families. When they are unable to help, they suffer intensely, but when they perceive small gains in those they help, they rejoice. They derive a tremendous sense of meaning from their work.

These helpers can only be effective as trauma supporters in schools to the extent that the schools are prepared to accommodate them in their structures. There are questions around the potential danger of their identification with others, both for themselves and for their clients, and about how best to support and supervise them around this. Furthermore, how might 'natural' checks and balances be put in place to protect these natural but psychologised helpers from constant and potentially ultimately debilitating boundary infractions by their neighbours? Such questions merit further engagement, because these helpers have demonstrated that their involvement in supporting their community can be a very valuable resource, both for themselves and for other community members.

CHAPTER FIVE: DISCUSSION AND RECOMMENDATIONS

"Piglet was so excited at the idea of being Useful that he forgot to be frightened any more."
- Winnie-the-Pooh, AA Milne, 1926

1. INTRODUCTION

In this chapter, the results of the study are discussed in relation to the literature. Implications for the literature are reviewed. Suggestions and recommendations for future consultation and training are made. Limitations are discussed, and a conclusion is provided.

2. BALANCING COSTS AND BENEFITS

This study has provided information about indigenous trauma volunteers living and working in extremely challenging circumstances. Without exception, they themselves were "survivor therapists" (Pearlman & Saakvitne 1995, pp. 354-355) and as such they were vulnerable to the risks of identifying strongly with their clients and of extending themselves in their helping relationships at their own expense. The volunteers' scores on the ProQOL Compassion Fatigue Subscale were higher than professional (and presumably middle-class) counterparts. However, this is perhaps not surprising given the extent of the challenges posed by their context. (Here it should be remembered that CF is conceptualised as the concatenation of primary traumatic stress, secondary traumatic stress and cumulative stress/burnout, Gentry, Baranowsky & Dunning, 2002). Furthermore, as argued earlier, the ProQOL findings in this study should be understood descriptively rather than definitively or diagnostically.

The volunteers' training, with its emphasis on empowerment, appears to have played a significant role in healing or enhancing many aspects of the self which may have been impaired as a result of primary and secondary trauma (Pearlman & Saakvitne, 1995; Saakvitne & Pearlman, 1996) and by their histories of structural oppression, deprivation and disempowerment. These effects, together with specific training in self-care, regular supervision and access to consultations with the supervisor and trainers on demand, also appear to have protected the volunteers against some of the risks of VT/CF.

The volunteers' helping activities appear to have functioned as "survivor missions" in much the same way described by Herman (1992). They clearly felt strongly that they were making a valuable societal contribution, and appear to have been supported in this by their religious affiliations. (In this regard, it is noteworthy that all the volunteers were loyal members of religious congregations.) They might be described as having displayed the adaptive coping strategy of "optimistic perseverance" (Medeiros & Prochaska, 1988) in the face of extremely harsh circumstances. It appears that they were experiencing high levels of compassion satisfaction, which, as Stamm (2002a) suggests, has a high component of self-efficacy, and may protect against compassion fatigue in the absence of overwhelming burnout.

The impulse towards helping others appears to have been framed within the context of a collectivist community culture, where connectedness is relatively highly valued in comparison with autonomy (Riger, 1993). This may have increased their tolerance for the demands of others. It appears that in at least some cases, the volunteers' contributions have been recognized and compensated by the community in very material ways, as was illustrated in the anecdote (quoted earlier) about the community paying for an air ticket.

Burnout appeared to be low. This may perhaps be explained by the autonomy afforded by volunteer (as opposed to employee) status which may have protected the volunteers against work overload within the school context (c.f. Nesbitt *et al.*, 1996, discussed on p. 17). Although the volunteers did report feeling somewhat impinged upon by members of the community within their home context, it is possible that their years of experience as natural helpers may have facilitated the development of appropriate protection strategies. However, this was not specifically investigated in this study, and more research in this regard may be useful in planning future strategies to assist indigenous volunteers in protecting themselves.

3. IMPLICATIONS FOR THEORY AND RESEARCH

As this is a qualitative study of one small sample from one programme, the findings are not generalizable. However, they may provide indicators of potentially relevant issues in similar programmes. The study has contributed to the literature on VT/CF in providing data on the experiences of indigenous trauma volunteers in a South African township context. The findings

imply that the specific effects of secondary trauma on indigenous trauma helpers in highly violent contexts may require further elaboration.

The study suggests that the experiences of *volunteer* indigenous South African paraprofessionals in township contexts may differ from those of paid indigenous paraprofessionals, in that the *meaning* both of the work and of the impingements and demands of neighbours for support may be different and potentially less distressing. Similarly, Holdsworth suggests that "people in occupations that do not necessarily carry the expectation of providing concern for mental health needs, find counselling a novel and interesting variation to their work and occupational identity" (1994, p. 54).

The study has similarly contributed to the literature on citizen participation and empowerment. Additionally, it has provided further data regarding specific experiences of the link between trauma and oppression, and appears to support a link between the construct of trauma healing and that of psychological empowerment as it is conceptualised within the community psychology literature (Zimmerman, 2000).

4. SUGGESTIONS AND RECOMMENDATIONS

As a group, volunteers wanted more training. They felt that they were handling situations for which they had not been sufficiently trained. The fact that they had sufficient confidence to handle many of these situations nonetheless speaks to generally high levels of self-efficacy, which (as discussed above) may have been a result of the empowering style of their training. However, further training is indicated for several reasons: 1) It may reinforce the benefits of healing and empowerment received through the initial training; 2) It may enable them to be better helpers; 3) It may provide frameworks for understanding their experiences, thus increasing their capacity to integrate the affect they experience in the course of their work, enhancing their coping skills and potentially reducing their risk for VT (Pearlman & Saakvitne, 1995). Thus it is suggested that regular training for the volunteers would be advantageous.

There were indications that the volunteers may be putting their clients at risk through their strong identification with them, potentially resulting in insufficient therapeutic distance and difficulty in differentiating between their own and their clients' issues. This is an important finding, confirming

concerns in the literature (Pearlman & Saakvitne, 1995) and requires attention at supervisory level. It also underscores the importance of supervision for lay trauma volunteers such as these.

On a practical level, the findings strongly affirm the need for continued supervision of volunteers, both for their own mental health and to protect those that they serve. Further, the issue of boundaries may require more thorough thinking through between the volunteers and their supervisor. It appears that there may have been some denial (or at least silence) in the supervisory relationship about the ways in which the volunteers are managing their relationships with the community, and understanding their association with the project in the light of their other volunteering activities. It may be useful to surface these difficulties and to work through their implications jointly, and in a non-judgemental manner. Further, it may be of value to raise the issue of boundaries with the community at community level, in order to sensitize community members to the concerns of volunteers and to begin to develop an appropriate set of norms regarding checks and balances. These concerns about identification also have implications for future approaches to training. It appears that the issue requires further thinking through.

With reference to further training and deployment of indigenous trauma volunteers in South Africa, the same concerns apply. For school-based projects however, this research (together with that reported by Moultrie and Ward, 2003) has highlighted the value of assessing the readiness and capacity of schools to be involved in this kind of project, and of implementing appropriate contracting and integration procedures and school-level management protocols.

5. CONCLUSION

This study has explored the psychological impact of indigenous trauma volunteerism in a school-based project in an extremely violent context, and has provided insight into indigenous volunteers' perceptions of their volunteer experiences and of its benefits and burdens.

The volunteers' experiences were co-constructed in interaction with the settings in which they operated. Experiences of training and supervision were affirming and empowering. Experiences of the school context were primarily mediated by the extent to which school hierarchies permitted access and integration into the school environment. Experiences of the community context were affected by the dynamics of identification, role fluidity and inter-setting negotiation. With regard to

the school-based trauma project, the volunteers' key roles were to remain accessible to the community and to advocate for social resources on behalf of the community.

The primary cost of involvement was distress relating to limitations on volunteers' capacity to help fellow community members with whom they strongly identified, and whom they felt intrapsychically, interpersonally and socially pressured to assist. These limitations included limited client resources (particularly poverty), limited personal resources (such as time, and money), limited occupational resources (such as training and influence to mobilise systemic resources) and limited systemic resources (such as referral resources). Other sources of distress or anxiety included context-related boundary management difficulties, institutional (school-related) stressors, difficulties in persuading children to disclose abuse and material costs of volunteering. Coping was facilitated by empowering training, supervision, consultation with trainers and peer support, and self-care practices which had been reinforced in their training.

Benefits accruing from training and supervision included the acquisition of psychological, interpersonal and occupational skills, improved personal relationships, greater social support, personal validation and personal healing. Benefits deriving from the school and community contexts included appreciation, recognition, support and role satisfaction.

The school-based trauma project is a very worthwhile one and it is worthy of replication. This research has highlighted that there are both costs and benefits to the individuals involved and that those who develop such programmes should attend to both factors.

This research has provided a rich picture of the experiences of survivor therapists working in an environment of continuous trauma. Further research will assist us to understand what is generalizable to other contexts.

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APPENDICES

APPENDIX A: CONSTRUCTIVIST SELF DEVELOPMENT THEORY

Table 1: Constructivist Self Development Theory: Aspects of the self impacted by psychological trauma

Frame of Reference

Framework of beliefs through which the individual interprets experience

- Identity: inner experience of self and self in the world, includes customary feeling states
- World view: life philosophy, general attitudes and beliefs about others and the world; values and moral principals; causality
- Spirituality: meaning, hope, faith; connection with something beyond oneself, awareness of all aspects of life including the non-material

Self Capacities

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

- Ability to experience, integrate and tolerate strong affect
- Ability to maintain a sense of self as viable, benign and positive, deserving of life and love
- Ability to maintain an inner sense of connection with others

Ego Resources

Abilities that enable the individual to meet psychological needs and to relate to others; interpersonal

- Self-awareness skills
  - Intelligence
  - Ability to be introspective
  - Willpower and initiative
  - Ability to strive for personal growth
  - Awareness of psychological needs
  - Ability to take perspective
- Interpersonal and self-protective skills
  - Ability to foresee consequences
  - Ability to establish mature relations with others
  - Ability to establish interpersonal boundaries
  - Ability to make self-protective judgements

Psychological needs and cognitive schemas

- Safety
  Self: to feel reasonably invulnerable to harm inflicted by oneself or others
  Other: to feel that valued others are reasonably invulnerable to harm inflicted by oneself or others
- Esteem
  Self: to feel valued by oneself and others
  Other: to value others
- Trust/dependency
  Self: to have confidence in one's own judgement and ability to meet one's needs
  Other: to have confidence in others to meet one's needs
- Control
  Self: to feel able to manage one's feelings and behaviours in interpersonal situations
  Other: to feel able to manage or exert control over others in interpersonal situations
- Intimacy
  Self: to feel connected to oneself
  Other: to feel connected to others

Memory and perception

- Verbal: the narrative of what happened before, during, and after the trauma
- Imagery: the mental pictures of traumatic events
- Affect: the emotions related to the trauma
- Somatic: the bodily experiences that represent the traumatic events
- Interpersonal: the relational patterns and behaviours that reflect the abusive traumatic relationship(s)

APPENDIX B: PROTOCOL FOR FOCUS GROUP INTERVIEWS WITH VOLUNTEERS

MODERATOR PROTOCOL FOR FOCUS GROUPS WITH TRAUMA SUPPORT WORKERS

Time: 90 minutes

Introduction *Hello everyone. As you know, my name is Alison and this is Kim, who will assist with the tape recorder and taking notes. Thank you for being here today to talk about your experiences of the trauma room project.*

Warm-up *Let's introduce ourselves. I'd like each of you to say your name, and the school you work at. Now let's go around the table starting here (point to person on moderator's left).* (5 min)

1. How did you come to be involved with the trauma support programme?	5
2. Have you been involved in any other volunteer work?	5
3. What is the best thing for you about being a trauma support worker?	5
4. What is the hardest thing for you about being a trauma support worker?	5
5. What does your work for the trauma support programme involve?	5
6. What aspects of your work would you like to do more of?	5
7. What aspects of your work would you like to do less of?	5
8. What has prepared you to do your work?	10
8.1. What makes you confident to do your work?	
8.2. How has your training prepared you for your work?	
9. What do you find challenging or difficult or stressful about your work?	10
10. How does your relationship with the principal and the educators at your school affect your work?	5
11. How do you cope with the challenges and stresses in your work?	10
11.1. How does supervision affect the way you cope with your work?	
11.2. How does peer support affect the way you cope with your work?	
12. What has changed in your life since you became a trauma support worker?	10
12.1. Does being a trauma support worker affect other areas of your life, either	

positively or negatively?

12.2. What has changed in the life of your family since you became a trauma support worker?

12.3. What are the benefits to you of the work?

13. Do the benefits to you of doing this work outweigh the costs?	5
14. How long do you see yourself working as a trauma support worker?	5
	90

Wrap-up Unfortunately, our time is nearly up. To sum up, let me repeat the main points that you made.

[Identify and summarize the main themes] (5)

Member check *I am going to ask each of you how you feel about some of the issues that we have just talked about. We are not going to discuss these points like we discussed the questions I just asked you. Instead, I would like to hear your feelings about the issue.* (5)

Closing statement *I want to thank you all very much for coming here and talking with me today. I really enjoyed meeting all of you, and your answers have really helped me to understand better what you feel about the work that you do. Again, I want to remind you that your answers are confidential and will not be personally identified. Do you have any last questions or comments?*

[Allow a few minutes for questions and answers.] (5)

APPENDIX C: ITEM COMPARISON BETWEEN PROFESSIONAL QUALITY OF LIFE COMPASSION SATISFACTION AND FATIGUE SUBSCALES – REVISION III (STAMM, 2002B) AND THE REVISED VERSION USED IN THE CURRENT STUDY

(seven modifications, indicated by strike-through and italic formatting)

Helping others puts you in direct contact with other people's lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a helper. Consider each of the following questions about you and your current situation. Write in the number that honestly reflects how frequently you experienced these characteristics ***in the last 30 days***.

0=Never 1=Rarely 2=A Few Times 3=Somewhat Often 4=Often 5=Very Often

_____1. I am happy.

_____2. ~~I am preoccupied with more than one person I help~~.

A lot of the time I think about more than one person I help.

_____3. I get satisfaction from being able to help people.

_____4. I feel connected to others.

_____5. I jump or am startled by unexpected sounds.

_____6. ~~I feel invigorated after working with those I help.~~

I have more energy after working with those I help.

_____7. I find it difficult to separate my personal life from my life as a helper.

_____8. I am losing sleep over a person I help's traumatic experiences.

_____9. I think that I might have been "infected" by the traumatic stress of those I help.

_____10. I feel trapped by my work as a helper.

_____11. ~~Because of my helping, I feel "on edge" about various things.~~

Because of my helping, I feel tense about various things.

_____12. I like my work as a helper.

_____13. I feel depressed as a result of my work as a helper.

_____14. I feel as though I am experiencing the trauma of someone I have helped.

_____15. ~~I have beliefs that sustain me.~~

I have beliefs that help me through difficult times and situations.

_____16. ~~I am pleased with how I am able to keep up with helping techniques and protocols.~~

I am pleased with how I am able to keep learning new skills for working with traumatized people.

_____17. I am the person I always wanted to be.

_____18. My work makes me feel satisfied.

_____19. Because of my work as a helper, I feel exhausted.

_____20. I have happy thoughts and feelings about those I help and how I could help them.

_____21. I feel overwhelmed by the amount of work or the size of my caseload I have to deal with.

_____22. I believe I can make a difference through my work.

_____23. I avoid certain activities or situations because they remind me of frightening experiences of the people I help.

_____24. I plan to be a helper for a long time.

_____25. ~~As a result of my helping, I have intrusive, frightening thoughts.~~

As a result of my helping, I have sudden, unwanted, frightening thoughts come to me.

_____26. ~~I feel "bogged down" by the system.~~

I feel stuck and frustrated by the system.

_____27. I have thoughts that I am a "success" as a helper.

_____28. ~~I can't recall important parts of my work with trauma victims.~~

I struggle to remember important parts of my work with trauma victims.

_____29. I am a sensitive person.

_____30. I am happy that I chose to do this work.

APPENDIX D: ITEM COMPARISON BETWEEN THE STRESSFUL LIFE EXPERIENCES SCREENING-SHORT FORM (STAMM, 1997B) AND THE REVISED VERSION USED IN THE CURRENT STUDY (*Four additional items and two modifications are indicated with italics.*)

We are interested in learning about your experiences. Below is a list of experiences that some people have found stressful. Please fill in the number that best represents how much the following statements describe your experiences. If you are not sure of your answer, just give us your best guess.

Describes your Experience (use in Describes Experiences Column)

0	1	2	3	4	5	6	7	8	9	10
I did not expenence	a little like my expenences					somewhat like my expenences				exactly like my expenences

Describes Experience	Life Experience
	I have witnessed or experienced a natural disaster; like a hurricane or earthquake.
	I have witnessed or experienced a human made disaster like a plane crash or industrial disaster.
	I have witnessed or experienced a serious accident or injury.
	I have witnessed or experienced chemical or radiation exposure happening to me, a close friend or a family member.
	I have witnessed or experienced a life threatening illness happening to me, a close friend or a family member.
	I have witnessed or experienced the death of my spouse or child.
	I have witnessed or experienced the death of a close friend or family member (other than my spouse or child).
	I or a close friend or family member has been kidnapped or taken hostage.
	I or a close friend or family member has been the victim of a terrorist attack or torture.
	I have been personally affected by political violence, or have lived in an area affected by political violence.
	I have been personally affected by gang violence, or have lived in an area affected by gang violence.
	I have been personally affected by taxi violence, or have regularly traveled on a route affected by taxi violence.
	I have been personally affected by train violence, or have regularly traveled on a route affected by train violence.
	I have been involved in combat or a war or lived in a war affected area.
	I have seen or handled dead bodies other than at a funeral.
	I have felt responsible for the serious injury or death of another person.
	I have witnessed or been attacked with a weapon other than in combat or family setting
	As a child/~~teen~~ *teenager* I was hit, spanked, choked or pushed hard enough to cause injury
	As an adult, I was hit, choked or pushed hard enough to cause injury
	As an adult or child, I have witnessed someone else being choked, hit, spanked, or pushed hard enough to cause injury.
	As a child/~~teen~~ *teenager* I was forced to have unwanted sexual contact.
	As an adult I was forced to have unwanted sexual contact.
	As a child or adult I have witnessed someone else being forced to have unwanted sexual contact
	I have witnessed or experienced an extremely stressful event not already mentioned. Please Explain:

APPENDIX E: VOLUNTEER EVALUATION QUESTIONNAIRE

END OF YEAR QUESTIONNAIRE FOR TRAUMA SUPPORT WORKERS

Please answer as many questions as you can. Your answers to these questions will create deeper understanding about the work of trauma support workers. This information is very important, as it will assist in assessing the successes and shortfalls of the project. Please do not put your name on this questionnaire. The answers of individuals to these questions will be kept confidential.

If you need more space for any question, or want to make any other comments about your experiences as a trauma support worker, please use the extra lined sheet that is attached.

1. Have you kept a record of the number and types of cases that you saw as a trauma support worker during 2002? YES / NO (Please circle one.) *If you circled "no", please try to remember the cases and learners that you saw during 2002 while you answer the following questions.*

2. During the 2002 school year, how many cases per week have you seen (on average)? (Please tick one box)

Less than 5 cases per week		10-15 cases per week	
5-10 cases per week		15 and more per week	

3. During 2002, how many learners have you counselled/ debriefed from each grade (in individual sessions)?

	Number of cases
Grade 1	
Grade 2	
Grade 3	
Grade 4	
Grade 5	
Grade 6	
Grade 7	
TOTAL	

	Number of cases
Grade 8	
Grade 9	
Grade 10	
Grade 11	
Grade 12	
TOTAL	

4. During 2002, how many learners have you seen..

	Number
..for one individual session	
..for two individual sessions	

	Number
..for three individual sessions	
..for more than three individual sessions	

5. During 2002, have you done any group debriefings for whole classes or other groups of learners? YES / NO (Please circle one.)
5.1. If yes, how many group debriefing sessions did you do? _____

6. During 2002, how many people other than learners have you counselled in your role as a trauma support worker?

	Number		Number		Number
School staff members		Other children		Other adults	

7. Which of the following kinds of cases were referred to you in 2002? (Please indicate how many of each type. Each case should be listed under only one category. Write down how many of each kind of case was referred on to another professional or service provider without having been seen by you and after being seen by you.)

	Number of cases		
	Referred to you	Referred on without being seen by you	Referred on after being seen by you
Child abuse:			
• physical			
• emotional			
• sexual			
Rape			
Sexual assault			
Physical assault			
Domestic violence:			
• parents			
• siblings			
Victims of criminal/gang violence:			
• learner involved personally			
• other family members involved			
Learning problems			
Substance abuse:			
• alcohol abuse			
• drug abuse			
Bereavement			
Other (please write down any others)			
TOTAL			

8. What efforts have been made to inform the school community about your work and role in the school as a trauma support worker? (Please tick all relevant boxes.)

Announcements in assemblies		Discussions in classes	
Announcements in staff-meetings		Newsletters for parents	
Newsletters for learners		Announcements in parent-teacher meetings	
Other (Please write these down.)			

9. How aware do you think the members of the school community are of the trauma rooms and the trauma support workers? (Please tick one box for each group.)

	0-20% are aware	21%-40% are aware	41% - 60% are aware	61% - 80% are aware	80% - 100% are aware
Learners					
Staff					
Parents					

10. What have been the sources of your referrals?

	No. of cases
Learners referring themselves	
Learners referring other learners	
Staff members referring learners	
Parents referring learners	
TOTAL	

	No. of cases
Staff members referring themselves	
Other adults referring themselves	
Other (please indicate)	
TOTAL	

11. Do you experience any problems with the way in which you receive referrals? YES/ NO

11.1. If yes, please explain.

_____

_____

_____

_____

_____

_____

12. As far as you know, are there any types of cases amongst the learners at your school that you are trained to handle but which are not referred to you? YES / NO / UNSURE (Please circle one.)
12.1. If yes, what types of cases are these, and where (if anywhere) are they referred? (Fill in below.)

Type of case	Where referred

13. To which of the following types of counsellors or professionals have you referred cases? (Write down how many cases you have referred to each kind of counsellor or professional in 2002.)

	No. of cases
Other trauma support worker	
Other lay counsellor (in another org.)	
Social worker	
Psychologist	
Psychiatrist	
Other (please write down any others)	

	No. of cases
Nurse	
Doctor	
Faith-based counsellor (e.g.	
Priest/ Pastor/ Imam)	
Traditional healer	

14. To which of the following kinds of organisations/service providers have you referred cases? (Write down how many cases or learners you referred to each kind of place in 2002. If you referred the same case or learner to more than one kind of place, it is ok to count it twice.)

	No. of cases
Athlone school clinic	
Outpatient clinic	
Hospital	
Police station	
Child Welfare	
Trauma Centre	
NICRO	
FAMSA	
Other (please write down any others)	

	No. of cases
Rape Crisis	
Private psychologist	
Private social worker	
Private psychiatrist	
Private doctor	
Child Line	
Safe Line	
Safe Schools Hotline	
Other help lines	

15. Do you experience any problems in referring cases/ learners to other service providers and organisations? YES/ NO (Please circle one.)
15.1. If yes, please explain.

_____

_____

_____

_____

16. For what purpose is the trauma room at your school most used? Please number these uses in order from most to least frequent use.

	Number from most to least frequent
Trauma counselling	
Guidance counselling	
Other counselling	
Trauma-related discussions or lessons with learners	
Other lessons (please write down any others)	
Other activities (please write down any others)	

17. In your role as a trauma support worker, have you ever counselled or performed other tasks after hours during 2002?

	Counselled (please circle yes or no)		Other tasks (please write these down)
After school hours	yes	no	
On weekends or public holidays	yes	no	
During school holidays	yes	no	

18. Have you been actively involved with any of the following voluntary/community activities or organisations during 2002? Please write down how you have been involved and how many hours (on average) you have spent per week during 2002.

	Involvement	Hours per week
Faith-based activities		
Eye on the Child		
NICRO		
Rape Crisis		
Council for the Aged		
Neighbourhood Watch		
Other (Please write these down)		
TOTAL		

19. Have you been involved with any of the following school activities or tasks during 2002? Please write down how many hours per week (on average) you have spent on each of these activities during 2002.

	Hours per week
Counselling (in your capacity as a trauma support worker)	
Any other counselling (Please explain.)	
Supervision of classes when teachers are absent	
Invigilating in tests and examinations	
Supervision or organisation of school sports activities	
School feeding	
Catering committee	
Administrative tasks	
Membership of school governing body	
Teaching classes (Please write down the subjects.)	
Giving awareness talks (Please write down the topics.)	
Other activities/ tasks (Please write these down.)	
TOTAL	

20. Were you involved with any of the above-listed (or any other) activities at the school before you received training on this programme and became a trauma support worker? YES / NO
20.1. If yes, with which activities were you/ have you been involved and for what period of time?

_____

_____

_____

21. In what ways has the school community benefited from your work as a trauma support worker in 2002?

_____

_____

_____

_____

22. What are your goals for 2003 as a trauma support worker? _____

_____

_____

_____

23. How many cases or learners per week would you like to see in 2003? (Please tick one box)

Less than 5 cases per week		10-15 cases per week	
5-10 cases per week		15 and more per week	

24. For how many years do you plan to continue working as a trauma support worker? _____

_____

25. If you are planning to continue working as a trauma support worker, what are your reasons for this decision?

_____

_____

_____

26. If you were to decide to stop working as a trauma support worker, what would be your reasons for stopping?

_____

_____

_____

27. Any other comments? (Please continue on the next lined page if you need more space.)

_____

_____

_____

_____

Thank you very much for taking the time to complete this questionnaire! ☺

APPENDIX F: VOLUNTEER DEMOGRAPHIC QUESTIONNAIRE

LIFESTYLE DETAILS
FOR TRAUMA SUPPORT WORKERS

Your answers to these questions will create deeper understanding about the lifestyles of trauma support workers, and how this may affect your work. This information is very important, as it will assist in assessing the successes and shortfalls of the project. Please do not put your name on this questionnaire. The answers of individuals to these questions will be kept confidential. If you need more space for any question, or want to make any other comments, please write on the back of this page.

1. Which suburb do you live in?

2. How old are you? (Please tick one box)

20-30	31-40	41-50	51-60	61-70	71-80

3. Are you currently married? YES/ NO (Please circle one.)

4. How old are your children? How many of your children (including grandchildren and foster children) are currently living with you? (please fill in the answers below)

	Sex	Age	Living with you now?
1.			
2.			
3.			
4.			
5.			
6.			
7.			

5. Are you currently employed? YES/ NO (Please circle one.) If yes, what is your job?

6. Have you worked in the past? YES/ NO (Please circle one.) If yes, what was your last job?

7. What was the highest standard that you passed in school?

8. What other courses or training have you done besides the trauma support training?

9. Do you practise as a Christian, as a Muslim or do you belong to any other religion? YES/ NO (Please circle one.) If yes, how many times in a week do you attend gatherings related to your faith (such as religious services and prayer meetings)?

Thank you very much for taking the time to complete this questionnaire! ☺

APPENDIX G: PROTOCOL FOR FOCUS GROUP INTERVIEW WITH TRAINERS

MODERATOR PROTOCOL FOR FOCUS GROUP INTERVIEW WITH TRAINERS

Aim: To explore their rationale for the design of the training programme and their assessment of the results.

Time: 90 minutes

1. Consultation process and initial contracting

1.1. Why did they get involved? What attracted them to the project?

2. Selection process

2.1. How and why designed?

2.2. Results

2.2.1. Quality of trainees?

2.2.2. How to increase retention rates in the future?

3. Training design

3.1. How was the training designed

3.1.1. Did they mix and match from trainings they had used elsewhere?

3.1.2. What experience did you bring to the design of the training?

3.1.3. Did they discuss the training with each other?

3.1.4. How did they decide on the length of the course and the time spent on each module?

3.1.5. What competencies were they training for?

3.1.5.1. personal skills

3.1.5.2. specific capacities

4. Modules

4.1. Context

4.2. Basic counselling

4.3. Debriefing

4.4. Care for caregivers

4.5. Evaluation

4.6. Case management

4.6.1. Assessment

4.6.1.1. How much focus on assessment for developmental stages?

4.6.2. Trauma mgt

4.6.2.1. What model of counselling and trauma management is used?

4.6.2.2. Rationale for this?

4.6.3. Referral

4.6.4. Liaison

5. Within each module

5.1.1. Length of time spent on each module?

5.1.2. Rationale for each module?

5.1.3. What competencies were they training for?

5.1.3.1. personal skills

5.1.3.2. specific capacities

5.1.4. Response Hanover Park first & second training, Elsies River

5.2. Areas improved/ future areas for improvement

6. Results of training

7. How did you see the training being used?

8. Has the training been used in the way you expected?

9. Did the TSWs respond as expected?

9.1. How so?

9.2. How not?

10. What are the TSWs qualified to do?

11. Implementation

11.1. Look at why things have worked in Hanover Park & why things haven't worked in Elsies River

11.2. Suggestions about the management of volunteers?

12. What are the **benefits** of the trauma project?

13. If you could **change** the trauma project in any way, what would you change?

Wrap-up Unfortunately, our time is nearly up. To sum up, let me repeat the main points that you made. [Identify and summarize the main themes]

APPENDIX H: PROTOCOL FOR INTERVIEW WITH SELF-CARE TRAINER

Aim: To explore her rationale for the design of her module of the training programme and her assessment of the results.
Time: 90 minutes

1. Training design
1.1. How was the training designed
1.1.1. What is your theoretical rationale and model?
1.1.2. Did you mix and match from trainings they had used elsewhere?
1.1.3. What experience did you bring to the design of the training?
1.1.4. Did they discuss the training with other trainers?
1.1.5. How did you decide on the length of the module?
1.1.6. What competencies were you training for?
1.1.6.1. personal skills
1.1.6.2. specific capacities
1.1.7. Response HP1, HP2, ER & Hanover Park 1 ongoing training
1.1.8. Areas improved/ future areas for improvement

2. Results of training
3. How did you see the training being used?
4. Has the training been used in the way you expected?
5. Did the TSWs respond as expected?
5.1. How so?
5.2. How not?

6. Implementation
6.1. Look at why things have worked in Hanover Park & why things haven't worked in ER
6.2. Suggestions about the management of volunteers?

7. What are the **benefits** of the trauma project?

8. If you could **change** the trauma project in any way, what would you change?

Wrap-up Unfortunately, our time is nearly up. To sum up, let me repeat the main points that you made. [Identify and summarize the main themes]

APPENDIX I: DEMOGRAPHIC DATA

Table 2: Age of volunteers (N=16)

	Sum	Percentage
30s	5	31%
40s	7	44%
50s	3	19%
60s	2	13%

Table 3: Marital status of volunteers (N=16)

	Sum	Percentage
Married	12	75%
Divorced or separated	3	19%
Widowed	1	6%

Table 4: Number of children living at home (N=16)

	Sum	Percentage
0*	1	6%
1	1	6%
2	4	25%
3	5	31%
4	4	25%
5	1	6%

*This participant's children had left home.
Note: These figures include grandchildren and foster children.

Table 5: Prior volunteering experience and training (N=16)

	Sum	Percentage
Attended at least one other training programme for volunteers	13	81%
Volunteered in another capacity	15	94%
Prior involvement with a school in a volunteer capacity	14	88%
Prior service on a school governing body	12	75%

Table 6: Employment at time of research (December 2002) (N=16)

	Sum	Percentage
Formally employed	5	31%
Self-employed	1	6%
On pension*	2	13%
Unemployed*	8	50%

*All had previously been employed

Table 7: Religious affiliation and attendance (N=16)

	Sum	Percentage
Christian*	12	75%
Muslim*	4	25%

*All attended faith-based functions at least once per week

APPENDIX J: DATA FROM STRESSFUL LIFE EVENTS SCREENING – SHORT FORM

Table 8: Sum and percentage of participants who have experienced each of the items on the Stressful Life Experiences Screening-Short Form, presented by item rank order

Rank	Item	Sum	Percentage
1	I have witnessed or experienced the death of a close friend or family member (other than my spouse or child).	14	88%
1	I have witnessed or experienced a serious accident or injury.	14	88%
3	I have been personally affected by gang violence, or have lived in an area affected by gang violence.	10	63%
3	I have witnessed or experienced a life threatening illness happening to me, a close friend or a family member.	10	63%
3	As an adult or child, I have witnessed someone else being choked, hit, spanked, or pushed hard enough to cause injury.	10	63%
6	I have been personally affected by taxi violence, or have regularly traveled on a route affected by taxi violence.	9	56%
6	I have been personally affected by political violence, or have lived in an area affected by political violence.	9	56%
6	I have seen or handled dead bodies other than at a funeral.	9	56%
9	As a child/teenager I was hit, spanked, choked or pushed hard enough to cause injury.	8	50%
9	As an adult, I was hit, choked or pushed hard enough to cause injury.	8	50%
11	As a child/teenager I was forced to have unwanted sexual contact.	6	38%
11	I have witnessed or experienced a natural disaster; like a hurricane, tornado, flood or earthquake.	6	38%
11	I have witnessed or been attacked with a weapon other than in combat or a family setting	6	38%
11	I have witnessed or experienced an extremely stressful event not already mentioned	6	38%
15	As an adult I was forced to have unwanted sexual contact.	5	31%
15	I have been personally affected by train violence, or have regularly traveled on a route affected by train violence.	5	31%
17	I have witnessed or experienced the death of my spouse or child.	4	25%
17	I have witnessed or been attacked with a weapon in a family setting	4	25%
17	I have witnessed or experienced a human made disaster like a plane crash or industrial disaster.	4	25%
20	As a child or adult I have witnessed someone else being forced to have unwanted sexual contact	3	19%
21	I have witnessed or experienced chemical or radiation exposure happening to me, a close friend or a family member.	3	19%
22	I or a close friend or family member has been the victim of a terrorist attack or torture.	1	6%
23	I or a close friend or family member has been kidnapped or taken hostage.	0	0%
23	I have been involved in combat or a war or lived in a war affected area.	0	0%
23	I have felt responsible for the serious injury or death of another person.	0	0%

APPENDIX K: DATA FROM PROQOL COMPASSION FATIGUE AND BURNOUT SUBSCALE

Table 9: ProQOL Compassion Fatigue and Burnout Subscales

	Risk for CF (n=11)	Risk for Burnout (n=11)
Mean	19.4 (norm is 13)	18.5 (norm is 23)
SD	6.9 (norm is 6)	3.5 (norm is 6)
Median	18.0	19.0
Mode	15.0	20.0
Range	6-31	13-23
No. falling in bottom quartile	1	5
No. falling in middle half	4	6
No. falling in top quartile	6	0

Note: The ProQOL is normed on a sample of 400 trauma workers who were either professionals themselves or volunteering in professional settings. For CF, normal ranges are as follows: bottom quartile: 0-7; middle half: 8-17; top quartile: 18+; For Burnout, normal ranges are as follows: bottom quartile: 0-18; middle half: 19-28; top quartile: 29-50

Table10: Mean score, standard deviation and range for each item on the ProQOL Compassion Fatigue Subscale, presented by item rank order

Rank	Item	Mean	SD	Range
1	A lot of the time I think about more than one person I help.	3.5	1	2-5
2	I feel as though I am experiencing the trauma of someone I have helped.	2.3	1	0-5
3	I struggle to remember important parts of my work with trauma victims	2.2	2	0-5
4	I find it difficult to separate my private life from my life as a helper.	2.1	1	0-5
5	I avoid certain activities or situations because they remind me of frightening experiences of the people I help	1.9	1	1-5
5	I jump or am startled by unexpected sounds.	1.9	1	0-4
8	As a result of my helping, I have sudden, unwanted, frightening thoughts come to me.	1.7	1	0-5
8	Because of my helping, I feel tense about various things.	1.5	1	0-2
8	I think that I might have been "infected" by the traumatic stress of those I help.	1.5	1	0-2
10	I feel depressed as a result of my work as a helper.	0.8	1	0-2

Table 11: Mean score, standard deviation and range for each item on the ProQOL Burnout Subscale, presented by item rank order

Rank	Item	Mean	SD	Range
1	I feel overwhelmed by the amount of work or the number of clients I have to deal with	2.9	1	1-5
2	***I am a sensitive person.***	2.3	2	0-4
3	I feel stuck and frustrated by the system.	2.2	2	0-4
4	Because of my work as a helper, I feel exhausted.	2.0	1	0-4
4	***I am happy.***	2.0	1	1-3
6	***I feel connected to others.***	1.8	1	1-4
7	I am losing sleep over a person I help's traumatic experiences.	1.6	1	1-3
8	***I have beliefs that help me through difficult times and situations.***	1.5	1	1-3
8	***I am the person I always wanted to be.***	1.5	1	1-3
9	I feel trapped by my work as a helper.	0.5	1	0-2

Note: Items in formatted in bold italics are reverse-scored.

APPENDIX L: DATA FROM PROQOL COMPASSION SATISFACTION SUBSCALE

Table 12: ProQOL Compassion Satisfaction Subscale

	Potential for CS (*n*=11)
Mean*	43.4 (norm is 37)
SD	4.1(norm is 7)
Median	45.0
Mode	45.0
Range	35-49
No. falling in bottom quartile	0
No. falling in middle half	4
No. falling in top quartile	7

Note: The ProQOL is normed on a sample of 400 trauma workers who were either professionals themselves or volunteering in professional settings. Normal ranges are as follows: bottom quartile: 0-31; middle half: 32-41; top quartile: 42-50

Table 13: Mean score, standard deviation and range for each item on the ProQOL Compassion Satisfaction Subscale, presented by item rank order

Rank	Item	Mean	SD	Range
1	I am happy that I chose to do this work.	**4.8**	**0**	4-5
1	I like my work as a helper.	**4.8**	**0**	4-5
3	I get satisfaction from being able to help people.	**4.7**	**1**	3-5
4	I plan to be a helper for a long time	**4.6**	**1**	**4-5**
5	I am pleased with how I am able to keep learning new skills for working with traumatized people	**4.5**	**1**	**3-5**
6	My work makes me feel satisfied.	**4.4**	**1**	**3-5**
6	I have happy thoughts and feelings about those I help and how I could help them.	**4.4**	**1**	**3-5**
6	I have thoughts that I am a "success" as a helper.	**4.4**	**1**	**3-5**
9	I believe I can make a difference through my work.	**4.3**	**1**	**2-5**
10	I have more energy after working with those I help.	**2.5**	**1**	**1-4**