EXPERIENCES AND COPING STRATEGIES OF CLINICAL PSYCHOLOGISTS AND INTERN CLINICAL PSYCHOLOGISTS WORKING WITH VICTIMS OF TRAUMA IN THE KHOMAS REGION, NAMIBIA

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ABSTRACT

The occurrence of traumatic incidences is common in Namibia. Clinical and intern clinical psychologists at times work with clients who have experienced these traumatic events during therapy. This puts them at risk of being affected by the accounts of their clients' experiences. There is limited research that has been conducted on the impact of working with victims of trauma in Namibia. This research, therefore, examined the experiences of working with victims of trauma from the perspectives of clinical and intern clinical psychologists. The impact of trauma work and the coping mechanisms utilised by clinical and intern clinical psychologists who work with victims of trauma were determined. The study applied a qualitative approach together with a case study design. Eleven participants, of which 90% were female, took part in the research and were all based in the Khomas region of Namibia. Data were collected by interviewing the participants using a semi-structured interview guide. The interviews were transcribed, and thematic analysis was applied for data analysis. The themes from the analysis were: the helper's perspectives on trauma work, responses to trauma work, risk factors, the role of empathy in trauma work, discomfort with the limitations of the role, work and professional issues, coping with trauma work, social support and self-care. Clinical and intern clinical psychologists are impacted in both negative and positive ways through their work with victims of trauma. These experiences were vicarious traumatisation, secondary traumatic stress, compassion fatigue, burnout, compassion satisfaction, vicarious resilience and post-traumatic growth. Institutions of higher learning should equip students with coping mechanisms for working with victims of trauma and with therapy work in general. The research findings will be shared and made available to the Psychological Association of Namibia and the Ministry of Health and Social Services.

Table of Contents

ABSTRACT i

LIST OF TABLES vii

LIST OF FIGURES viii

LIST OF ABBREVIATIONS AND ACRONYMS ix

ACKNOWLEDGMENTS xi

DEDICATION xii

DECLARATION xiii

CHAPTER ONE: INTRODUCTION 1

1.1 Background of the study 1

1.2 Statement of the problem 2

1.3 Research objectives 4

1.4 Significance of the study 4

1.5 Limitations of the study 5

1.6 Delimitation 5

CHAPTER TWO: LITERATURE REVIEW 6

2.1 Introduction 6

2.2 The clinical psychology profession 6

2.3 Traumatic experiences: Definition and prevalence in Namibia 7

2.4 Effects of trauma on mental health professionals working with victims of trauma 9

2.4.1 Research findings 10

2.5 CONCEPTS DEFINING THE IMPACT OF TRAUMA WORK ON MENTAL HEALTH PROFESSIONALS 13
2.5.1 Vicarious traumatisation 14
2.5.2 Secondary traumatic stress and compassion fatigue 15
2.5.3 Burnout 17
2.5.4 Compassion satisfaction 19
2.5.5 Vicarious resilience 20
2.5.6 Post-traumatic growth 22
2.6 PREVALENCE AND RISK FACTORS FOR MENTAL HEALTH PROFESSIONALS 23
2.7 COPING STRATEGIES 27
2.8 CONCEPTUAL FRAMEWORK 29
2.9 CHAPTER SUMMARY 30
CHAPTER THREE: METHODOLOGY 31
3.1 INTRODUCTION 31
3.2 RESEARCH DESIGN 31
3.3 POPULATION 32
3.4 SAMPLE AND SAMPLING PROCEDURE 32
3.5 RESEARCH INSTRUMENTS 34
3.6 DATA COLLECTION PROCEDURE 35
3.7 DATA ANALYSIS 36
3.8 MAINTAINING TRUSTWORTHINESS 39
3.8.1 Credibility 39
3.8.2 Transferability 40
3.8.3 Dependability 41

3.8.4 Confirmability 41
3.9 ETHICAL CONSIDERATIONS 42
3.10 DEFINITION OF KEY TERMS 43
3.10.1 EXPERIENCES 43
3.10.2 COPING STRATEGIES 43
3.10.3 SELF-CARE 43
3.10.4 SOCIAL SUPPORT 44
3.10.5 CLINICAL AND INTERN CLINICAL PSYCHOLOGISTS 44
3.10.6 VICTIMS OF TRAUMA 44
3.10.7 KHOMAS REGION, NAMIBIA 45
3.11 CHAPTER SUMMARY 46
CHAPTER FOUR: RESULTS 47
4.1 INTRODUCTION 47
4.2 DESCRIPTION OF PARTICIPANTS 47
4.3 THEMES 49
4.3.1 The helper's perspectives on trauma work 50
4.3.2 Responses to trauma work 53
4.3.2 Risk factors 66
4.3.3 The role of empathy in trauma work 67
4.3.4 Discomfort with the limitations of the role 68
4.3.5 Work and professional issues 69
4.3.6 Coping with trauma work 71
4.3.7 Social support 76
4.3.8 Self-care 77

4.4 Chapter summary 78

CHAPTER FIVE: DISCUSSION 79

5.1 Introduction 79

5.2 The helper's perspectives on trauma work 79

5.2.1 Responses to trauma work 80

5.3 Risk factors 85

5.4 The role of empathy in trauma work 87

5.5 Discomfort with the limitations of the role 87

5.6 Work and professional matters 88

5.7 The coping strategies used by clinical and intern clinical psychologists 89

5.7.1 Boundaries 89

5.7.2 Supervision, debriefing and therapy 89

5.7.3 Engaging in other activities 90

5.8 Support system 91

5.9 Self-care 91

5.10 Application of the constructivist self-development theory conceptual framework 92

5.11 Chapter summary 94

CHAPTER SIX: CONCLUSION 95

6.1 Introduction 95

6.2 Conclusions 95

6.3 Limitations of the study 96

6.4 IMPLICATIONS AND RECOMMENDATIONS 97

REFERENCES 100

APPENDICES 137

Appendix A: Ethical clearance certificate 137

Appendix B: Approval letter from the Ministry of Health and Social Services 138

Appendix C: Invitation letter to participants 139

Appendix D: Informed consent form 140

Appendix E: Semi-structured interview schedule 144

Appendix F: Socio-demographics form 145

Appendix G: Declaration of language editing 146

LIST OF TABLES

Table 4.1: Participant demographic information……………………………………………..47

Table 4.2: Years of psychotherapy experience of the participants…………………….…...48

Table 4.3: Types of trauma cases…………………………………………………………...48

Table 4.4: Themes and sub-themes………………………………………………………....49

LIST OF FIGURES

Figure 1: Map of Namibia and its fourteen administrative regions……………………45

LIST OF ABBREVIATIONS AND ACRONYMS

APA	American Psychological Association
CDC	Centres for Disease Control and Prevention
CF	Compassion Fatigue
CS	Compassion Satisfaction
CSAT	Centre for Substance Abuse Treatment
CSDT	Constructivist self-development theory
DSM-5	Diagnostic and Statistical Manual of Mental Disorders-5th Edition
HPCNA	Health Professions Councils of Namibia
ISTSS	International Society for Traumatic Stress Studies
KRC	Khomas Regional Council
MGEPESW	Ministry of Gender Equality, Poverty Eradication and Social Welfare
MoHSS	Ministry of Health and Social Services
MVA	Motor Vehicle Accident
NAMPOL	Namibian Police
NSA	Namibia Statistics Agency
PAN	Psychological Association of Namibia
PTG	Post-traumatic growth
PTSD	Post-Traumatic Stress Disorder

STS Secondary Traumatic Stress

UNICEF United Nations International Children's Emergency Fund

VR Vicarious Resilience

VT Vicarious traumatisation

WHO World Health Organisation

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DEDICATION

This study is dedicated to my Creator for giving me strength and making the completion of this project possible. I give all glory to Him. "The LORD himself goes before you and will be with you. He will never leave you nor forsake you. Do not be afraid, do not be discouraged." Deuteronomy 31.8

The research is also dedicated to my grandparents, the late Christian Stephanus Shivolo and Hilma Niimbondi Shivolo. I am because you were.

DECLARATION

I, Albertina P. Luaanda, hereby declare that this study is my own work and is a true reflection of my research, and that this work or any part thereof has not been submitted for a degree at any other institution.

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Name of Student	**Signature**	**Date**

CHAPTER ONE: INTRODUCTION

1.1 Background of the study

Reports indicate that there is a high prevalence of traumatic incidents in Namibia. For example, a total of 168 crimes including assault, rape and murder were committed during the week of 04-10 May 2019 alone, nationwide (Namibian Police [NAMPOL], 2020). Moreover, 11.8% of females and 7.3% of males who participated in the study indicated that they experienced sexual violence before the age of 18 (Ministry of Gender Equality, Poverty Eradication and Social Welfare [MGEPESW], 2020). Additionally, 35.9% of ever-partnered women in the Khomas region in Namibia indicated that they had experienced physical and sexual violence from their intimate partners (World Health Organization [WHO], 2005). Finally, 3718 motor vehicle accidents and 571 fatalities were reported in the country in 2018 (Motor Vehicle Accident Fund [MVA Fund], 2018). Clinical and intern clinical psychologists come into contact with victims of trauma as they assess, diagnose and treat these victims (Ministry of Health and Social Services [MoHSS], 2009). Given the high occurrence of potentially traumatising events in the country, it is important to understand the experiences of clinical and intern psychologists who work with victims of trauma and how this impacts them.

Trauma work puts clinical and intern clinical psychologists at risk of being affected by the accounts of their clients' experiences. According to Sadock et al. (2015), trauma is defined in the *Diagnostic and statistical manual of mental disorders* (5th ed.) (DSM-5) as exposure to real or threatened death, major injury or sexual violation, which is experienced either directly or indirectly. Examples of traumatic events include violent

accidents, crime, war, assault, kidnapping, natural disasters, terminal illness and physical or sexual abuse (Sadock et al., 2015).

The impact of working with victims of trauma may be both negative and positive. If the impact of trauma work is negative, it may result in vicarious traumatisation (VT) (Pearlman & Mac Ian, 1995), secondary trauma, and emotional stress or burnout (Kamel et al., 2020). Working with victims of trauma may also lead to traumatic counter-transference (Adams et al., 2001), secondary traumatic stress (STS), or compassion fatigue (CF) (Jenkins & Baird, 2002). On the other hand, trauma work may result in compassion satisfaction (CS), vicarious post-traumatic growth (PTG), and vicarious resilience (VR) (Hernandez-Wolfe et al., 2015).

1.2 Statement of the problem

There is a long history of violence in Namibia, stemming from the time of apartheid and continuing to the present day (Wessels, 2017). This violence has harmed the Namibian society and has resulted in first-hand experiences of traumatic events by those in the country (Feinstein, 2002). Clinical and intern clinical psychologists in the country are faced with the task of providing counselling and therapy to victims of such traumatic events. This can affect them and their ability to effectively do their work (Kamel et al., 2020).

There is a paucity of research on the subject of working with victims of trauma in Namibia. Previous research has been conducted on the impact of traumatic events on police officers in Namibia (Haufiku, 2015), but not on clinical or intern clinical psychologists. Haufiku (2015) found that 60% of the participants reported being overly cautious and protective with loved ones, while some participants reported being

particularly disturbed by incidences that involved children (Haufiku, 2015). Moreover, 73% of the participants reported using alcohol as a coping mechanism, while all participants reported that talking about the incidents with colleagues was an effective coping mechanism (Haufiku, 2015). The most relevant research within the Namibian context was conducted by Perstling and Rothmann (2012), which focused on social workers but the research took a descriptive, cross-sectional and quantitative approach. That research found that the participants' work environment was demanding, with 55.2% of the participants having worked with a minimum of one victim of trauma in the previous two months (Perstling & Rothmann, 2012). It is therefore crucial to add an in-depth understanding of trauma work on clinical and intern clinical psychologists in the Namibian context to the existing body of literature through an in-depth qualitative approach.

Research conducted in South Africa on this topic indicates that working with victims of violent crimes may result in STS in counsellors or therapists (MacRitchie & Leibowitz, 2010) and this may have a negative and positive impact on nurses (Elkonin & Van der Vyver, 2011). Additional studies conducted in South Africa found that psychologists and social workers who work with victims of trauma may also develop vicarious trauma (VT) (Capri et al., 2013; Sui & Padmanabhanunni, 2016). Another study conducted in northern Uganda by Kabunga et al. (2020) found that 60.4% of psychotherapists who work with victims of trauma had high levels of CF. These studies focused specifically on STS, VT and CF respectively. The current research provides an in-depth understanding of the impact of working with trauma victims on registered clinical and intern clinical psychologists within the Namibian context.

1.3 Research objectives

The main aim of this research was to gain an in-depth understanding of the experiences of clinical and intern clinical psychologists who work with victims of trauma and how they cope with such work. The objectives of the research as outlined below were to:

1. investigate how clinical and intern clinical psychologists and intern clinical psychologists experience working with victims of trauma;
2. examine the effects of working with victims of trauma on clinical and intern clinical psychologists; and
3. determine the coping strategies used by clinical and intern clinical psychologists who work with victims of trauma.

1.4 Significance of the study

The findings of this study may create awareness about the impact of trauma work on clinical and intern clinical psychologists. This may lead to clinical and intern clinical psychologists being encouraged to take available courses in trauma work after reading about the negative impacts that trauma work may have on their own mental health as indicated in this study. Understanding the impact of working with victims of trauma on clinical and intern clinical psychologists may also help these professionals to become more aware of the need for them to learn about the tools that are available to support them in their work with trauma victims. This is the first study conducted on this topic in Namibia, hence it may, therefore, illuminate the importance of the MoHSS to add more supportive structures for clinical and intern clinical psychologists working with victims of trauma. The findings of this study and recommendations about the support required to

assist clinical and intern clinical psychologists working with victims of trauma will be provided by the researcher to the MoHSS. Finally, these research findings may encourage lecturers in the Department of Psychology and Social Work who teach students at the Masters level at the University of Namibia to include more material regarding trauma work in certain modules.

1.5 Limitations of the study

The research only focused on participants who are located in the Khomas region and this may, as a result, not be fully representative of the broader population of clinical and intern clinical psychologists across the country. The researcher was the primary instrument for data collection and analysis. This may have resulted in researcher bias due to the researcher's role and influence in the interpretation and analysis of research data. However, the researcher used reflexivity to reduce researcher bias throughout the research process. Lastly, the research did not focus on other professionals who work with trauma work, such as social workers, and this may, therefore, not be generalisable to other professions involved in working with victims of trauma.

1.6 Delimitation

The research focused on clinical and intern psychologists working in the private clinical practice sector and the Psychiatric Department in Windhoek. It did not focus on social workers or any other professionals who work with victims of trauma in other contexts. The research also did not include any clinical and intern clinical psychologists who are not based in the Khomas region. Finally, only clinical and intern clinical psychologists who were registered with the Health Professions Councils of Namibia (HPCNA), and have provided psychotherapy to victims of trauma were included in this research.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter provides an overview of the literature by focusing on the profession of clinical psychology including within the Namibian context. The section thereafter focuses on traumatic experiences, as well as the definition of trauma, and its prevalence and impact in Namibia. The potential effects of trauma on clinical and intern clinical psychologists working with victims of trauma are then highlighted. This is followed by an overview of the different concepts that are used to define the unique phenomenon of working with victims of trauma. The conceptual framework used for the research is discussed while the potential risk factors of being negatively impacted by trauma work are discussed. The chapter concludes with the coping strategies that are used by clinical and intern clinical psychologists to cope with trauma work.

2.2 The clinical psychology profession

Clinical psychology is a branch of psychology that is interested in the mind and how it influences behaviour, which traditionally strived to alleviate human suffering (Joseph & Wood, 2010). This branch of psychology focuses on the diagnosis and treatment of abnormal behaviour, mental illness and psychological disorders in people (Tang, 2013). It also involves identifying the causes of distress and delivering interventions to reduce that distress (Burns & Zitz, 2015). Clinical psychology aims to improve the psychological well-being of individuals and reduce adversity. This is done by tackling different mental disorders and combining the science of psychology with the assessment, prevention, diagnosis and treatment of different human problems (American Psychological Association [APA], 2014).

Clinical psychologists are professionals who provide services that are related to clinical psychology. A clinical psychologist's scope of practice includes the professional assessment, diagnosis and treatment of psychological illness in people and dysfunctions in human behaviour (MoHSS, 2009). Clinical psychologists deal with a large number of issues and symptoms that include depression, anxiety, learning disabilities and vocational problems, to name a few (Trull & Prinstein, 2013). Clinical psychologists usually operate as part of a multi-disciplinary team, providing interventions that address psycho-social elements of well-being (Burns & Zitz, 2015). Intern clinical psychologists may perform any of the above-mentioned duties as part of their training, provided that this is done under the supervision of an appropriately registered and experienced clinical psychologist (MoHSS, 2009). In Namibia, it is required for an individual to obtain a Master in Clinical Psychology qualification before being able to be registered as an intern clinical psychologist with the HPCNA, specifically with the Social Work and Psychology Council of Namibia. Intern clinical psychologists, therefore, have the same university training as clinical psychologists. An intern clinical psychologist may become a registered clinical psychologist after completing a supervised internship for one year and completing the evaluation of the HPCNA (MoHSS). There were 69 registered clinical psychologists and 13 intern clinical psychologists in Namibia at the time of the compilation of the 2020/2021 annual report (HPCNA, 2021).

2.3 Traumatic experiences: Definition and prevalence in Namibia

Trauma is defined in the DSM-5 as exposure to real or threatened death, major injury or sexual violation, which is experienced either directly or indirectly (Myers et al., 2013; Sadock et al., 2015). It may also be defined as an emotional response to a traumatic incident

which may result in shock and denial shortly after the incident occurs (APA, 2021). When such an experience is accompanied by intense fear, horror and helplessness, it may result in the development of PTSD (Sherin & Nemeroff, 2011).

Symptoms of trauma can be divided into three clusters: avoidance, intrusion and hyperarousal (Dass-Brailsford & Myrick, 2010). These symptoms include distressing and intrusive memories, irritability, hypervigilance, poor concentration, difficulty sleeping, poor concentration and avoidance (Yehuda et al., 2015). Examples of traumatic events include natural disasters, war, rape, emotional abuse or accidents (Hesse, 2002). Trauma may result in a change in the worldview of the victim of trauma (APA, 2020). It may also change a person's perception of well-being, thus causing them to become increasingly fragile and unstable, which may change their identity into that of a victim (Perrotta, 2019). People tend to respond differently to traumatic events. Some may exhibit symptoms of PTSD, while others may display more resilience and show some symptoms without fully meeting the criteria for PTSD (Centre for Substance Abuse Treatment [CSAT], 2014). Additionally, there has been an increase in research about adverse childhood experiences and their impact on mental health as these experiences have also been found to result in mental health challenges including post-traumatic stress disorder (PTSD) (Anda et al., 2006; Hambrick et al., 2021; Oral et al., 2016).

There is a high occurrence of trauma in Namibia. Media reports about traumatic incidents in the media have become common. For instance, some of the most disturbing news reports between 2019 and 2021 included a nephew hacking his uncle to death (Haidula, 2019), a man stabbing his girlfriend to death (Ngatjiheue, 2021), and a 16-year-old boy who was assaulted to death and buried by his aunt (Shaanika, 2021). Additionally, 150 cases of

gender-based violence were reported in the Oshana region between January to May 2021, including 28 cases of rape (Nembwaya, 2021). Moreover, a study about violence against children and violence in Namibia found that 32.9% of female and 41.2% of male participants reported experiencing physical violence during their childhood (MGEPESW, 2020). A study about the prevalence and types of injuries in the Khorixas district hospital found that injuries such as cuts or stab wounds, motor vehicle accidents, assaults and gunshot injuries accounted for 6.8% of all admissions at that hospital (Oyefeso et al., 2011). Road injuries are listed as being part of the top ten causes of death in Namibia (Centers for Disease Control and Prevention [CDC], 2020). This high occurrence of trauma in the country indicates that clinical and intern clinical psychologists are likely to work with victims of trauma at some point in their careers.

2.4 Effects of trauma on mental health professionals working with victims of trauma

Numerous studies have focused on the impact of working with victims of trauma on therapists and therapist trainees (Adams & Riggs, 2008; Collins & Long, 2003; Dagan et al., 2015; Deighton et al., 2007; Hernandez-Wolfe et al., 2015; Hesse, 2002; Iliffe & Steed, 2000; Kanno & Giddings, 2017; McCann & Pearlman, 1990; Saakvitne, 2002; Silveira & Boyer, 2015; Tosone et al., 2012; Trippany et al., 2004; Voss Horrell et al., 2011; Yilmaz, 2021). Some studies have also focused on the impact of working with victims of trauma on social workers (Boscarino et al., 2004; Cunningham, 2004; Levine, 2001), nurses (Hinderer et al., 2014; Ogińska-Bulik et al., 2021; Von Rueden, 2010), paramedics (Austin et al., 2018; Avraham et al., 2014; Regehr et al., 2002), and on case managers (Donohue, 2020).

On the contrary, there is a paucity of studies that have focused on the impact of trauma work on mental health professionals in the African context. For instance, a study in South Africa

focused on how therapists are impacted by working with victims of trauma within the context of vicarious trauma (Sui & Padmanabhanunni, 2016), while another study focused on the impact of social workers working with victims of trauma (Munyoro & Mavhungu, 2021). Another study conducted in South Africa (MacRitchie & Leibowitz, 2010) focused on STS among trauma workers in South Africa, ranging from volunteers to counsellors. In Nigeria, there is a study that focused on vicarious trauma as experienced by clinicians who work with victims of sexual violence (Ilesanmi & Eboiyehi, 2012). There is, therefore, a need for more research to be conducted on this topic, particularly within the African context and more specifically, in Namibia.

2.4.1 Research findings

The following section of this research comments on the impact of trauma work on clinical and intern clinical psychologists, social workers, counsellors, and case managers. These professionals are referred to as mental health professionals and they include psychologists, psychiatrists, social workers, other medical doctors, nurses, occupational therapists and other paid workers working in mental health (WHO, 2014).

Research indicates that mental health professionals who work with victims of trauma are indirectly affected by their client's traumatic accounts. This is because they are required to practice empathy towards their clients. Therefore, when these professionals practice compassion and empathy, it may result in them suffering too (Figley, 2002). In addition to having empathy, working with victims of trauma requires mental health professionals to be present, focused, calm and highly skilled, which may be both strenuous and rewarding (McKim & Smith-Adcock, 2013). Mental health professionals may experience intense stress and anxiety as they listen empathically to their clients' trauma (Kanno & Giddings, 2017),

which may occur at conscious and unconscious levels (Devilly et al., 2009). In addition, these professionals can be impacted by trauma work in both negative and positive ways. An individual battle with the consequences of trauma may result in negative, positive and a combination of both positive and negative experiences (Calhoun & Tedeschi, 2004). For example, working with victims of trauma has the potential to transform the professional's worldview from being meaningful to realising that terrible things happen to people (Molnar et al., 2017). Furthermore, working with victims of sexual abuse may result in mental health professionals having negative and positive experiences as a result of the nature of their work (Pack, 2014).

Moreover, it was found that mental health professionals who work with victims of trauma may experience a disruption in their schemas about themselves and the world, which may be subtle or shocking (McCann & Pearlman, 1990). These disruptions occur in five main areas of psychological needs: safety, trust or dependency, esteem, control and intimacy (Baker, 2012). This is illustrated in a study by Sui (2015), which found that mental health professionals experienced fragmented assumptions about the world, symptoms similar to those of PTSD and psychosomatic symptoms. Similarly, mental health professionals who work with victims of sexual trauma become exposed to graphic images and thoughts of violence and abuse that have been experienced by their clients, which may result in distortions in the professional's perceptions of themselves and others (Hunt, 2018). Another study by Merriman and Joseph (2016) found that all mental health professionals who participated in their study experienced negative emotional responses to their client's traumatic stories including feelings of horror, sadness, anger, fear and feeling overwhelmed by these emotions. Additionally, while there are no studies conducted in Namibia about

clinical and intern clinical psychologists, some studies conducted in Namibia such as the study by Haufiku (2015) found that some participants reported symptoms similar to those of PTSD as a result of working with victims of trauma, and reported experiencing fear, feeling desensitised, and continuously thinking about the victims of trauma. Moreover, another research study conducted on social workers in Namibia found that 33.6% of the participants experienced life satisfaction, while participants who experienced high levels of STS also experienced low levels of psychological well-being, particularly self-acceptance and purpose in life (Perstling & Rothmann, 2012).

It is therefore recommended that having empathy towards clients who have experienced trauma must not involve over-identification with or avoidance of the client's trauma material. Rather, it requires an appropriate balance of clear boundaries, perspective and being intimately present in the therapeutic relationship with the client (Harrison & Westwood, 2009).

Despite the above-mentioned implications of trauma work on mental health professionals, there seems to be a lack of consensus in the literature regarding the extent of the impact of trauma work on these professionals. For instance, a study by Makadia et al. (2017) found that exposure to trauma work was not related to psychological distress, however, it correlated with symptoms of trauma, including avoidance, intrusions and arousal. On the other hand, Devilly et al. (2009) argue that the impact of working therapeutically with victims of trauma is overemphasised. Moreover, exposure to trauma cases seemed to have a minimal impact on the development of VT, STS and burnout (Devilly et al., 2009). There may also be potential implications for trainee mental health professionals because they work therapeutically with a variety of clients, including victims of trauma during their training,

although the degree of exposure is not yet known (Makadia et al., 2017). Traumatised mental health professionals are likely to be less effective and may re-traumatise clients, therefore, student graduates must be prepared through training about the impact of working with victims of trauma and developing effective coping strategies (O'Halloran & O'Halloran, 2001).

2.5 Concepts defining the impact of trauma work on mental health professionals

The different concepts that have been developed by researchers to describe the different effects that trauma work may have on mental health professionals will first be defined before going into the research. It should be noted that although there have been attempts to differentiate these concepts, there is a lack of data to confirm that these concepts are distinct from each other (Craig & Sprang, 2010). There seems to be division about these concepts being distinct or having the same meaning. Research concerning the impact of trauma work on mental health professionals has usually been limited by a lack of clarity about the different concepts used to describe the impact of such work (Devilly et al., 2009).

Seven concepts have been developed to define the impact of trauma work on mental health professionals. The four related concepts describing the negative effects of working with traumatised clients are VT, STS, burnout and CF. On the other hand, the three related positive concepts are compassion satisfaction, PTG and VR. Although De Kock (2013) states that each concept has a different meaning, Baird and Kracen (2006) found that there was a lack of clarity in the literature between VT and STS which they attributed to a lack of research on these concepts at the time. Similarly, Devilly et al. (2009) found that the concepts of VT, STS and burnout seem to measure the same phenomenon and that they are accurately predicted by the model for burnout rather than by their theoretical models. Craig and Sprang

(2010) also stated that the concepts of CF, VT and STS are used to apply to the same condition which indicates that there is a lack of conceptual clarity about this phenomenon (Craig & Sprang, 2010). Nevertheless, the different concepts are outlined and explained based on the available literature in the following section.

2.5.1 Vicarious traumatisation

According to Pearlman and Mac Ian (1995), VT is a concept that describes the impact that trauma work can have on mental health professionals. It may also be defined as the response of those who have witnessed, been exposed to explicit knowledge of or were responsible for intervening in a very distressing or tragic event (Lerias & Byrne, 2003). It is the cumulative impact of identifying with a client's account of a traumatic experience which can affect the mental health professional's emotions, thoughts, schemas, self-esteem, locus of control, sense of safety and worldview (Baird & Kracen, 2006; Kadambi & Truscott, 2004; Puvimanasinghe et al., 2015). Collins and Long (2003) consider the concept of VT as only referring to negative changes in the mental health professional's frame of reference and therefore, being insufficient as a conceptual framework to understand the complete range of the impact of trauma work on mental health professionals.

This phenomenon results from a mental health professional engaging empathically with the client's disclosure of traumatic events during therapy (Collins & Long, 2003; Pack, 2013; Caringi & Pearlman, 2009). It is seen as a normal response to a client's trauma material but at the expense of the professional (Baird & Kracen, 2006). It appears that some individuals who work with victims of trauma may be more prone to developing VT than others.

Symptoms of VT usually have a rapid onset (Rothenberg et al., 2008). These may include fear, feeling alienated and a shattered worldview (Lerias & Byrne, 2003; Pross, 2006).

Additional symptoms may include sadness, crying, nervousness, hypervigilance, fatigue, psychosomatic symptoms, sleep difficulties and nightmares (Baker, 2012), fear, flashbacks and avoidance (Rothenberg et al., 2008). VT can potentially negatively impact a mental health professional's interactions with others, seeing as it can disrupt cognitive, emotional, and/ or psychological schemas in a person (Tabor, 2011). When VT is unaddressed, it may result in the mental health professional confusing boundaries in therapeutic relationships which may result in misconduct (Iqbal, 2015).

Not all mental health professionals who work with victims of trauma will develop VT. Additionally, these professionals may experience both VT and VR which may help them to cope with their work and reduce burnout (Welsh, 2014). Those who experience VT are often overlooked because the degree of their distress may not be regarded as significant enough. They therefore suffer in silence until the distress becomes visible (Lerias & Byrne, 2003).

2.5.2 Secondary traumatic stress and compassion fatigue

STS results from indirect exposure to trauma through hearing a client recount their first-hand account of a traumatic experience (Sabo, 2011; Vîrgă et al., 2020; Zimering et al., 2003). It is conceptualised as physical, emotional and psychological exhaustion that results from exposure to chronic work-related stress (Xie et al., 2021). STS includes psychological, cognitive and emotional symptoms that are similar to PTSD and are reported by the victim of trauma (Cohen & Collens, 2013; Zerach, 2013). Similarly to VT, empathy and exposure to a traumatised individual are two main elements in STS (Beck, 2011). Another similarity with VT is that STS can have a sudden onset, with symptoms including hopelessness, confusion and feeling isolated from supporters (Beck, 2011). Despite these similarities, Jenkins and Baird (2002) differentiate VT from STS, explaining that the former places

emphasis on cognitive schemas while the latter places emphasis on burnout and posttraumatic symptoms.

This relationship between STS and posttraumatic symptoms is illustrated in a study by Makadia et al. (2017), which found that exposure to trauma work significantly correlated with symptoms of trauma such as intrusions, avoidance and arousal and it was found to be an important predictor of symptoms of trauma which supports a model of STS. This impact is regarded as a form of re-victimisation and can result from a person being repeatedly exposed to a single traumatic event (Tabor, 2011).

The remaining section uses CF and STS interchangeably as there seems to be agreement that the concepts refer to the same thing. Some studies indicate that STS is the same concept as CF. STS was known as CF in the past however, this concept was changed to STS as it was considered a more user-friendly concept (Devilly et al., 2009). It is also stated that CF is a type of STS reaction that reduces the mental health professional's ability to bear the suffering of their clients (Abendroth & Figley, 2013; Figley, 2002). Conversely, there seems to be a clear distinction between CF and VT. CF is differentiated from VT in that it is not always associated with victims of trauma (Tabor, 2011).

A mental health professional who is experiencing CF may have a preoccupation with their traumatised client and re-experience the traumatic events, avoidance, numbing or hypervigilance associated with their client (Abendroth & Figley, 2013; Baird & Kracen, 2006; Figley, 2002). Additional symptoms of CF may include feelings of hopelessness, helplessness and feeling upset (Negash & Sahin, 2011). CF may be worsened when mental health professionals feel they have less control over their work environment, have increased

over-involvement with clients and have high case-loads of victims of trauma (McKim & Smith-Adcock, 2014).

There seems to be a lack of consensus in the literature about whether CF differs from burnout. Stamm (2010) breaks CF into two parts which are burnout and STS, while CF is defined as a type of burnout by Negash and Sahin (2011). Letson et al. (2020) theorise that if CF is left unattended, it may turn into burnout (Letson et al., 2020), therefore suggesting that burnout may be more severe. In contrast, Arvay (2001) argues that there is an agreement in the research that STS differs as a construct from burnout.

2.5.3 Burnout

There was initially no uniform definition of burnout and there was a wide range of opinions about what it is and what can be done about it (Maslach et al., 2001). Burnout is defined as a defensive reaction to long-term occupational exposure to interpersonal situations that results in psychological pressure (Jenkins & Baird, 2002). It is a cumulative process that results from continuous emotional and interpersonal stressors in the workplace and is characterised by emotional exhaustion as the most commonly reported symptom (De Kock, 2013; Schaufeli & Greenglass, 2001; Tabor, 2011). It may also be defined as the psychological stress that results from working with difficult situations, such as with victims of trauma (McCann & Pearlman, 1990). It may result from a reduction in self-efficacy, using emotion-focused strategies, an increase in work demand and role conflict (Rodriguez & Carlotto, 2017). Other causes of burnout can be categorised according to personality characteristics, attitudes related to work and work characteristics (Sabo, 2011).

Burnout is characterised by three features, which are emotional exhaustion, depersonalisation and a reduced sense of personal accomplishment (Maslach et al., 2001;

Rupert & Morgan, 2005). To expand on the above-mentioned characteristics, emotional exhaustion is defined by a lack of energy and feeling worn out, depersonalisation is characterised by a negative approach to others and treating them as objects as a way to cope and a reduced accomplishment may result from a lack of work-related resources (Ben-Zur & Michael, 2007; Hammond et al., 2018). Additional symptoms of burnout include feelings of hopelessness, difficulty being effective in one's work and feeling that one's efforts do not make a difference (Rothenberg et al., 2008). Symptoms of mental stress, decreased personal accomplishment, fatigue, negative affect, insomnia, reduced productivity and motivation and depersonalisation were also reported as being part of burnout (Hammond et al., 2018).

D'souza et al. (2011) found that stress and perfectionism were important indicators of personal, client-related and work-related burnout. Other indicators may include demographic factors such as formal education and age, personality characteristics and attitudes related to work (Maslach et al., 2001). Trainee psychologists may especially be vulnerable to developing burnout with 49% having reported experiencing high levels of burnout, which was related to a higher level of physical health problems (Kaeding et al., 2017).

A study by Sim et al. (2016) found that participants experienced categories of burnout in their responsibilities including clinical and non-clinical professional relationships with peers and supervisors and personal difficulties. Stress and burnout are a concern among mental health professionals because they can negatively impact the quality of patient care, including longer recovery times and lower patient satisfaction (Eriksson et al., 2018). The impact of working with victims of trauma is, however, not always negative as it may also result in satisfaction, growth and resilience. These concepts are now be examined.

2.5.4 Compassion satisfaction

This concept refers to the pleasure that may be experienced by mental health professionals as a result of their ability to do their work effectively (Huggard et al., 2013; Samios, 2018; Stamm, 2010). CS may also be defined as the pleasure, purpose and satisfaction that mental health professionals experience when they contribute to the well-being of patients and their families (Sacco & Copel, 2018). It is a positive result of helping others that may outweigh the difficulty of performing a job (Hunsaker et al., 2015; Yildirim et al., 2021).

This phenomenon results from empathy, which causes altruistic behaviours from the mental health professional and alleviates the client's suffering, which in turn enables the professional to cope with the negative aspects of their work (Sacco & Copel, 2018). CS is linked to empathy, seeing one's profession as a calling, improved work performance, competence and engagement that impact the quality of the care that will be given to the patient (Sacco & Copel, 2018). Having more years of experience with trauma work, perceived control over one's work and using evidence-based practices may result in CS (Craig & Sprang, 2010; McKim & Smith-Adcock, 2014). Family support, relationships with colleagues, empathy and resilience were found to have contributed significantly to CS (Cao et al., 2021). CS may also be experienced when a mental health professional can interact with their colleagues and contribute meaningfully to their work environment or toward the greater good of their society (Huggard, et al., 2013; Ringenbach, 2009).

Self-care and CS may be protective factors that may prevent CF and burnout (Kraus, 2005). CS may also lower negative mood and protect against the development of CF (Craigie et al., 2016). Moreover, Yildirim et al. (2021) found that CS indirectly affected and served as a protective role against burnout by enhancing self-efficacy, hope, resilience and optimism.

Specialised trauma training was found to have enhanced CS and reduced the degree of CF and burnout (Sprang et al., 2007). This suggests that mental health professionals must receive training to be more equipped to work with trauma victims. There seems to be an antagonism between CS and CF as firstly, they are opposites conceptually and findings indicate that there was a balance experienced by mental health professionals in their professional quality of life (O'Callaghan et al., 2020). Secondly, an increase in CF may suppress the mental health professional's sense of efficiency and hinder their ability to experience CS (Rossi et al., 2012). Lastly, higher scores of mindfulness were found to result in higher scores of CS, while CS predicted increased positive affect, greater life satisfaction and less depression (Samios, 2018).

2.5.5 Vicarious resilience

This is a relatively new concept that was based on a qualitative study about the experiences of mental health professionals who work with victims and families of victims of political violence (Frey et al., 2017; Hernandez et al., 2007). VR occurs when mental health professionals learn about overcoming adversity as a result of working with victims of trauma (Iqbal, 2015; Puvimanasinghe et al., 2015). Mental health professionals who work with victims of trauma may experience a process of resilience, which is characterised by a unique and positive impact that causes a change in the therapist's response to the victim of trauma's resilience (Hernandez et al., 2007; Hernandez et al., 2010). This type of growth may occur in a therapist personally and professionally (Hernandez-Wolfe et al., 2015). Mental health professionals may also learn to reframe negative experiences and coping skills as a result of working with victims of trauma if they have an awareness of, and are open to the usefulness of VR (Acevedo & Hernandez-Wolfe, 2014). This concept may be extended to refer to a

continuous process of witnessing the resilience and suffering of colleagues experiencing very stressful situations (Jun, 2020).

VR shares many elements with PTG, however, the primary difference between the two concepts seems to be that PTG specifically refers to growth or improvement (Puvimanasinghe et al., 2015). A further distinction is made between the two concepts in that PTG is a phenomenon that refers to the growth that is experienced by clients who are affected by traumatic events, while VR focuses on the growth of the mental health professional (Engstrom et al., 2008). Moreover, unlike VR, PTG does not specifically include satisfaction with or valuing of the process of therapy, hence, PTG seems to be an element of VR (Frey et al., 2017).

The relationship between VR and VT is also noted. These phenomena occur naturally and may co-occur in mental health professionals who work with victims of trauma as they listen empathically to their client’s accounts of disruption, powerlessness, resourcefulness and adaptation (Hernandez-Wolfe, 2018). Moreover, paying attention to CF and VR may help to strengthen the mental and physical health of those working with victims of trauma and may result in them making proactive decisions about balancing their work and life and taking better care of themselves (Hernandez-Wolfe, 2018).

The findings from the study by Engstrom et al. (2008) indicate that aspects that contribute to VR in mental health professionals include the recognition of the human ability to flourish, a shift in an individual's perspective of life and an acknowledgement of the importance of therapeutic work. VR also encourages the recognition of the reciprocal nature of therapy, enabling mental health professionals to balance the difficult and painful facets of trauma work with those bringing hope and promoting growth (Killian et al., 2017). VR may assist

in reducing helplessness in mental health professionals as they work with challenging cases and may increase optimism and work satisfaction among these professionals (Silveira & Boyer, 2015). It may, therefore, serve as a necessary protective factor against mental health professionals being negatively affected by trauma work.

2.5.6 Post-traumatic growth

PTG refers to a person's experience of substantial positive change that results from experiencing a major life crisis (Calhoun et al., 2000). It is a process through which a victim of trauma is positively transformed by their experience of a traumatic event (Hernandez et al., 2010). Mental health professionals may also develop PTG, which includes positive changes in their life's philosophy, self-perception and renewed hope (Sui & Padmanabhanunni, 2016; Tosone et al., 2016). The definition of PTG, therefore, involves how traumatic life experiences can have a transformative impact on an individual's personality (Jayawickreme & Blackie, 2014).

PTG has five components: increased appreciation of life, interpersonal relationships, a sense of personal growth, a change in priorities and a richer life (Tedeschi & Calhoun, 2009). In contrast, Hobfoll et al. (2007) warn that PTG has two aspects, one being the functional constructive side, while the other is a self-deceptive and dysfunctional aspect. Both of these may be referred to as positive illusions, which may result in continued negative consequences if the meaning obtained from the traumatic experience is not turned into action (Hobfoll et al., 2007).

According to Zoellner and Maercker (2006), PTG and PTSD are different concepts that have separate but continuous dimensions. Although PTG may not successfully eliminate the intrusive thoughts and cognitions that are characteristic of PTSD, it may act as a positive

buffer and may be experienced simultaneously with PTSD (Bluvstein et al., 2013; Morrill et al., 2008). Conversely, it has been theorised that PTG differs from recovery from trauma in that PTG entails more than experiencing a reduction in psychological symptoms (Wild & Paivio, 2004).

PTG may often result in people experiencing increased psychological distress but in some circumstances, it may serve as a protective factor against distress (Hobfoll et al., 2007). Some survivors of trauma may experience a profound positive transformation after a traumatic experience, while others report experiences with PTG may be dissociative beliefs that may increase their vulnerability to re-victimisation (Lahav et al., 2020). It is therefore important to identify this distinction in victims of trauma as they may guide clinical interventions aimed toward reducing the victims of trauma's risk for re-victimisation (Lahav et al., 2020). It must be noted that PTG may enable individuals to develop ways of thinking and guidelines for action to deal with future demands and challenges which may increase resilience (Tedeschi & McNally, 2011). However, despite the potential positive impact of PTG, Hobfoll et al. (2007) recommend that PTG must only be considered a positive phenomenon if and when its relationship to psychopathology is understood more clearly. Now that the terms describing the impact of trauma work have been defined, the next section of the research will focus on the extent to which this impact may be experienced by mental health professionals.

2.6 Prevalence and risk factors for mental health professionals

Studies about the impact of VT on mental health professionals found that they experienced moderate affective and cognitive symptoms of VT (Maguire & Byrne, 2017; Newman et al., 2019). It has also been found that mental health professionals in areas that are affected by repeated traumatic events reported significantly high levels of VT (Finklestein et al., 2015).

Moreover, a study found that 19% of mental health professionals reported experiencing symptoms of STS to an extent that met the criteria for a diagnosis of PTSD (Bride et al., 2009). On the other hand, only 5% of the participants were found to have high levels of STS (Kadambi & Truscott, 2004). Another study about STS in mental health professionals found that most of the participants reported mild to no symptoms of STS (Newman et al., 2019). Additionally, 24% of mental health professionals reported experiencing high levels of CF (Rossi et al., 2012). In terms of burnout, a study found that most participants reported low to moderate scores of burnout and it was theorised that mental health professionals who experienced higher levels of burnout may have chosen to leave the field (Rosenberg & Pace, 2006). Additionally, Pieters and Matheus (2020) found that professionals who had high job demands experienced components of burnout namely, emotional exhaustion and cynicism. Moreover, 29% of mental health professionals reported high levels of burnout in a study by Rossi et al. (2012).

Findings about the more positive effects of trauma work have found that CS was low in mental health professionals experiencing psychological distress (Rossi et al., 2012). On the other hand, mental health professionals with specialised training in trauma work were found to experience high levels of CS (Sprang et al., 2007). In addition, although there seems to be a paucity of research about PTG in mental health professionals, 76.8% of frontline workers reported experiencing moderate or more PTG (Feingold et al., 2022). Additionally, 68.8% of paediatric intensive care personnel reported experiencing high levels of PTG as a result of their work (Rodríguez-Rey et al., 2017). Lastly, mental health professionals were found to be positively affected by the resilience of their clients and experiencing an increased appreciation for their work with clients, therefore experiencing VR (Engstrom et al., 2008;

Hernandez et al., 2007). In addition to the extent of the impact of trauma work on mental health professionals, it has been theorised that several factors may cause some mental health professionals to be at increased risk of being negatively impacted by trauma work compared to others.

According to Kamel et al. (2020), having insufficient experience, a lack of skills, and working in areas prone to traumatic events increases the risk of such a negative impact on mental health professionals. Furthermore, a younger age, lack of trauma training, a high caseload of clients with PSTD, working with young victims of trauma and a lack of evidence-based coping skills have been found to negatively impact therapists (Craig & Sprang, 2010; Ireland & Huxley, 2018; McLean et al., 2003). Similarly, a shorter length of time giving therapy for sexual abuse cases was a predictor of greater intrusions and trauma for clinicians treating survivors of trauma (Way et al., 2004). However, although Makadia et al. (2017) agree that trainee psychologists may be at an increased vulnerability of being impacted negatively due to younger age and lack of experience, they add that it is also possible that being a trainee psychologist reduces the risk of being negatively impacted by their client's trauma material due to lower caseloads.

Additional risk factors which may result in distress among therapists include experiencing burnout in the workplace and changes in the beliefs about one's safety (Devilly et al., 2009). Interestingly, type A personality, coping styles including problem-solving, escape-avoidance and the big five traits including neuroticism, openness to experience, extroversion, conscientiousness and agreeableness may also be risk factors for therapists doing trauma work (Sabo, 2011). Furthermore, comparisons of male and female clinicians treating victims of trauma found that females were at increased risk of VT (Abendroth & Figley, 2013; Tabor,

2011). Furthermore, some studies found that there were significantly higher frequencies of personal trauma in the histories of female mental health professionals, compared to women in other professions (Follette et al., 1994).

A history of past trauma has also been theorised as being a possible risk factor. More specifically, it is thought that the degree of the negative impact of trauma work on therapists is influenced by the experience of trauma, training, education, personality styles and self-care strategies (Pack, 2013). However, there have been mixed findings about whether a history of personal trauma puts people at risk of developing VT (Dunkley & Whelan, 2006). According to Caringi and Pearlman (2009), therapists with past histories or personal trauma may have a deeper understanding and help victims of trauma than those who do not, but they may also be more vulnerable to developing VT (Caringi & Pearlman, 2009). This is however, contradicted by a study by Iqbal (2015) in which a history of past trauma was not found to put mental health professionals at risk of developing VT. Similarly, a study by Follette et al. (1994) found that therapists with a personal history of trauma did not report significantly higher levels of being negatively impacted during therapy sessions with victims of sexual abuse compared to therapists who did not report a personal history of abuse. Additionally, Ray et al. (2013) found that there was no significant difference in CF in mental health professionals with or without a history of trauma, although, CF scores were higher in those with a trauma history than those without. Finally, McCormack and Adams (2016) found that a lack of professional support, can put therapists at risk of poor self-actualisation and chronic psychopathology however, with time, therapeutic integrity can result in revived altruism and honesty.

2.7 Coping strategies

Coping strategies are consistent strategies for overcoming challenges during stressful situations (Cao et al., 2021). The role of coping strategies may be two-fold. Firstly, they may help therapists to avoid symptoms of STS and secondly, they may lead to positive psychological growth (Manning-Jones et al., 2016). Coping strategies can be positive or negative. Positive coping strategies include expressing feelings, humour, emotional support, hobbies, good physical health, spirituality and social support (Follette et al., 1994; Tabor, 2011). Negative coping strategies include using drugs or alcohol, denial and disengagement (Dunkley & Whelan, 2006; Follette et al., 1994). Unfortunately, those who experienced greater trauma effects were more likely to use negative coping strategies (Way et al., 2004).

The following coping strategies have been proposed for clinicians working with victims of trauma: engaging in peer support groups, having reasonable caseloads related to trauma, educational or training sessions for trauma work, external supervisory and peer support, formal psychotherapy and external training and education specific to trauma work (Harrisson, 2007; Iqbal, 2015; Kanno & Giddings, 2017). Having a clear sense of values, an ability to actively advocate, more experience, the ability to continuously learn and reflect, self-care strategies and progress in clients may also serve as protective factors (Roberts et al., 2018).

Social support, self-confidence and improving physical well-being have also been found to prevent the negative impact of working with victims of trauma (Kamel et al., 2020). Proper supervision and consultation for both qualified psychologists and those in training are important when working with victims of trauma (Cook et al., 2011). Gaining self-awareness, adjusting perspective, setting boundaries, adjusting work schedules and personal therapy was

also found to be some of the coping strategies used by psychologists (Sim et al., 2016). McCann and Pearlman (1990) recommend maintaining work-life balance, balancing caseloads with other professional involvements and with victim and non-victim clients, and having an awareness of personal boundaries, self-care and involvement in political work for social change as effective coping strategies. Additionally, Welsh (2014) proposes having a ritual that enables therapists to switch off from work at the end of the day.

Studies have also focused on coping skills for specific phenomena that result from working with victims of trauma. One study found that mental health professionals who use mindfulness reported lower symptoms of PTSD-related symptoms (Pow & Cashwell, 2017). Another study found that a high level of resilience resulted in fewer symptoms of vicarious trauma (Masson, 2019). Self-care, social support and humour are some of the coping strategies that can help to reduce STS and increase PTG (Manning-Jones et al., 2016).

Despite the wide range of coping strategies, it was found that engaging in the recommended coping strategies did not seem to have an impact on immediate traumatic symptoms for trauma therapists (Bober & Regehr, 2006). The effectiveness of these coping strategies, therefore, seems unclear. It is recommended that psychologists be open to each other about their struggles with working with victims of trauma instead of remaining silent about it (Figley, 2002). Finally, in addition to therapists taking the initiative to engage in coping strategies, organisations must also provide support to the therapists in their employment. This support may be in the form of social support which includes peer supervision and support (Manning-Jones et al., 2016).

2.8 Conceptual framework

The conceptual framework for this study is the constructivist self-development theory (CSDT). According to Pearlman and Mac Ian (1995), this framework considers a person's adjustment to trauma as an interplay between their personality and the traumatic event. This is within the context of cultural and social elements that influence psychological responses (Pearlman & Mac Ian, 1995). The basis of the CSDT is that people construct their realities through developing cognitive schemas, which guide their understanding of life (Trippany et al., 2004).

The CSDT proposes that extended therapeutic work with victims of trauma may result in changes in one's sense of self, others and the world (Moulden & Firestone, 2007), and may impact their personal and professional lives (Trippany et al., 2004). This may result in individuals experiencing distortions in their psychological needs related to their safety, intimacy, esteem, control and trust (Miller et al., 2010). According to Miller et al. (2010), safety needs include the desire to feel safe instead of vulnerable, while intimacy needs involve the desire to feel connected to others and the community. Additionally, esteem needs relate to feeling involved and appreciated, control needs concern the desire to be in charge of the self and others, while the need for trust involves trust in the world and personal relationships (Miller et al., 2010).

McCann and Pearlman (1990) posit that the unique effects of working with victims of trauma on therapists may be comprehensively understood within this theoretical framework. CSDT requires expansion to include the wide majority of the impact of trauma work as it does not differentiate between increased awareness and disruptions in cognitive schemas (Dunkley & Whelan, 2006).

2.9 Chapter summary

This chapter provided an overview of the impact of working with victims of trauma on clinical and intern clinical psychologists. Firstly, the profession of clinical psychology was discussed, followed by an overview of traumatic experiences and their prevalence in Namibia. The potential impact of working with victims of trauma was then outlined, after which, the different concepts for defining the phenomena of working with victims of trauma were defined. Thereafter, the conceptual framework was discussed and the potential risk factors were examined. Finally, the coping strategies used by clinical and intern clinical psychologists who engage in trauma work were summarised. The next chapter focuses on the research methodology that was used for this study.

CHAPTER THREE: METHODOLOGY

3.1 Introduction

This chapter discusses the research approach that was applied as well as the population that was selected for the study. The sampling methods, research instrument and data collection procedures employed during the research are then described. The data analysis, including the different phases involved in the thematic analysis approach, is then outlined. Finally, the ethical considerations that were followed during the research are presented.

3.2 Research design

The research study used a qualitative approach with a case study design. Qualitative designs typically focus on a few participants who can describe their experiences with a certain phenomenon (Baškarada, 2014). The research, therefore, focused on interviewing a few clinical and intern clinical psychologists, to allow them to extensively describe their experiences of working with victims of trauma.

A case study design supports comprehensive investigations that are aimed towards answering how and why questions (Rowley, 2002). This type of design may be defined as a group of approaches that aim to understand the experiences of individuals who share similarities in culture and space (Frankel & Devers, 2000). Additionally, Breakwell et al., (2012) state that qualitative research aims to present the participant's subjective experiences and how they make sense of their world. This research study therefore allowed the participants to provide in-depth information about their experiences with working with victims of trauma, and share how they cope with that type of work. Victims of trauma in this context were those who have been exposed to a traumatic incident. In qualitative research, the researcher is the primary instrument in the design process, which makes every

qualitative study unique (Lloyd-Jones, 2003).

3.3 Population

According to Asiamah et al. (2017), research participants belong to a research population, which is a group of individuals who have one or more characteristics that the researcher is interested in studying. The target population for this study was clinical and intern clinical psychologists in private practice and at the state Psychiatric Department, in the Khomas region. The selection of this region was based on the ease of access to the participants and the fact that most of the target population is in the Khomas region. There were 69 clinical psychologists and 13 intern clinical psychologists on the registers of the HPCNA in its 2020/2021 annual report (Health Professions Councils of Namibia [HPCNA], 2021). From the above-given number, there are currently 54 Clinical Psychologists and 3 intern clinical psychologists in the Khomas region (A. Kathindi, personal communication, August 22, 2022).

3.4 Sample and sampling procedure

Sampling is the process of selecting a representative part of the population to determine the characteristics of the entire population (Mugo, 2002). Sampling methods are divided into probability and non-probability sampling. Ideally, probability sampling methods should be used, as they ensure representativeness and generalisability (Acharya et al., 2013). However, if non-probability sampling is used, as is the case with this research, caution must be exercised when interpreting the results (Acharya et al., 2013). This research employed purposeful sampling and then snowball sampling to select 11 participants from registered clinical and intern clinical psychologists. Out of the 11 participants, 8 were clinical psychologists, while 3 were intern clinical psychologists. Furthermore, 5 clinical

psychologists and 1 intern clinical psychologist were working in the private sector (private clinical practice), while 3 clinical psychologists and 2 intern clinical psychologists were working in the public sector (the Psychiatric Department).

The purposeful sampling technique is often used in qualitative research to select small samples, which enables the researcher to learn a lot about the research topic (Patton, 2002). In line with the purposeful sampling technique, 2 participants were contacted after their details were obtained from the Psychological Association of Namibia (PAN), while 1 participant at the Psychiatric Department was also approached to participate in the research. These participants were then requested to refer the researcher to other potential participants who are in the same profession, and whom they knew were involved in working with victims of trauma. This is a type of non-probability sampling known as snowball design, which involves establishing cases of interest from sampling participants who know individuals with similar characteristics, who in turn know individuals who have similar experiences (Palinkas et al., 2015). The snowball design approach made the process of contacting and accessing additional participants faster and easier for the researcher.

A small proportion (30%) of the participants were known to the researcher and were approached to participate in the research using purposeful sampling, which is also a non-probability sampling method but involves the participants being selected by the researcher (Stratton, 2021). The sample size for this research is guided by the principle that the samples in qualitative research tend to be small, as the aim is to collect in-depth information from participants (Vasileiou et al., 2018). The research sample includes clinical and intern clinical psychologists from different levels of experience in both sectors which will be outlined in chapter four. No limitations were placed on the age, gender, or years of

experience of the participants.

3.5 Research instruments

The research instrument that was used for this study was a semi-structured interview guide/schedule. Semi-structured interviews are flexible in their design and administration, and they allow participants to freely express their thoughts while enabling a thorough examination of the responses (Horton et al., 2004). They are an effective tool for capturing people's opinions and understanding how they make sense of their experiences (Rabionet, 2009). The semi-structured interview guide consisted of specific unstructured questions relating to experiences with working with victims of trauma and was accompanied by a socio-demographic section.

The first part of the interview guide contained an introduction to the purpose of the research. The second part looked at the participant's definition of a victim of trauma and their motivation to do trauma work. The third part of this research instrument focused on the experience of working with victims of trauma and the potential impact of such work. The final part of the interview guide looked at coping mechanisms, training and information about trauma work, and requesting for contact information of other potential participants. The socio-demographic form that accompanied the semi-structured interview guide focused on obtaining information about the gender, age, level of qualification, context of work, years of experience and caseload of the participants.

The interview schedule was pilot-tested before the interviews to be used for this research were conducted. The pilot study is essential as it helps to determine how well the semi-structured interview guide will work in the actual research by recognising potential problems and areas that need to be changed (Dikko, 2016). The pilot study helped to refine and broaden

the research questions before the research was conducted.

3.6 Data collection procedure

Ethical clearance was obtained from the University of Namibia (UNAM) (see Appendix A) to conduct the research. Permission was then acquired from the MoHSS (Appendix B), to approach clinical and intern clinical psychologists working under that ministry at the Psychiatric Department and request their participation in the research. Additionally, permission was obtained through the Head of the Psychiatric Department to conduct research with the clinical and intern clinical psychologists working in that department. The recruitment has been described under the sampling section. Letters of invitation to participate in the research (Appendix C) were sent to potential participants through email and those who responded with interest were then contacted to arrange for the interviews. The interviews were conducted based on the participants' availability and in environments they felt comfortable in. The venues in which the interviews were conducted included the therapy rooms and offices of the participants. Informed consent and permission to audio-record the interviews (Appendix D) were obtained from participants. Interviews were conducted face-to-face by the researcher and took an average of 37 minutes per participant. The interviews were conducted using a semi-structured interview guide after which they were transcribed by the interviewer. This is recommended by Braun and Clarke (2006) who suggest that when collecting verbal data through interviews, it must be transcribed to carry out the thematic analysis. The interview schedule focused on the definition of trauma, the experience of working with victims of trauma and the coping mechanisms used by clinical and intern clinical psychologists while working with victims of trauma. As a result of the pilot study, the interview schedule was separated from the socio-demographic form, questions were

added to help with probing about the consequences of trauma work and the interviewer first focused on the negative consequences and then followed up with the positive consequences of trauma work. The prevailing COVID-19 regulations then were adhered to during the interviews.

3.7 Data analysis

According to Hilal and Alabri (2013), data analysis in thematic analysis involves finding the relationship between themes and categories of data that are collected to understand a phenomenon. Thematic analysis was used to analyse the data for this research. This type of analysis is used to systematically identify, organise, and provide insight into patterns of themes across a data set (Braun & Clarke, 2012). Thematic analysis has the benefit of flexibility, and it minimally organises and defines a data set in depth (Braun & Clarke, 2012).

To analyse the data, the researcher used the 6 phases of thematic analysis that are outlined by Braun and Clarke (2006) as being: familiarisation with the data, generating initial codes, searching for themes, reviewing potential themes, defining and naming themes, and producing the report. The process of analysis must not be viewed as moving from one phase to the next, but rather one where there is movement back and forth, as required throughout the process (Braun & Clarke, 2006). During the first phase, the data was collected through audio recordings, after which, the researcher listened to each recording once, and then typed out the conversations in Microsoft word while listening to each recording for the second time. The researcher then became immersed in the data to fully understand it while remaining mindful of not becoming overwhelmed by the amount of the data collected, as there is a thin line between being immersed in the data and being buried

by it (Seers, 2012). This aided the researcher in becoming familiar with their data as the transcribed interviews acted as memory aids and triggers for coding and analysis (Braun & Clarke, 2012). This is in line with the purpose of this phase, which is to help the researcher to start noticing things that may be related to the research question (Braun & Clarke, 2012).

The second phase began when the researcher completed reading and familiarising themselves with the collected data and created their first list of what was to be included in the data and what they found interesting (Braun & Clarke, 2006). The data was then organised to make the process of making sense of it easier. This was done through coding, which involved searching for related phrases or words that were expressed by interviewees, which were then combined to understand the associations between them (Hilal & Alabri, 2013). Codes identify and assign a label to an element of the data that may be relevant to the research question (Braun & Clarke, 2012). Coding can be done through manual approaches or through using computer-assisted qualitative data analysis software (Tracy, 2019). A manual approach was used for this research and involved developing codes by using line-by-line coding in Microsoft word to highlight the different portions of text in different colours. Notes were then typed out next to each line of the text being coded. The researcher relied on the advice from Braun and Clarke (2006) to code for as many potential themes as practically possible, keep some of the surrounding data where relevant to maintain context and remember that an extract of data can be uncoded, coded once or coded many times where needed.

During the third phase, the different codes were sorted into themes and arranged into a table using Microsoft word (Braun & Clarke, 2006). Codes that share similar features were clustered together or collapsed to generate themes and sub-themes (Braun & Clarke, 2012).

This phase was completed with a collection of potential themes and sub-themes and all other extracts of data that did not fit into any themes were retained, as it is advised that nothing must be discarded during this phase (Braun & Clarke, 2006).

According to Braun and Clarke (2006), the fourth phase involves reviewing and refining themes, which occurs at two levels. The first level required the researcher to read all the compiled extracts for each theme, consider if they formed a pattern, and then changed the theme to a new one where necessary. This involved moving the extracts to a more suitable theme or removing them from analysis, and then moving on to the next level once all the themes properly captured the coded data (Braun & Clarke, 2006). During level two, the researcher proofread the entire data set to determine whether the themes were valid to the data set and to code additional data into themes that may have been missed during the initial coding stage (Braun & Clarke, 2006). When this was satisfactory, the researcher moved to the next phase. However, when it was not, the researcher further refined and reviewed the collected data to ensure that it was adequately captured (Braun & Clarke, 2012).

The fifth phase involved the researcher defining and refining the themes and analysing the data within them (Braun & Clarke, 2006). The researcher had to explicitly state what was unique and specific about each theme in a few sentences (Braun & Clarke, 2012). Ideally, themes in the thematic analysis must have the following attributes according to Braun and Clarke (2012): a singular focus, correlate but do not overlap and directly address the research questions. The researcher also had to determine whether a theme contained sub-themes, which are themes contained in a theme and give structure to large and complex themes and show the hierarchy of meaning within the data (Braun & Clarke, 2006).

Finally, phase 6 involved the researcher completing several themes and this is where the final analysis and write-up of the report were done (Braun & Clarke, 2006). The researcher had the task of explaining their data based on their analysis compellingly and clearly which also needed to be scholarly (Braun & Clarke, 2012). Although this is the last phase during analysis, in qualitative research, it does not only occur at the end. This is because writing and analysis are interconnected, from the notes that are made informally to the formal writing of the report (Braun & Clarke, 2012). Themes must be connected in a meaningful and logical way and must build on previous themes to provide a coherent story of the data (Braun & Clarke, 2012).

3.8 Maintaining trustworthiness

An essential part of data analysis is ensuring that the findings from the research can be trusted. Determining the trustworthiness of a qualitative study is however, a complicated task, primarily because there is a lack of consensus about the set of criteria to use (Curtin & Fossey, 2007). The trustworthiness of qualitative research is also often questioned because the concepts of validity and reliability cannot be used in the same way as they are used in quantitative research (Shenton, 2004). Guba (1981, as cited in Shenton, 2004) developed four criteria that he proposed may be used in qualitative research to ensure the trustworthiness of the study namely, credibility, transferability, dependability, and confirmability.

3.8.1 Credibility

This criterion is the substitute for internal validity in qualitative research (Shenton, 2004). The techniques that may be used to ensure the credibility of a study are prolonged engagement, persistent observation, triangulation, peer debriefing, negative case analysis

and member checks (Schwandt et al., 2007). Peer debriefing and member check techniques were employed to ensure the validity of the research findings.

Peer debriefing involves sharing the findings of the research with an objective professional peer to aid in establishing hypotheses, formulating and examining the emerging design and receiving emotional release (Schwandt et al., 2007). Peer debriefings were done through regular consultations with the research supervisor to review the transcripts, methodology and outcomes as well as to obtain feedback and raise any concerns that were noted during the process of conducting the research.

Member check is the process of continuous informal investigation of information, requesting the reactions of the participants to the researcher's reconstruction of the information obtained during the research and to the constructions given by other participants (Schwandt et al., 2007). Member checks were conducted during the interviews by summarising what was said by the participants and confirming its accuracy.

3.8.2 Transferability

This involves the use of thick descriptive data or a narrative about the context of the research, so that other researchers who may want to use some or all parts of the findings in other studies may determine the level of similarity between the studies (Schwandt et al., 2007). Transferability is related to external validity, however, as qualitative research typically focuses on small groups of participants, it is not possible to show that the findings of such a study can be generalised to other populations (Shenton, 2004). The researcher, therefore, ensured that rich data was provided about the phenomenon being studied, to enable other readers to gain a proper understanding of it and to enable comparisons to their situations (Shenton, 2004).

3.8.3 Dependability

This concept relates to reliability and aims to ensure that if the research is repeated under the same circumstances, it would yield similar results (Shenton, 2004). This involves carrying out an external audit to confirm the audit trail and conducting an audit by a competent external and objective auditor (Schwandt et al., 2007). A detailed description of the research methods, the results and the findings have been provided in the research paper to ensure that they can be followed and repeated by researchers in the future.

3.8.4 Confirmability

This concept aims to ensure objectivity by taking the necessary steps to guarantee that the findings of the research are an accurate reflection of the participant's ideas and experiences rather than the preferences of the researcher (Shenton, 2004). Reflexivity and triangulation were used for this research to ensure that the researcher remained objective. These processes are described below.

3.8.4.1 Reflexivity

The researcher practised self-appraisal and took account of their position during the research, and the impact that it may have on the setting and participants, the questions that are asked, the collection of data and its interpretation (Berger, 2015). As a result, the researcher needed to be self-aware and sensitive, have a good understanding of their role while conducting and compiling the research, carefully monitor the impact of their own beliefs, biases and personal experiences on their research and keep a balance between what is personal and what is universal (Berger, 2015). The researcher did not have previous exposure to the process of conducting research, and this may have influenced the approach taken toward the research. In addition, the researcher has a background of working with

victims of trauma, which may have created insight into the experiences of the participants, but also may have created an expectation in the researcher about the results of the research. Finally, the researcher was familiar with some of the participants, which may have influenced how comfortable the researcher and/or the participants felt in asking or answering some of the interview questions respectively. The researcher made use of a journal to reflect on her experience of each interview and reflected on the research process as she progressed. This reflection was done with the aim of reducing the researcher's subjectivity and bias. The researcher also maintained an open dialogue with her research supervisor throughout the research process to maintain objectivity.

3.8.4.2 Triangulation

Triangulation involves double-checking the data by using different methods, sources and investigators (Schwandt et al., 2007). Triangulation has also been regarded as a strategy in qualitative research to measure validity through the merging of information from different sources (Carter et al., 2014). Data source triangulation were used for this research study.

Data source triangulation involves the researcher using different sources of information including participants and other researchers, to increase the validity of the study (Guion et al., 2011). The participants in this research were clinical psychologists and intern clinical psychologists with different levels of experience and working in different contexts. Additionally, the researcher regularly consulted her research supervisor throughout the research process, which made data source triangulation possible for this research.

3.9 Ethical considerations

The aim of the research and the fact that participation is voluntary were explained to the participants. Written consent for the interviews to be audio-recorded was obtained before

interviews commenced. The collected data has been locked in a cupboard in the researcher's office and the recordings will be wiped clean within five years following the making of the recordings. No names have been used as each participant was assigned an identifying number to maintain anonymity. Owing to the potentially sensitive nature of the topic of the research, the researcher offered de-briefing to participants. Contact information about counselling services was made available to participants when such services were required. The results of the research will be made available on the UNAM database upon approval of the final research report.

3.10 Definition of key terms

3.10.1 Experiences

An experience is an event that is lived through and not only imagined or thought about (APA, 2023). Experiences in the context of this study refer to the views and beliefs of the participants about their work with victims of trauma.

3.10.2 Coping strategies

Coping strategies are defined by Noorbakhsh et al. (2010) as the specific behavioural and psychological efforts that people use to master, tolerate, reduce, or minimise stressful events. For this study, coping strategies refer to any attempts made by clinical and intern clinical psychologists to help them cope with working with victims of trauma.

3.10.3 Self-care

This refers to the continuous use of different activities to improve well-being and involves promoting psychological well-being, having self-awareness, practising self-reflection and avoiding incorrect coping strategies (Barnett et al., 2009).

3.10.4 Social support

This term is defined as the act of providing help or comfort to others particularly to help them cope with psychological, biological or social stressors (APA, 2023). Furthermore, social support may result from interpersonal relationships in a person's social network including friendships, family, religious community, colleagues or support groups (APA, 2023).

3.10.5 Clinical and intern clinical psychologists

According to Rief (2019), clinical psychologists are experts in mental health and behavioural disorders, who diagnose, treat and scientifically investigate mental and behavioural disorders. In Namibia, a clinical psychologist must be registered with the HPCNA, to be able to practice within the scope of their profession. An intern clinical psychologist is a person who has completed the academic qualification required to become a clinical psychologist and is undergoing training toward becoming a clinical psychologist (Republic of Namibia [RNAM], 2004). In Namibia, an intern clinical psychologist is required to undergo an internship training for one year fulltime, followed by a mid-term and end-term oral evaluation at the Social Work and Psychology Council, which needs to be successfully passed before they may be registered as a clinical psychologist.

3.10.6 Victims of trauma

A victim of trauma is a person who has experienced real or threatened risk of death, injury or physical or sexual abuse either directly or indirectly (International Society for Traumatic Stress Studies [ISTSS], 2016). For the purpose of this study, indirect exposure to trauma may result from listening to accounts of traumatic incidences that have happened to victims

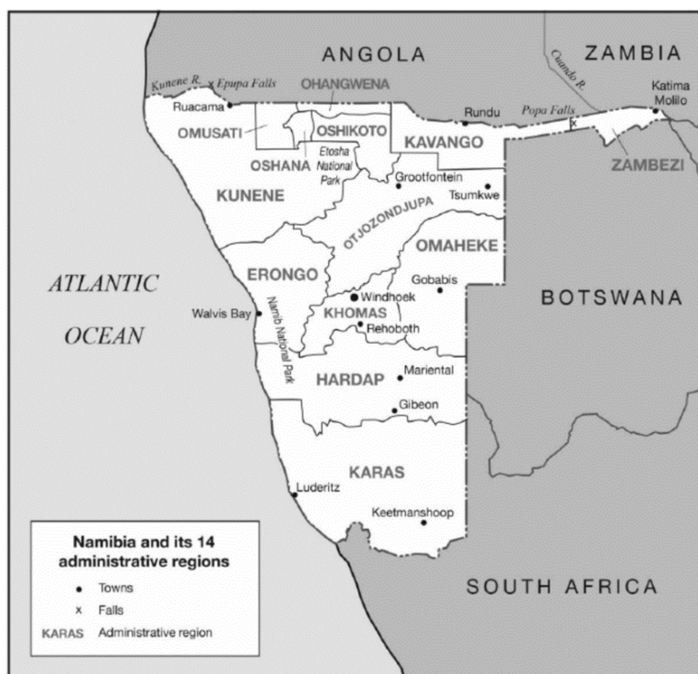
of trauma during the course of the clinical or intern clinical psychologists work, or to someone known to these professionals (May & Wisco, 2016).

3.10.7 Khomas region, Namibia

This is the most central region in Namibia, where the capital city of the country, Windhoek (figure 1), is situated (Hitchcock, 2015). It has a surface area of 36 805 KM squared and its population represents more than 11% of the total population in Namibia (Khomas Regional Council [KRC], 2015).

Figure 1

Map of Namibia and its fourteen administrative regions



Note. Map of Namibia illustrating the towns and regions in the country including the Khomas region indicated in the middle of the map. From "Map of Namibia and its fourteen administrative regions," by R. K. Hitchcock, 2015, *Anthropological Forum*, *25*(3), p.262, Figure 1 (https://doi.org/10.1080/00664677.2015.1027658). CC BY.

3.11 Chapter summary

This chapter described the research design and the population that participated in the study. A detailed description of the sampling methods, research instrument and data collection procedures used was also provided. The chapter also outlined the data analysis including the different phases involved in the thematic analysis approach. Finally, the ethical considerations that were employed during the research were discussed.

CHAPTER FOUR: RESULTS

4.1 Introduction

This chapter outlines the results of the thematic analysis. Firstly, a description of the participants is provided, after which the results from the thematic analysis which include the themes and sub-themes are outlined. Finally, the chapter is concluded.

4.2 Description of participants

As indicated in the previous chapter, 11 participants were interviewed for the research. They included 1 male and 10 females. The ages of the participants ranged from 29 to 60 years, (mean = 41). Of the 11 participants, 6 were from private practice while 5 worked at the State Psychiatric Department (Table 4.1). The number of years of the participant's psychotherapy experience ranged from 5 months to 28 years (mean = 8.3), (see Table 4.2). Table 4.3 shows the types of trauma cases encountered by the participants during their work.

Table 4.1

Participant demographic information

Code	Gender	Age	Position	Context	Estimated trauma caseload	Trauma caseload converted per year
P1	Female	60	CP	Private	15 per year	15
P2	Female	51	CP	Private		
P3	Female	31	CP	Private	5 per month	60
P4	Female	29	ICP	Private	3-5 per month	36-60
P5	Male	55	CP	Private	52 per year	52

P6	Female	37	CP	State	3-4 per week	156-208
P7	Female	31	ICP	State	2-3 per month	24-36
P8	Female	34	CP	State	100 per year	100
P9	Female	44	ICP	State	8 per week	416
P10	Female	38	CP	State	10 per month	120
P11	Female	41	CP	Private	50 per year	50

Note. P = participant; 1 to 11 = order in which interviews were conducted; CP = clinical psychologist; ICP = intern clinical psychologist

Table 4.2

Years of psychotherapy experience of the participants

Years of experience	**Number of participants**
0-2	4
2-10	4
10-30	3

Note: The number of years the participants have been doing psychotherapy work

Table 4.3

Types of trauma cases

Type of trauma	**Number of participants who indicated working with the trauma**
Rape	10
Motor vehicle accidents	5
Unresolved childhood trauma	4

Trauma resulting from COVID-19	4
Domestic violence	3
Bereavement	3
Witnessing the death of others	2
Robberies	1
Verbal and emotional abuse	1
Climate change	1

Note: The trauma cases reported by participants as having been experienced by the victims of trauma they have worked with during psychotherapy

4.3 Themes

Table 4.4 below indicates a total of nine themes that were identified during the analysis. The main themes that were identified were the helper's perspectives on trauma work, responses to trauma work, risk factors, the role of empathy in trauma work, discomfort with the limitations of the role, work and professional issues, coping with trauma work, social support and self-care. These are presented in the next section of the chapter.

Table 4.4

Themes and sub-themes

Theme	**Sub-themes**
1. The helper's perspectives on trauma work	
2. Responses to trauma work	1. Burnout 2. Vicarious/secondary traumatic stress 3. Increased professional skills 4. Personal growth 5. Rewarding 6. Healing 7. Increased awareness of societal concerns

	8. Hope
3. Risk Factors	
4. The role of empathy in trauma work	
5. Discomfort with the limitations of the role	
6. Work and professional issues	
7. Coping with trauma work	1. Maintaining boundaries 2. Supervision 3. Debriefing and therapy 4. Engaging in other activities
8. Social support	
9. Self-care	

Note: Themes that resulted from the thematic analysis

4.3.1 The helper's perspectives on trauma work

The first part of this theme explains the definition of trauma as provided by the participants then it focuses on how the participants generally view working with victims of trauma. All the participants provided the standard definition of a victim of trauma however, more than half (n=6) of the participants indicated that trauma may cover additional elements that are not included in the current standard definition. Additionally, fewer (n=3) participants emphasised the need for adverse childhood experiences to also be considered traumatic.

P1: *There is also new research that is showing that ummm…trauma can also be defined in broader terms…every client who is walking in may potentially have trauma. …issues such as neglect, severe abandonment, umm…neglect, severe abandonment,*

rejection, from a young age could actually be traumatic…adverse childhood experiences…

P2: *And I think just, we, if you look at the economy, if you look at the war in Ukraine, if you look at COVID, and that financial impacts petrol prices going up people losing their jobs, all of these things are traumatic.*

P3: *But I think sometimes that doesn't include everything because people um, experience certain things that might not count as trauma, might experience things as, as traumatic events.*

The participants seem to infer that clinical and intern clinical psychologists must consider the possibility that all the clients they work with may be victims of trauma even if they do not speak about it. Traumatic events in this instance may include the indirect results of events occurring internationally such as war, the aftermath of a pandemic or adverse childhood experiences.

In addition, although all the participants have worked with victims of trauma, they all indicated that they did not particularly seek out trauma work. Victims of trauma were reported to have been encountered during the participant's work as they work with the cases that are presented to them. Although some (n=4) participants indicated that trauma work is an area of interest for them, they also emphasised the importance of maintaining a balance and avoiding working solely with victims of trauma. A small proportion (n=2) of the participants indicated that they enjoy trauma work but also highlighted that this is as long as they also have non-trauma victims on their caseloads. This is because it may

put clinical and intern clinical psychologists at risk of experiencing secondary trauma, which is discussed later in this chapter.

> P3: *Like I said, I actually like working, with trauma. But I think there's also a balance. I wouldn't just want to work purely with trauma.*

> P8: *To be honest, um, where I work, you don't get to choose what cases to deal with. We don't have that luxury, you deal with whatever comes your way. Yes. Um, so, I just happen to be dealing with trauma because you pick any patient that comes.*

> P11: *Um, it is definitely a field of interest, for sure. But um, in terms of who ends up in therapy with me, referral isn't based on that.*

There seemed to be an assumption that clinical and intern clinical psychologists who work in certain contexts had the opportunity to decide whether or not they wanted to work with victims of trauma. The ability to have this option was even referred to as a luxury by one of the participants, although all participants reported that they eventually ended up with victims of trauma on their caseloads.

In addition to discovering that victims of trauma are eventually likely to fall in their caseloads, there also seems to be the realisation that learning about coping with such work is also something clinical and intern clinical psychologists have to learn about on their own. It seems this may be an unanticipated revelation for some participants particularly when first starting to practice in the profession.

The participants gave mixed responses about how they view working with victims of trauma. Generally, trauma work was regarded by most (n=7) of the participants as being tiring, difficult and evoking strong emotions. On the other hand, fewer (n=3) participants

reported that trauma work may result in positive experiences as it may be liberating, fulfilling and rewarding. The participants reported that trauma work may provide an opportunity for them to witness the recovery of the victims of trauma.

> P5: *I think the experience number one is, initially is anger, you know. Getting angry with the perpetrator, um, feeling quite sad on behalf of the client who happens to be the victim, anxiousness, you know.*

> P10: *[pause] Shu, it's um, I think what I like about trauma and working with victims of trauma is that…it's, you have an opportunity to see…to see recovery.*

The next theme outlines the different responses that clinical and intern clinical psychologists may have when working with victims of trauma. The participants identified the types of responses they experienced while working with victims of trauma as being positive and negative.

4.3.2 Responses to trauma work

All the participants reported experiencing different types of responses as a result of working with victims of trauma. These responses were reported as being burnout, VT/STS, increased professional skills, personal growth, reward, healing, increased awareness of societal concerns and hope.

4.3.2.1 Burnout

Many (n=7) of the participants defined burnout as physical and emotional exhaustion that may result from working with a high caseload of victims of trauma and/or engaging in trauma work over long periods. The participants, however, indicated that burnout also

results from doing therapy work in general as their work requires them to be present with each client or patient they work with during therapy.

> P2: *...like you see it with some of the other people, also the other counsellors and therapists, you get to a point where you start feeling a little bit burnt out, you know, it's another person, it's another person. And you get fed up, you know, just seems like you, you don't want to do this anymore.*

> P5: *Burnout. Yes, I would have burnt out almost every other time. So, you know, the clinical practice is always quite demanding, it saps on the energy.*

> P6: *As a helper, with, like I said, it's very, you're at high risk of burnout because you have to leave yourself and be there for that person, you know, and that person is the only important person in that room. And you're doing that for each and every single patient or client that you have. It can be very draining, very exhausting um, at the end of the day, literally, I don't really want to talk to anybody.*

Clinical and intern clinical psychologists may run the risk of burnout due to the demand of the work they do and may at times notice signs of burnout being displayed by their colleagues. This may result in them feeling depleted and isolating themselves from others.

Additional symptoms of burnout reported by the participants were feelings of helplessness as reported by few (n=2) participants. It is usually accompanied by worry that the work the clinical or intern clinical psychologist does may not add much value. A lack of motivation was also reported by a few (n=3) participants as well as feeling overwhelmed. Participants reported feeling detached from the victims of trauma and as a result, rushing the sessions particularly when they have been working with many victims of trauma. The

importance of participants being mindful of how they feel and engaging in objective self-introspection was noted as being vital to prevent burnout.

P2: *One becomes angry, angry at what is happening, and you start feeling frustrated and helpless to a certain extent because you see the people after the fact.*

P11: *I think it's, you either become so overly strategic with everything or you just really feel helpless. Because you actually, there's often the realisation that perhaps that would, that which you are doing, doing is a drop on a hot stone ne, it's just gonna, in the end, not really make that much of a difference.*

P4: *I, what I've, what I've noticed is you…without noticing you become kind of detached. I think it becomes dangerous when you don't remain mindful of where you're at emotionally, you know. Because you just keep on going, you never take the time to stop and evaluate where you're at. Um, you get to a point where you get burned out emotionally.*

Listening to the traumatic accounts of the victims of trauma may evoke strong emotions including anger, and cause clinical and intern clinical psychologists to feel that the work they are doing with the victim of trauma may not be having much of an impact. The clinical or intern clinical psychologist may therefore either become very organised in their approach with the trauma victim in an attempt to make a significant impact in their healing or they may become detached.

Additionally, one participant reported feeling overwhelmed, which is often accompanied by feelings of irritability. Not paying attention to this may result in a clinical or intern

clinical psychologist falling ill frequently and experiencing changes in their sleep patterns as reported by a few (n=2) of the participants.

> P6: *So, it can be quite overwhelming and there's always the risk of burnout. And when you experience, when I start experiencing that, obviously, you know, becoming irritable, being impatient, it affecting the sleep and things like that, then I know okay, it's time to take a break. And usually, in cases where I don't really listen to my body, I end up getting sick. So, and then you're forced to take a break anyway.*

> P10: *...or you're just irritated, um, constantly irritated and also just feeling constantly exhausted. Regardless of how much sleep you get. You just feel tired. Constantly, you just recovered from a flu or whatever and again, you're sick three days later.*

> P4: *...because you're exhausted, you could see eleven clients a day, 50% of them are trauma cases or some type of thing like that, and then you get home and you are exhausted*

Feelings of irritability and exhaustion coupled with regularly falling ill were also reported. This may prompt the question as to whether these responses to trauma work may be carried over into professional and personal relationships and the possible implications of that.

Isolating oneself from others was also reported as a symptom of burnout by a few (n=2) participants. This is usually due to the clinical or intern clinical psychologist feeling too exhausted to be around people or anticipating that their loved ones may have problems that they want to share with them. Finally, self-doubt in their ability to do their work was also reported by fewer (n=3) participants as being an experience of burnout.

P4: *...and then having to be present to, to also receive, in my case, my husband's day, and, and his emotions or my children's wishes, they're still small, or friends, you know, there was a period, like a month ago where I wasn't as involved with, with my friends, for instance, because it was just a lot, you know.*

P9: *Uncertain, whether I was doing what I was supposed to be doing. And for me, I think emotionally it was a very, also exhausting process. And it was the beginning of my internship, I was always tired. Very emotionally drained.*

P11: *um, I think it becomes, you know, on the other end of the spectrum is the difficult work where…when you work with trauma victims, and there's a reality of re-traumatisation in the background there, um, that it becomes very difficult work because you have to second guess everything that you're doing.*

It also seems that trauma work may be experienced as lonely. The experience of feeling isolated from others while doubting the impact of their work with trauma victims may be a difficult position for clinical and intern clinical psychologists to find themselves in. This is while having to continue working and being present with their clients.

4.3.2.2 Vicarious/secondary traumatic stress

Nearly half (n=5) of the participants reported experiencing VT or STS as they worked with victims of trauma. Clinical and intern clinical psychologists reported feeling traumatised through listening to the accounts of traumatic experiences of the victims of trauma. This happens especially when the participant frequently does trauma work, when the victims of trauma are children, when the cases are based on gender and when the traumatic experience is considered overwhelming by the participant. Participants also

reported that clinical and intern clinical psychologists may be more likely to experience VT if they or their loved ones have experienced the same traumatic experience.

P5: *Although vicariously I think people go through quite a lot of trauma, even ourselves, as we listen to these narratives. I think, I think it's quite a common thing, that as we listen to it and sometimes we do referencing, you know, that you, especially if it might have happened to you, or to a close family member, it's easy to reference you know that. So, it happens quite a lot vicariously to psychologists.*

P6: *But we are human beings. And once you start hearing um, some of these incidences, especially when it comes to GBV cases, when it involves children, it can be quite um…traumatising, if I can say, to the therapist as well, to myself.*

P8: *I think it can also cause them trauma as well. Which we call is it vicarious trauma? Yes, you can also get secondary trauma from working with patients that are traumatised. But if the event is so overwhelming, it can actually cause you to somewhat be traumatised as a clinician.*

Participants were affected by the traumatic accounts of the victims of trauma, particularly those that hit close to home or those involving children, perhaps due to their vulnerability. This was regarded by a participant as being a common occurrence amongst those in the profession. This may lead to the question of whether most clinical and intern clinical psychologists acknowledge this impact on them and if they seek assistance to ensure it is addressed.

Symptoms of VT or STS that were reported include losing a sense of safety for themselves or their loved ones, which was reported by some (n=4) of the participants. Working with

victims of trauma was also reported to affect a clinical or intern clinical psychologist's mood and evoke emotional responses from participants, including anger, sadness, anxiety, devastation, and feeling overwhelmed. Additionally, it was reported by a few participants (n=3) that they experienced physical reactions such as feeling sick to their stomach. An inability to stop thinking about the victims and interpersonal relationship stressors including marital problems were also reported.

> P11: *Like there's…yeah, you do become a little bit paranoid. Because, your mind really has seen so much proof of what, what is out there and the potential of trauma. Um, so, you are possibly I think, personally a little bit overly cautious. Especially I think for me when it comes to my own children.*

> P2: *Um, negatively affected in a way that it upsets your mood? Yes, I think so. Because I think that…we are just human and, one feels for the people that you're working with. Ummm, and things can sometimes be severely traumatising.*

> P8: *[sigh] to some, yeah, to be honest, sometimes I would feel sick in my stomach…*

Additional symptoms of VT and STS were reported to include difficulty with maintaining professional boundaries with the client, as reported by few (n=3) of the participants, avoiding working with victims of trauma which was reported by fewer (n=2) participants and over-identifying with the client particularly when the clinical or intern clinical psychologist has experienced trauma themselves according to the (n=3) participants.

> P9: *But it's almost like um, in my second case, I, I had to remind myself of the role that I have as a therapist because sometimes you can get so invested in what your client is going through that you, almost like, I need to be the activist for my client.*

P3: *Um, I also think it depends also on the therapist's background, because sometimes you, and I think in general, um, transference can definitely happen if you've gone through similar traumatic events, then what your client is going through.*

It is important for the clinical and intern clinical psychologists to also be aware of how their past experiences may influence the therapeutic relationship to avoid crossing boundaries with the victims of trauma. There is also the need to be well versed about where the clinical and intern clinical psychologist's role begins and where it ends to maintain the professional boundaries with the trauma victims.

4.3.2.3 Increased professional skills

The majority (n=8) of the participants reported that trauma work has helped with their professional growth. Trauma work was reported to have increased their empathy, coping skills, creativity, effective ways of working with victims of trauma and the ability to identify trauma when it was not obvious or reported by the victim. It must be noted that it was observed that some participants seemed reluctant to reflect on the positive impact of working with victims of trauma and took time to reflect before they responded to the question. One of the participants reported feeling that although they have gained the ability to improve their skills, they felt this could be obtained in different ways instead of having to learn it through working with clients who are traumatised.

P1: *[Silence] So, I…I'm not so sure about…what…positive impact can you get from working with someone who is traumatised other than maybe gaining…better understanding that would equip you to provide better care because you hone your skills.*

P4: *So it's a growth, you know, there are professional growth and knowledge that you gain from that. But also able to identify symptoms when trauma is not brought up.*

P9: *...it reminds you of empathy, it, it reminds you of standing in that person's shoes, literally stepping in, and understanding their experiences from their perspective.*

Working with victims of trauma may sharpen the clinical and intern clinical psychologists' skills, however, this seems to be bittersweet for the participants. This is because this increase in skills may be regarded as coming with the price of working with people who have experienced something horrific.

4.3.2.4 Personal growth

In addition to professional growth, some (n=4) participants reported experiencing personal growth as a result of working with victims of trauma. This growth includes an increased awareness of personal areas that the clinical or intern clinical psychologist realises may need to work on. This personal growth also includes becoming mindful about raising children as a parent and feeling stronger and empowered.

P6: *And in that way, it can also help in terms of personal growth, to say, you know, what, this, I've dealt with this before, or this issue is bringing up my own issues that maybe I haven't necessarily dealt with properly.*

P9: *For me, at least, that I can, um, and even when you have children, or even if you plan to have children, you, there are certain things that you pick up that maybe*

as a parent, you would have never thought of, that as a future parent, you're like an okay when I have a child, I need to be mindful of this.

P10:*..from Post-Traumatic Stress Disorder to Post-Traumatic Stress Growth. Because that's now the concept I think that we using because…instead of now suffering from, that there can be growth, from trauma, basically.*

Personal growth here seems to be inspired by the resilience exhibited by trauma victims, which may lead to the clinical or intern clinical psychologist reflecting on their own experiences and deciding to grow from them and not remain a victim. It may also mean learning from others' painful experiences and applying it to better the lives of others.

4.3.2.5 Rewarding

Trauma work was also reported to be rewarding by nearly half (n=5) of the participants, particularly when the victim of trauma starts to show progress, as the participants feel they have played a role in helping the victim of trauma until they start to see progress. The participants described working with a victim of trauma as going on a journey and witnessing the transition from being in distress to returning to normal functioning.

P3: *yes, but it's also very satisfying. If you can see the progress if you can see someone is actually dealing with what they went through and their, their quality of life is improving. So even though it's draining, it's also very rewarding.*

P8: *Okay. Um, for me, I should say that it is fulfilling in a sense that, to see a patient recover from the traumatic experiences and you being able to treat them is rewarding.*

P10: *because now it's rewarding, you, its recovery. You, you've been instrumental as a therapist, you've been instrumental in a person's recovery stage.*

Participants realising that the role they have played in the trauma victim's life has had a positive impact may be rewarding to them. They deal with people who may seem broken and it may therefore be satisfying to witness victims of trauma start to make progress and heal.

4.3.2.6 Healing

More than half (n=6) of the participants indicated that clinical and intern clinical psychologists are also able to heal from their own traumatic experiences. They reported that this may occur through working with victims of trauma which may also result in increased empathy. In that sense, trauma work was regarded by the participants as not only being beneficial for the victims of trauma but for the participants as well. As the clinical or intern clinical psychologist works with a victim of trauma who experienced a similar traumatic experience, they are also granted the opportunity to heal from their trauma if they are open to it.

P4: *And it always gives you an opportunity, to grow and heal from your own [pause] experiences or trauma.*

P6: *But I think it can be positive in the sense that it's…or this may be an area where I need to um, possibly get into therapy for myself.*

P10: *But now what do we do with that? How do we find healing in a way that we're not also…it doesn't, so to say, injure us? For lack of better word. Yeah,*

yeah. Because I mean, it's it hurts to see human suffering. We're also human beings.

There seems to be a notion held among the participants that part of what attracts clinical and intern clinical psychologists to the profession may be due to experiences that they have gone through and may not have recovered from. Trauma work seems to be able to provide the opportunity for such healing for the clinical and intern clinical psychologist. This healing may also result from being aware of the importance of healing from the impact of trauma work and not necessarily from personal trauma.

4.3.2.7 Increased awareness of societal concerns

According to the participants, trauma work also creates awareness in clinical or intern clinical psychologists about concerns in society and the need to do more for others in their personal or professional capacity. This was reported by some (n=4) of the participants who spoke about trauma work bringing them in touch with reality and amplifying the needs that exist in their communities. Instead of operating in isolation, they become aware of the additional contributions they may make to their communities and extend their services or personal resources to assist where required.

> P2: *To sort of stay in touch with reality and not to just live in your bubble. Um, it forces you to have to look at the societal concerns, psychosocially, what is going on.*

> P5: *So, so I think we can be affected positively to go beyond the usual, the daily and say, what can I do as a human being?*

P8: *I think so. Because to some degree, if you're involved in such type of work, it also amplifies the need that is out there in society.*

Working with victims of trauma also exposes the participants to what is happening in society and the needs that people in the country have. This motivates them to seek out ways to do more for the country other than only doing work that is related to their profession and also extending their services to their communities.

4.3.2.8 Hope

Some (n=3) participants reported experiencing hope through witnessing victims of trauma being able to overcome their traumatic experiences. The participants reported experiencing encouragement and awe through witnessing the ability that victims have to overcome devastating experiences. This results in clinical and intern clinical psychologists experiencing hope in the resilience that people have to overcome even the harshest of experiences.

P7: *But maybe also um, it will just boost you as a therapist and encourage you that even when you get the most um, traumatised people, they still, there's hope for them.*

P10: *So, from a place of suffering, a place of distress, you know, you've been, you're walking the journey with them until such a point as where they, they, you know, they, they're able to function again*.

P11: *So that's the beauty in trauma work that realise oh, my goodness, people get up out of really bad situations, they do.*

Similar to personal growth, trauma work also inspires hope in the clinical and intern clinical psychologists as they witness the resilience of the victims of trauma they work

with. The realisation that a person can experience trauma and still be able to recover from it creates hope in the clinical and intern clinical psychologist about people's ability to overcome painful situations.

4.3.2 Risk factors

It was also reported that there are risk factors that may put the clinical and intern clinical psychologists at an increased risk of experiencing negative responses to trauma work. For instance, half (n=6) of the participants shared that they find trauma work more difficult when there are similarities between themselves and the victims of trauma. These similarities range from gender, age, previous illness and loved ones who have gone through a similar experience as the victim of trauma.

> P1: *As I was seeing clients who were coming to me with their own trauma, I was going through my own trauma as well coz I was losing people, I had COVID myself. So there were too many similarities between what was happening to those clients and what was happening to me.*

> P2: *And that was hard for me this week, especially because she's more or less my age and more or less in the same phase of my life. And, I could identify so strongly. So that was hard for me.*

> P8: *It was disturbing, because, and, and also I think another thing is because I'm also female, and it's very easy to picture these things happen. You know, it's easy to picture it in your mind. And you could somewhat yeah, almost feel…yeah, imagine what they would be feeling.*

Risk factors in this context seem to be geared more toward the participant identifying with the trauma victim’s traumatic experience. The ability to easily imagine experiencing the same or similar traumatic event or a loved one experiencing it seems to contribute to being at risk of being impacted negatively by trauma work. Sharing similarities with the victim of trauma and being able to relate to them also seems to highlight that everyone, including the clinical and intern clinical psychologist, is at risk of exposure to traumatic events.

The role of empathy in trauma work is outlined under the next theme. Although empathy was mentioned in some of the previous sections of the chapter, the next theme focuses on how it impacts the relationship between the clinical or intern clinical psychologist and the victim of trauma.

4.3.3 The role of empathy in trauma work

Most participants (n=7) reported that empathy enables clinical and intern clinical psychologists to connect with, and gain a better understanding of the victim’s world of trauma. This, therefore, enables them to help the victims of trauma in their healing process. Although participants reported having empathy for the victims of trauma, nearly half (n=5) of the participants mentioned that this does not interfere with their ability to maintain a professional relationship with them. These participants were able to have empathy and compassion for the victims of trauma without allowing the victim's experiences negatively affect them. This is mostly due to having boundaries, which is outlined later in the chapter under the section on coping with trauma work. On the other hand, fewer (n=2) participants reported that having empathy for the victims of trauma has resulted in them being negatively affected by working with them.

P2: *...and you can be Ummm, empathic about it, but not to the degree where you stop listening to what the person saying because it does go back to client and not about you.*

P7: *but I think I...like with all my other patients, hey, it's not that I will not be affected, I will not be emotionally affected, of course, I feel empathy for that person.*

P9: *But when understanding comes, then empathy comes and you want to do more for this person because you're like, this is not how the person was from the beginning. What can I do to make their life a little bit more functionable for them?*

Although participants reported experiencing burnout and VT/STS, empathy seems to neutralise these responses. When practising empathy, the participants are present with the victim of trauma and are not detached, while also maintaining their role in the therapeutic relationship.

This leads to the next theme, which looks at the roles of clinical and intern clinical psychologists and the limitations of their roles. Although this theme is similar to the sub-theme about boundaries which was discussed earlier under the negative responses to trauma work, they differ in that the next theme focuses on the rules guiding clinical and intern clinical psychologists in their work.

4.3.4 Discomfort with the limitations of the role

A few (n=3) participants spoke about feeling that they cannot protect children as other professionals such as Social Workers do, which makes them feel disempowered. This results in them wishing they could take action beyond what their roles allow to be able to keep the victims of trauma safe. Concerns were raised about victims of trauma being re-

traumatised as a result of their cases not being handled properly or having to disclose their experiences to multiple service providers before they are seen by the clinical or intern clinical psychologist.

> P2: *The negative one is the…disempowering feeling of not being able to umm, manage and control all the systems that are involved because I think, unlike the other cases that we see, this is a, these are cases that involve multiple umm, systems, especially when were are dealing with trauma in children and, and sexual trauma especially. Umm, the same thing with car accident victims as well.*

> P11: *So, I think there's um, what I noticed in myself is that I go into social worker mode. And you don't, you don't do but you start thinking about it ne. What if I could just do this or organise that for this, for this kid?*

This seems to speak to feeling hopeless and struggling with professional boundaries, particularly when the victim of trauma is perceived as being vulnerable. Having systems that the victim of trauma has to engage with that may not always be effective evokes an urge in the participant to perform the work on behalf of those involved in these systems in an attempt to protect the trauma victim.

4.3.5 Work and professional issues

Furthermore, all the participants indicated that they have received training in trauma work at the university level and during internships. However, more than half (n=6) of the participants reported that they do not believe there is enough information about coping with trauma work. This may result in clinical and intern clinical psychologists using negative coping mechanisms or using the wrong therapeutic approaches when working

with victims of trauma. In contrast, few (n=2) participants believed that there is sufficient information about coping with trauma work. There was also uncertainty expressed by a few (n=2) participants about whether there is enough information or whether additional training about trauma work is necessary. These participants felt that clinical and intern clinical psychologists have been equipped with training and have access to information about trauma work to prepare them for that type of work.

> P1: *I have decided that I use my weekends for self-study. The, answer is…I don't think so… So sometimes I find in Namibia that the things that you have to accrue even to get your CPD points uhh…it makes sense for newer, younger therapists but for me, it's not something that I would benefit from, because I may have done those things already.*

> P5: *I don't think so. I think it's a…deal with yourself, try to find how you cope. You know, that's why you find people either dissociate, people disconnect, people scrape on the surface. I don't think we have. Um, we could have that if we were having some specialised focused areas units, where we are taking care of people who are dealing with trauma, for example, but there isn't.*

> P11: *I don't know if we need so much extra. Um, I think we all understand trauma for what it is.*

The next section of this chapter focuses on how clinical and intern clinical psychologists cope with trauma work. The different coping mechanisms used by the participants are outlined.

4.3.6 Coping with trauma work

Participants spoke about the different coping techniques that they use to cope with trauma work which include having boundaries, supervision, debriefing and therapy, and engaging in other activities. The majority of the participants (n=8) indicated that the coping mechanisms they use have been effective in helping them to cope with trauma work. Additionally, participants reported that their coping mechanisms protect them from becoming overwhelmed and have been effective in preventing burnout.

> P3: *I don't tend to feel too overwhelmed. I think it's because of the support and because of also the things that I do for myself, to de-stress.*

> P5: *Yes, I think they've been working. I don't think if I was not doing that, I would have um, been quite functional. No, I think it's working very well.*

> P8: *I remember we did, there was a point we selected a day in a week to do praise and debriefing, which has really been helping.*

Conversely, nearly half (n=5) of the participants reported that clinical psychologists who have been in the profession longer tend to cope better with trauma work compared to those who are newer to the profession. This was reported to come with experience as participants reported learning about effective coping strategies over time as they do trauma work. In addition, participants reported that intern clinical psychologists tend to be more motivated and eager to take on cases compared to clinical psychologists who have been practising for a long time. This was reported to also motivate seasoned clinical psychologists for them to keep up.

P2: *And I think that is also nice, you know, you still have the younger people coming in and they are all fired up and motivated. And then for of us older ones then you feel again…aah, okay, you know, we have to keep up.*

P4: *Um, and if I compare us to some of the older clinicians, or those that have been in practice for much longer, you can see the difference in how we cope.*

P6: *you'll realise where your strengths are and where your weaknesses are in terms of dealing with certain types of cases. So I think that's probably where experience would come in. Yeah, as opposed to someone maybe who's still starting, they haven't probably been as exposed maybe to certain cases*.

These coping mechanisms enable participants to work with victims of trauma without being negatively affected professionally or personally. This in turn prevents them from harming the victims of trauma as they work with them therapeutically.

4.3.6.1 Maintaining boundaries

Nearly all (n=10) of the participants spoke about the importance of having boundaries between themselves and the victims of trauma and between their personal and professional lives. This is to protect themselves from the potential negative impact that working with victims of trauma may have as outlined earlier in the chapter. Setting boundaries for the participants ranged from having the ability to disconnect from their work with victims of trauma to being realistic about what their role allows them to do and what it does not.

P1: *…being mindful, of putting things in my mind that help me to build my emotional muscles, the same way that I do my physical health.*

P5: *Yeah, sometimes. Yeah. But I think I've developed a mechanism of disconnecting. For example, if I go home, if I've got a report, I already disconnect.*

P11: *I remind myself that I'm human. I do a little therapy with myself and reflect on the realism. Yeah, just try and be realistic about what I am capable of doing.*

Although the majority of the participants indicated that they maintain boundaries, the participants also indicated, as mentioned in the previous section of the chapter, struggling with maintaining professional boundaries. There seems to be a contradiction about whether they are in reality applying the coping mechanisms and if they are indeed being effective.

4.3.6.2 Supervision

More than half (n=6) of the participants spoke about supervision being an effective way of coping with working with victims of trauma. Supervision helps clinical and intern clinical psychologists to gain a sense of the direction to take with victims of trauma and helps them to deal with trauma work. Participants reported that supervision is done at a group and individual level to ensure continuous support with cases.

P2: *…we set aside Fridays for group supervision or individual supervision. So, it, and I think that makes a world of difference is that we are, we don't work alone.*

P6: *And I also need to take this into therapy, you know, or in supervision, otherwise, obviously, I'm gonna be crying with all my patients.*

P9: *But then later on, when I got supervision, I was like, okay, and the nice thing is, you present your cases here um, in a, with a fellow psychologist, so you get the input, you get the guidance.*

4.3.6.3 Debriefing and therapy

Having the opportunity to debrief and go for therapy was also reported as an effective coping mechanism by many (n=7) of the participants. Having the opportunity to speak about difficult cases to colleagues or personal psychologists was reported as being necessary. This was reported to help the participants cope not only with working with victims of trauma but with therapy work in general. Debriefing and therapy were also reported by participants as being effective in helping them with regulating their emotions. Participants emphasised that clinical and intern clinical psychologists need to ensure that they are well and taking care of themselves while doing trauma work.

> P6: *Um, and these are occasions where I would then need to get debriefing as well. Um, see my therapist to basically, like I said, debrief and talk about some of my feelings, in, respect to some of the cases because some of the cases can be quite heavy to…to take in.*

> P7: *Because even when I'm here, I'm one person that really also believes in going to therapy myself as a psychologist, because you cannot be doing this type of work and not be well, emotionally.*

> P8: *And I do have a psychologist, personal psychologist as well, to go vent out on some of these things.*

The participants seek help by receiving therapy with their own clinical psychologists. Having the opportunity to have an outlet to express their feelings assists them in feeling well emotionally and maintaining perspective in their work. This may also make it

possible for them to speak honestly about the feelings that they may not be comfortable to express with those in their personal lives or with colleagues.

4.3.6.4 Engaging in other activities

Some (n=4) of the participants also reported that engaging in activities that are different from their clinical work is effective in helping them cope with trauma work. This includes having hobbies that the clinical or intern clinical psychologist enjoys, creative activities, art and teaching. According to the participants, other activities enable them to disconnect from their work and focus on other aspects of their lives. This also prevents them from falling into a routine that may become mundane.

> P3: *…and having hobbies, having things that you enjoy. So that you, you're not constantly just work, home, work, home.*

> P4: *Um, so taking time to do things that just brings you joy, you know. So in my case, it's art. So I love painting and drawing and sketching, and those types of things. Um, anything that's, that's creative.*

> P6: *Yeah, but yeah, I do try to engage in activities that I really, really enjoy. Just so that I take my mind off from work because when I'm at home, I'm not working. I'm not a therapist.*

An additional element that assists with disengaging from trauma work is being involved in activities that are different from trauma work. As they get involved in these activities, the participants are reminded of the other aspects of their lives that they enjoy and about maintaining a balance between their interests and their work.

4.3.7 Social support

Having good social support was also considered important by more than half (n=6) of the participants when doing trauma work. This support system includes support from colleagues at work and loved ones on a personal level. According to participants, working together with colleagues in the same profession helps them to feel more supported and enables them to have breaks in between difficult cases before continuing with work. A good support system was reported by the participants as having helped them to survive during COVID-19 and when working with trauma victims.

> P2: *And you know, and I think that that, that, that carried us through the whole COVID, you know, thing umm, is the fact that we are each other's support.*

> P3: *I think maybe we did touch on this just re-emphasising that, I think having support, both professionally, like colleagues, and in a social setting, that is very important when dealing with trauma.*

> P4: *And it's important that you, once again, also make sure that your, your support system personally is solid.*

Having a support system seems to be similar to supervision in that both coping mechanisms speak to receiving support and obtaining guidance about dealing with cases. Participants mentioned these coping mechanisms help them to cope with difficult cases and situations in life. This support is both at an individual and collective level and helps to remind participants to maintain therapeutic boundaries as they work with the victims of trauma.

4.3.8 Self-care

Over half (n=6) of the participants mentioned that self-care is important and helps them cope with trauma work. Self-care activities that were reported include taking long baths and taking care of their physical health such as exercising and massages. Additional self-care activities reported by the participants were: avoiding reading traumatic news, taking vitamins, going for walks, reading, watching television, cooking, baking, gardening, going to church and listening to gospel music. Participants reported ensuring that they engage in self-care activities as a way of coping with trauma work and with therapy in general.

> P1: *And I think what helps me is to…I've always made self-care, umm, a, a part of my existence. I, I just take care of myself in ways that help me to not be too consumed.*

> P2: *And, and to also do other stuff sometimes, you know, like, which has to do with self-care stuff, take that long hot bath in the winter. You know, just little things. Umm, but I think boundaries and exercise. I mean, taking care of your physical health, you know, just, drink your vitamins that kind of stuff that works.*

> P10: *So yeah. And also, okay, debrief and self-care, yes. Because what helps me quite a lot, it's just prayer. Yes, so, I go to church, spend time in just worship or prayer or even at home I just put on, um yeah, my gospel songs*.

Taking the time to take care of themselves particularly when it becomes a habit helps the participants to cope with working with victims of trauma. Self-care took different forms for the participants and ranged from physical activity to practising spirituality. This may

help with them being able to disengage from work and engage in activities that relate to them taking care of their well-being.

This concludes the themes and sub-themes section of the chapter which outlined the different responses to trauma work, the role of empathy and the coping techniques used by clinical and intern clinical psychologists as they work with victims of trauma.

4.4 Chapter summary

This chapter outlined the results of the thematic analysis and presented the four main themes from the thematic analysis. These themes were the helper's perspectives on trauma work, responses to trauma work, risk factors, the role of empathy in trauma work, discomfort with the limitations of the role, work and professional issues, coping with trauma work, social support and self-care. A discussion of the results follows in the next chapter.

CHAPTER FIVE: DISCUSSION

5.1 Introduction

This chapter discusses and interprets the results of the thematic analysis. Firstly, the findings of the research are discussed according to the objectives of the research, which guided the structure of this chapter. As outlined in chapter one, the objectives of this research are to investigate how clinical and intern clinical psychologists experience working with victims of trauma, examine the impact of working with victims of trauma on clinical and intern clinical psychologists, and determine the coping strategies that they use while working with victims of trauma. The CSDT is then applied to provide a framework to understand the findings after which the chapter will be concluded.

5.2 The helper's perspectives on trauma work

It is worth noting that all the participants of this research indicated that they did not initially seek to work with victims of trauma. Rather, they encountered victims of trauma in the course of their work, as they became part of their caseloads due to the high number of traumatic incidences that occur in Namibia. This high occurrence of traumatic events in Namibia is consistent with reports by Nembwaya (2021), Oyefeso et al. (2011) and the CDC (2020).

The research also found that participants experience working with victims of trauma as being difficult, exhausting and at times unsettling. Emotions such as anger, sadness, frustration, anxiety and powerlessness were also found to have been experienced by participants as a result of listening to the accounts of the victims of trauma. Similar challenges experienced by mental health professionals as a result of listening to the traumatic accounts of victims of trauma have been reported in previous studies (Kanno & Giddings, 2017; Merriman & Joseph, 2016). Moreover, participants reported discomfort with the narrow definition of

trauma when being applied in their context. Namibia has been faced with many challenges including high unemployment rates, HIV/AIDS, income inequality and poverty (Mwinga, 2012). This limited definition has been noted by South African authors such as Eagle and Kaminer (2013), who propose a broader definition of trauma that incorporates the impact of living in environments with continuous violence or danger. Additionally, Goodman (2015) argues that traditional DSM-based disorders do not take into account matters such as social structures and contextual elements that tend to worsen trauma, particularly for marginalised populations.

Additionally, while participants seemed to find it easier to speak about the negative experiences of trauma work, the research also found that it can be rewarding, fulfilling and liberating, indicating that trauma work may be experienced in both negative and positive ways, similar to findings from previous studies (Calhoun & Tedeschi, 2004; Craig & Sprang, 2010; Pack, 2014). Having broadly discussed the experience of working with victims of trauma for clinical and intern clinical psychologists, the next section of the chapter focuses on the specific ways in which these professionals reported being affected by trauma work.

5.2.1 Responses to trauma work

The research found that participants responded differently to trauma work which ranged from burnout and VT or STS to an increase in professional skills, personal growth, finding trauma work rewarding when witnessing a recovery, the opportunity for the participants to heal from previous trauma, an awareness of societal concerns and hope about the resilience of human beings. Although some of the participants referred to these concepts directly, others described the elements associated with them. These findings are further discussed in the next section of the chapter.

5.2.1.1 Burnout

Exhaustion was one of the symptoms most associated with burnout by the participants, similar to findings from previous studies (De Kock, 2013; Jenkins & Baird, 2002; McCann & Pearlman, 1990; Schaufeli & Greenglass, 2001; Tabor, 2011). In addition, helplessness, a lack of motivation to work, becoming detached from the victims of trauma, self-doubt and isolation were also reported, particularly when working with many similar trauma cases. Previous studies have found similar symptoms of burnout to have been experienced by mental health professionals working with victims of trauma (Ben-Zur & Michael, 2007; Hammond et al., 2018).

In contrast to an earlier study (Hammond et al., 2018), participants in this research did not report experiencing negative affect or reduced productivity as a result of trauma work. This may be due to the coping mechanisms that the participants reported using while doing trauma work, which is discussed in the coping strategies section. Another reason may be that the consequences of burnout were not explored extensively through the interviews due to insufficient probing to obtain more comprehensive responses.

The next section of the chapter discusses another response to trauma work, VT or STS. Participants often used the term burnout to refer to the negative impact of working with victims of trauma. This may be because burnout tends to be the more commonly known term compared to VT or STS. It has been found that these concepts are at times linked to burnout and have been found to measure the same phenomenon (Devilly et al., 2009), although Jenkins and Baird (2002) have argued that they are different from each other.

5.2.1.2 Vicarious/Secondary Traumatic Stress

On a practical level, it seemed that participants were using the terms VT or STS interchangeably. This indicates how closely linked these concepts are believed to be as demonstrated in the literature (Baird & Kracen, 2006; Craig & Sprang, 2010). Interestingly, participants were more likely to use burnout when describing the impact of trauma work. The participants reported the indicators of VT/STS as including difficulty maintaining professional boundaries, shifts in their worldview, avoidance of trauma work, hypervigilance, physical reactions and over-identifying with the client. Iliffe and Steed (2000) similarly found that participants in their study experienced physical reactions including nausea, churning stomach and heaviness when hearing about accounts of domestic violence. Additional consequences were reported to include changes in mood, relationship stressors and an inability to stop thinking about the victims of trauma. Similar findings of symptoms of VT/STS were also reported in previous studies (Baker, 2012; Iqbal, 2015; Lerias & Byrne, 2003; Pross, 2006; Rothenberg et al., 2008; Tabor, 2011).

The participants also reported as was found by former studies (Dass-Brailsford & Myrick, 2010; Perrotta, 2019; Yehuda et al., 2015), that working with victims of trauma increased their awareness of what is happening in society and caused changes in their worldviews. This was found to create a realistic view for the participants about the needs in their communities and the extent of potential exposure to trauma for others and themselves.

Although the research found that participants experienced these consequences as being unpleasant, participants did not report experiencing distress or difficulty with their ability to perform their work. This may be due to them using coping strategies such as discussing

challenging cases during supervision or therapy, which may improve their ability to cope, and are discussed further on in the chapter.

5.2.1.3 Professional and personal growth

The research found that working with victims of trauma was reported by participants to influence their growth in two areas, namely, professionally and personally. The participants reported that professionally, they experienced an increase in empathy toward the victims of trauma, increased creativity, an improvement in coping skills and an ability to identify trauma when it is not obvious. Additionally, participants reported increased insight into personal experiences that they may need to heal from, in addition to feeling stronger, empowered and striving to be better parents.

These findings correlate with components of PTG, which is growth or positive change that is experienced by mental health professionals through witnessing victims of trauma overcome their traumatic experiences (Sui & Padmanabhanunni, 2016). This leads to an increase in the mental health professional's personal development (Tedeschi & Calhoun, 2009). PTG was reported by participants in this study as in a previous study (Sui & Padmanabhanunni, 2016), to have resulted in positive changes in their perceptions of themselves and their life's philosophy.

5.2.1.4 Rewarding

The research further found that participants reported that trauma work can be rewarding particularly when the victims of trauma start to show progress. This finding has components of CS, which is the pleasure and satisfaction experienced by mental health professionals when they contribute to the well-being of their clients (Huggard et al., 2013; Samios, 2018; Stamm, 2010). The participants reported experiencing satisfaction as they witnessed the

victims of trauma transforming from being devastated by the traumatic experiences to experiencing fewer symptoms of trauma.

This progress was reported by the participants as being rewarding as it improved their confidence and belief that they can effectively do their work as also reported in other studies (Huggard et al., 2013; Samios, 2018; Stamm, 2010). This in turn made working with victims of trauma bearable for the participants as the feeling of reward outweighed the burden of trauma work (Hunsaker et al., 2015; Yildirim et al., 2021). CS was also found in previous studies (Huggard, et al., 2013; Ringenbach, 2009) to increase the need for mental health professionals to contribute positively to their communities, which was also reported by the participants of this study.

5.2.1.5 Healing and hope

According to participants of this research, clinical and intern clinical psychologists can heal from their own experiences as a result of witnessing victims of trauma heal from traumatic experiences while working with them in therapy. Similar to the finding from an earlier study (Hernández et al., 2007), the participants reported that as they witnessed the healing of victims of trauma, they would also reflect on their own experiences. There is limited information available about this research finding in the literature. It is therefore an area that needs to be explored further.

An additional finding of this study that was reported by participants is that of hope. This finding showed that participants experienced hope through witnessing the resilience of victims of trauma as they overcame devastating experiences. According to the participants of this research, this contributed positively to their resilience as they felt encouraged to reframe and overcome personal hardships consistent with previous studies (Iqbal, 2015;

Puvimanasinghe et al., 2015). Healing and hope may have components of VR which is reported to include changes in life goals and perspective, having hope in the client, an increase in self-awareness and an increased capacity for resourcefulness (Hernandez-Wolfe, 2018).

The findings about their positive responses to trauma work have components of CS, VR and PTG, even though the participants did not use these terms to describe these responses to trauma work. Professional and personal growth was found to have components of PTG while finding trauma work rewarding correlated with CS. Additionally, healing and hope had components of VR.

The next section focuses on risk factors that have been found according to the participants to potentially put some clinical or intern clinical psychologists at an increased risk of being negatively impacted by trauma work more than others.

5.3 Risk factors

This research found that participants reported that sharing certain similarities with the victims of trauma made trauma work harder. These similarities include similar age or phase of life, same gender, experiencing a similar illness or having loved ones who had similar experiences as the victims of trauma. It was also believed by some of the participants that clinical and intern clinical psychologists who have experienced trauma were at an increased risk of being negatively affected by trauma work, consistent with findings from previous studies (Craig & Sprang, 2010; Kamel et al., 2020; Way et al., 2004). None of the participants disagreed with the possibility that a personal experience of trauma may be a risk factor for clinical and intern clinical psychologists, however, not all of the participants reported having this belief. This echoes earlier findings that indicate that studies have yielded mixed results

about consensus regarding this being a risk factor (Dunkley & Whelan, 2006; Iqbal, 2015; Pack, 2013).

According to the participants, additional risk factors include working with many victims of trauma, engaging in trauma work over long periods, working with victims of trauma who are children, and participants experiencing the traumatic event as being overwhelming, correlating with previous findings (Ireland & Huxley, 2018; Lerias & Byrne, 2003; McLean et al., 2003).

The intern clinical psychologists who participated in this research in both private and public contexts reported having high caseloads of trauma. The results of this research seem to be in contrast to a former study (Makadia et al., 2017), which found that although intern clinical psychologists were at risk of being negatively impacted by trauma work due to a lack of experience, that risk may be reduced because they tend to have lower caseloads of trauma. This may be due to the high number of traumatic incidences in the country, or due to the broad definition of trauma that was provided by some of the participants as reported earlier in chapter three. Lastly, a lack of support both at a personal and professional level consistent with available literature (McCormack & Adams, 2016), was also reported by participants in this study as being another risk factor for being negatively affected by trauma work, as it was also found by.

The next section of the chapter discusses the role of empathy in trauma work and how it may impact clinical or intern clinical psychologists as they work with victims of trauma. This is followed by how participants feel about the limitations of their role when working with victims of trauma before moving on to the section about coping strategies.

5.4 The role of empathy in trauma work

According to the participants of this research, empathy enables clinical and intern clinical psychologists to gain a better understanding of the impact of traumatic experiences on victims of trauma and how they make sense of such experiences. The results of this research indicate that a few of the participants were negatively impacted by trauma work because of having sympathy instead of practising empathy toward victims of trauma. This was then reported to have resulted in the participants over-identifying with the victims of trauma and experiencing difficulty with maintaining professional boundaries. According to Figley (2002), therapists may suffer too as a result of having empathy for trauma victims. Therapists are therefore cautioned not to over-empathise with the victims of trauma. This also enabled the participants to maintain professional boundaries and with coping with trauma work (Sacco & Copel, 2018).

5.5 Discomfort with the limitations of the role

Another important finding was that participants reported feeling limited about the extent to which they can help the victims of trauma due to the limitations of their roles. Participants expressed wishing they could protect victims of trauma, particularly children in the same ways that their colleagues in similar professions can. This concern was particularly expressed when the victims of trauma are children or when the type of trauma is sexual abuse. This finding is similar to what Iliffe and Steed (2000) found in their study that participants working with domestic violence cases found it particularly difficult when hearing about violence that is committed toward children. This may speak to feelings of powerlessness, and difficulty with maintaining professional boundaries which were discussed earlier in the section on the negative effects of trauma work and reported in previous studies (Hernandez-

Wolfe, 2018; Hesse, 2002; Iqbal, 2015). This finding relates to the ethical aspects of the participants' professional roles in terms of where their responsibilities end, despite concerns about the safety of their clients.

There is limited availability of infrastructure and mental health professionals particularly in the public sector to provide mental health services to the public in Namibia (MoHSS, 2005). Furthermore, there is a shortage of places of safety for victims of violence and trained professionals to work at these facilities in the country (Kangootui, 2014). This makes ensuring the safety of victims of trauma and preventing them from being re-traumatised difficult. This may also lead to professionals feeling that they should go beyond their professional roles to help these victims as was reported by the participants of this research. This may be linked to matters such as the lack of housing and high poverty rates in the country that may further negatively impact trauma victims (NSA, 2021). There is, however, a paucity of information relating to this finding hence more research needs to be conducted.

5.6 Work and professional matters

The participants indicated that more training is needed for them to be better equipped for working with victims of trauma and to cope better with that type of work as similarly stated in previous studies (Sprang et al., 2007; O'Halloran & O'Halloran, 2001). The participants also reported that such training needs to be accessible, affordable and take into consideration the training needs of clinical and intern clinical psychologists.

The participants reported the effects of working with victims of trauma and they also shared the coping strategies they use to cope with trauma work. These coping strategies are discussed in the next section of the chapter and are boundaries, supervision, debriefing and therapy and engaging in other activities.

5.7 The coping strategies used by clinical and intern clinical psychologists

The study found that participants reported using six different coping mechanisms when doing trauma work namely, maintaining boundaries, supervision, having a support system, going for debriefing and therapy, engaging in self-care and in other activities that are not related to therapy work. These coping strategies are discussed in the next section.

5.7.1 Boundaries

The participants of this research reported ensuring that they maintained professional boundaries between themselves and the victims of trauma. These boundaries were reported to have been extended to keeping their personal and professional lives separate. Participants also reported that they set boundaries by making peace with the limitations of their roles, avoiding disturbing information in the media and disconnecting from their work after hours. These coping strategies are consistent with findings in the literature (Harrison & Westwood, 2009; McCann & Pearlman, 1990; Sim et al., 2016). This research, however, found that although the participants used a variety of coping mechanisms, including having boundaries, they may not always be effective. This may be due to various reasons including risk factors and whether or not the participants consistently use the reported coping mechanisms. Studies have found that although there is a variety of coping strategies used by mental health professionals, they were not always effective in protecting them from the negative impact of trauma work (Bober & Regehr, 2006; Figley, 2002).

5.7.2 Supervision, debriefing and therapy

The participants reported talking about challenging cases through supervision, debriefing and psychotherapy as some of the ways that helped them to cope with trauma work. These enabled participants to receive guidance about effectively assisting victims of trauma while

having the opportunity to safely have an outlet and express their feelings. It also made it possible for participants to survive the pressure they experience from trauma work and therapy work in general. These results were found to be similar to previous studies (Kamel et al., 2020; Manning-Jones et al., 2016; Sim et al., 2016; Welsh, 2014).

5.7.3 Engaging in other activities

Another interesting finding from this research was that participants found it effective to spend their free time doing activities that are different from trauma and therapy work in general. This was reported to help participants with disconnecting from their usual work and focusing and enjoying activities that require a different set of skills and which they found to be fun. Some examples that were reported by the participants included lecturing, hobbies such as art or painting and outdoor activities consistent with findings in a previous study (Manning-Jones et al., 2016; Welsh, 2014). The participants reported that these activities were effective in the short term as they helped them to switch off from trauma work temporarily and maintain a boundary between their work and other areas of their lives.

None of the participants reported using negative coping mechanisms although some participants indicated that it may generally be possible that some clinical and intern clinical psychologists may turn to negative coping mechanisms. These responses may be due to the interviewer and interviewees both being in the same profession. Additionally, the approach of semi-structured interviewing, which removed the anonymity of participants from the interviewer and possibly social desirability may have resulted in the interviewees avoiding disclosing negative coping strategies. The participants reporting that some in their profession may use negative coping strategies is in line with the previous research findings (Dunkley & Whelan, 2006; Follette et al., 1994) that found that professionals may turn to the use of drugs,

and alcohol, being in denial or disengaging from their work as negative ways to cope with their work.

The research found that the coping strategies that were listed previously were considered effective by the participants in helping them to cope with trauma work and with therapy work in general. This is despite the findings (Bober & Regehr, 2006) that the recommended coping strategies did not seem effective in immediately reducing secondary trauma symptoms experienced by therapists. Additionally, Bober and Regehr (2006) found that participants who suffered from the long-term negative impact of trauma work were less likely to use coping strategies such as leisure activities. This contrast may be due to the small sample of the present study, as a bigger sample size may have yielded different results.

5.8 Support system

It was found in this study that receiving support at work and privately played an important role in whether or not the participants coped effectively with trauma work. Professionally, support system involved sharing challenges with colleagues and also offering support to colleagues. Personally, it involves ensuring that they have a good support system to rely on. This is in agreement with findings in the literature (Cohen & Gagin, 2005; Galek et al., 2011; Michalopoulos, & Aparicio, 2012; Rzeszutek et al., 2015). Although some studies (Ben-Porat & Itzhaky 2015; Ogińska-Bulik et al., 2021) found that social support did not significantly improve burnout among mental health professionals.

5.9 Self-care

The research further found that participants use several self-care activities as coping strategies. These activities were listed as taking long baths, taking care of their physical health such as exercising, massages, avoiding reading traumatic news, taking vitamins, going

for walks, reading, watching television, cooking, baking, gardening, and listening to gospel music. These activities were reported to help the participants to disconnect from their work while keeping them physically healthy and mentally strong to continue effectively doing their work while being available to their families. The findings about these self-care activities used by mental health professionals correlate to those in previous studies (Kamel et al., 2020; Manning-Jones et al., 2016; O'Halloran & O'Halloran, 2001; Pow & Cashwell, 2017; Sprang et al., 2007).

5.10 Application of the constructivist self-development theory conceptual framework

As discussed in chapter two, the current research used the CSDT conceptual framework. According to Pearlman and Mac Ian (1995), a person's adjustment to trauma within the CSDT framework is influenced by an interplay between their personality and the traumatic event. Participants provided mixed responses regarding how they experience trauma work. Most of the participants negatively described trauma work, however, some participants found that it may also be a positive experience. This may indicate that there may be differences between participants that may influence how they adjust to trauma work.

Additionally, this framework proposes that exposure to long periods of working with victims of trauma may cause professionals to experience changes in their sense of self, others and the world (Moulden & Firestone, 2007). This may as a result impact them personally and professionally (Trippany et al., 2004), causing distortions in psychological needs related to safety, intimacy, control, esteem and trust (Miller et al., 2010). The results of the research indicate that being exposed to the victim's traumatic accounts resulted in some participants over-identifying with the victims of trauma which may be reflective of changes in their sense of self. Moreover, participants reported becoming more distrustful and judgmental of others

which is consistent with changes in their view of others. Changes in worldview were also reported as participants gained a more realistic view of the needs in their communities and the potential trauma that they and their loved ones may be exposed to.

It was also found that participants became hyper-vigilant and at times avoided trauma work as a result of how negatively it affected them, which speaks to their safety needs being negatively impacted. Relationship stressors were also reported as being a possible consequence of trauma work. This is consistent with changes in safety, intimacy and trust needs as reported by (Miller et al., 2010). Additionally, participants experienced self-doubt in their ability to help the victims of trauma they work with, which may be indicative of distortions in esteem needs (Miller et al., 2010).

The mixed responses to trauma work that were reported by the participants as mentioned earlier in this section are grouped into negative and positive responses to trauma work. The negative responses are VT or STS, CF and burnout. The positive responses are VR, PTG and CS. Despite the negative experiences, however, participants were found to be generally managing with trauma work and not experiencing distress that interfered with their ability to perform their work. This may be due to the coping mechanisms reported to be utilised by the participants.

The CSDT provided a conceptual framework that could be applied to the findings of this research and illustrated that exposure to trauma work may result in distortions in psychological needs. This framework may however need to be expanded to include the positive experiences of trauma work instead of only focusing on cognitive distortions.

5.11 Chapter summary

This chapter focused on interpreting and discussing the research findings. The experience of trauma work and its impact were discussed, followed by a discussion of the risk factors that may put clinical and intern clinical psychologists at risk of being affected negatively by trauma work. Additionally, the role that empathy plays in trauma work and the different mechanisms used to cope with working with victims of trauma were also discussed. Finally, the findings of the research were discussed within the CSDT conceptual framework. The next chapter is the final chapter of this research paper and it provides a summary of the essence of the research, tying together the different chapters compiled for the research.

CHAPTER SIX: CONCLUSION

6.1 Introduction

This final chapter of the thesis provides a reflection on the research process. The objectives of the chapter and how they were addressed by the research are discussed as well as the limitations of the research, followed by the recommendations for future similar research.

6.2 Conclusions

Trauma work may result in clinical and intern clinical psychologists being affected by the accounts of the victims of trauma (Figley, 2002; McCormack & Adams, 2016). Additionally, Namibia has a high occurrence of traumatic incidences (Motor Vehicle Accident Fund [MVA Fund], 2018; NAMPOL, 2020; UNICEF, 2015), which makes the likelihood of clinical and intern clinical psychologists working with victims of trauma highly likely.

The research found that there are mixed reactions concerning the way these professionals experience trauma work. On the one hand, trauma work was described as difficult, exhausting and unsettling. It was also found to be rewarding and fulfilling. In addition, the research findings showed that there was a spectrum of responses to trauma work. Participants were found to have been affected negatively by experiencing burnout and VT or STS. Risk factors were also found to put some clinical or intern clinical psychologists at risk of being negatively affected by trauma work such as shared similarities with the victims of trauma and past experiences of trauma. The research also found that participants at times felt limited by their roles when it comes to their need to protect the victims of trauma they work with. In addition, it was found that it is also possible for clinical and intern clinical psychologists to be affected positively and experience growth, hope and healing through working with

victims of trauma. Finally, the research found that participants engage in several coping strategies which were found to be effective in helping them to cope with trauma work. These strategies ranged from having boundaries to engaging in fun activities that are not related to trauma work.

The research aimed to obtain an in-depth understanding of the experiences of trauma work from the perspective of clinical and intern clinical psychologists within the Namibian context. The research findings indicate that the participants in Namibia experience and cope with trauma work in similar ways as clinical and intern clinical psychologists in other contexts.

6.3 Limitations of the study

Several limitations were noted concerning the process of conducting this research and must be reflected on. Firstly, the research used a small sample size of 11 participants and only focused on clinical and intern clinical psychologists in the Khomas region. Caution must therefore be exercised when interpreting the findings of this research because it may not be generalisable to the broader population of clinical and intern clinical psychologists in the country.

Secondly, only clinical and intern clinical psychologists participated in this research. There are several other professionals in the country who work with victims of trauma such as social workers, police officers, nurses or first responders who may have provided a broader view of the research topic if they were included. Thirdly, only one male participant was part of the research. Although it was not the aim of this research to compare results based on gender, including more male participants may provide more balanced findings between male and

female clinicians. However, clinical psychology tends to be skewed toward higher female psychologists compared to their male counterparts (Skinner & Louw, 2009).

The final limitation involves two matters concerning the research methods. Firstly, although the research was able to obtain in-depth information to address the objectives of the study using the qualitative approach, using a quantitative approach may have improved the findings of the research by including a larger sample which may have improved the generalisability of the research findings. Secondly, the researcher's role as the primary instrument of data collection and analysis may have influenced the outcome of these processes. The researcher has previously worked with victims of trauma which may have invoked researcher bias. However, although researcher bias was a possibility, the researcher used reflexivity to be self-aware and monitor the influence of their beliefs, biases and personal experiences on the research (Berger, 2015). Triangulation was also used to ensure that the researcher maintained objectivity.

6.4 Implications and recommendations

This research demonstrates that clinical and intern clinical psychologists in Namibia are indeed affected by the accounts of the victims of trauma they work with in therapy. Although some of this impact is positive, it was also found that they are also affected negatively. It is therefore important for increased attention to be given to the negative impact of trauma work to create awareness as it may affect the ability of the clinical and intern clinical psychologists to perform their work effectively as was found in a previous study (Kamel et al., 2020).

The research also found that participants felt that the training and information about working with victims of trauma is not sufficient. Although few participants felt that there is sufficient information and training and that the onus is on the clinical and intern clinical psychologists

to equip themselves with such knowledge. This amplifies the need for training and information about trauma work and coping with it to be made available and accessible to ensure they feel more prepared for such work.

The research further revealed the importance of positive coping strategies and that if clinical and intern clinical psychologists neglect using coping mechanisms, it may add to their vulnerability and interfere with their work and/or personal lives.

There is a paucity of information about the impact of trauma work on professionals in Namibia, although similar studies have been conducted previously (Haufiku (2015; Perstling & Rothmann, 2012). This research adds to the available body of literature on this topic within the Namibian context, not only for clinical and intern clinical psychologists but for all other professions in the country involved in working with victims of trauma.

It is recommended for future research to use larger sample sizes for the results to be more generalisable. This may mean using a quantitative or mixed methods approach to be able to accommodate more participants and to bring a different angle to the findings as done in studies in different countries (Froman, 2014; Gilroy et al., 2002; Hernández et al., 2007). It may also determine the prevalence of the impact of trauma work. Moreover, the use of an anonymous survey may have yielded more authentic data compared to the semi-structured interview approach that was used for this research.

Secondly, it is recommended for future research to focus on other professionals who work with victims of trauma to broaden the insight into the impact of trauma work on different professionals in Namibia as done in previous studies (Haufiku, 2015; Perstling & Rothmann, 2012). This may provide a more balanced view and may also enable the findings of the

different research studies to be generalisable to different professions in the country and possibly other contexts. The third recommendation is to include more male participants in future research for better representation and to establish whether there are differences or similarities in the way they experience and cope with trauma work compared to their female counterparts, similar to a former study (Meyers & Comille, 2013).

The final recommendation is for the importance of self-care and coping strategies to be emphasised at the university level and through training. Therefore, the University of Namibia, particularly the Department of Psychology and Social Work under the Faculty of Health Sciences and Veterinary Medicine, and the School of Allied Health Sciences may consider adding a module to its curriculum at the Bachelors and Masters level that will prepare future mental health professionals for working and coping with trauma work. Additionally, the findings from this study will be shared with PAN by the researcher who will also request PAN to sensitise Namibian clinical and intern clinical psychologists about these findings, and the need for professionals to take additional courses about trauma work. This may create awareness for those newer to the profession about the possible impact of trauma work and possibly prevent embarrassment and reluctance to seek help due to not realising that it is a normal response to trauma work.

In conclusion, the research explored how clinical and intern clinical psychologists experience trauma work and how they cope with it. The research objectives were addressed although there were limitations. Therefore, some recommendations are provided to improve similar research that may be conducted in the future. Recommendations are also provided to improve the situation of clinical and intern clinical psychologists and all other professionals who work with victims of trauma in Namibia.

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APPENDICES

Appendix A: Ethical clearance certificate

ETHICAL CLEARANCE CERTIFICATE

Ethical Clearance Reference Number: SAH06/21 Date: 01/11/2021

This Ethical Clearance Certificate is issued by the University of Namibia Decentralized Ethics Committee (DEC) in accordance with the University of Namibia's Research Ethics Policy and Guidelines. Ethical approval is given in respect of undertakings contained in the Research Project outlined below. This Certificate is issued on the recommendations of the ethical evaluation done by the School of Allied Health Sciences Decentralized Ethics Committee.

Title of Project: Experiences and coping strategies of clinical psychologists and intern clinical psychologists working with victims of trauma in the Khomas region, Namibia
Researcher: Albertina Luaanda
Student Number: 200533592
Supervisor: Dr Shelene Gentz
Centre for Research Services

Take note of the following:

1. Any significant changes in the conditions or undertakings outlined in the approved Proposal must be communicated to the ethics committee. An application to make amendments may be necessary.
2. Any breaches of ethical undertakings or practices that have an impact on ethical conduct of the research must be reported to the ethics committee
3. The Principal Researcher must report issues of ethical compliance to the ethics committee (through the Chairperson) at the end of the Project or as may be requested by the ethics committee
4. The ethics committee retains the right to:

i) Withdraw or amend this Ethical Clearance if any unethical practices (as outlined in the Research Ethics Policy) have been detected or suspected,
ii) Request for an ethical compliance report at any point during the course of the research.

The ethics committee wishes you the best in your research.

____

Dr T.W. Shumba (Chairperson, Ethics Committee)

____

Prof. Davis Mumbengegwi (Head, Multidisciplinary Research)

Appendix B: Approval letter from the Ministry of Health and Social Services

REPUBLIC OF NAMIBIA

MINISTRY OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE EXECUTIVE DIRECTOR

Ministerial Building
Harvey Street
Private Bag 13198, Windhoek

Tel: No: 061 -203 2507
Fax No: 061-222 558
Andreas.Shipanga@mhss.gov.na

Ref: 17/3/3/APL
Enquiries: Mr. A. Shipanga

Date: 06 April 2022

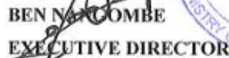
Ms. Albertina P. Luaanda
PO Box 1170
Oshakati
Namibia

Dear Ms. Luaanda

Re: Experiences and coping strategies of Clinical Psychologists and Intern Clinical Psychologists working with victims of trauma in the Khomas region, Namibia.

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**
   3.1 The data to be collected must only be used for academic purpose;
   3.2 No other data should be collected other than the data stated in the proposal;
   3.3 Stipulated ethical considerations in the protocol related to the protection of Human Subjects should be observed and adhered to, any violation thereof will lead to termination of the study at any stage;
   3.4 A quarterly report to be submitted to the Ministry's Research Unit;
   3.5 Preliminary findings to be submitted upon completion of the study;
   3.6 Final report to be submitted upon completion of the study;
   3.7 Separate permission should be sought from the Ministry for the publication of the findings.
4. All the cost implications that will result from this study will be the responsibility of the applicant and **not** of the MoHSS.

Yours sincerely,



BEN NANGOMBE
EXECUTIVE DIRECTOR

All official correspondence must be addressed to the Executive Director.

Appendix C: Invitation letter to participants

To Whom It May Concern

Invitation to participate in research for academic purposes

My name is Albertina-Popepi Luaanda, a student at the University of Namibia. I am studying towards a Master of Arts in Clinical Psychology at the University of Namibia (UNAM). Part of the requirements for completing my studies is to conduct research.

I am hereby inviting you to participate in a qualitative research titled: experiences and coping strategies of clinical psychologists and intern clinical psychologists working with victims of trauma in the Khomas region, Namibia.

The sample of my study will be drawn from clinical psychologists and intern clinical psychologists working in the public sector namely, the Psychiatric Department at the Windhoek Central Hospital, and the private sector namely, private clinical practices in the Khomas region.

The proposed study has been approved by UNAM's ethics committee. Attached please find the ethical clearance certificate from UNAM. Ethical consideration will be applied throughout the study.

Yours sincerely

____

Albertina P. Luaanda

Mobile No. 0812292425

Email: albertinaluaanda@gmail.com

Appendix D: Informed consent form

UREC Annex 5F: Informed Consent for Qualitative Studies

INFORMED CONSENT FORM

Title of the research: Experiences and coping strategies of clinical psychologists and intern clinical psychologists working with victims of trauma in the Khomas region, Windhoek.

Name of Principal Investigator:	Albertina-Popepi Luaanda

This Informed Consent Form has two parts:

- **Information Sheet (this section, to share information about the study with you)**
- **Certificate of Consent (for signatures if you choose to participate)**

You will be given a copy of the full Informed Consent Form.

PART I: INFORMATION SHEET

Introduction: I am Albertina Luaanda, pursuing a Master's degree in Clinical Psychology at the University of Namibia. You are invited to take part in the research because you are a clinical psychologist or intern clinical psychologist working at the state Psychiatrist Department or in private clinical practise and you give psychotherapy to victims of trauma. Please ask me to stop as we go through the information if you have any questions and I will take time to explain.

Purpose of the Research: We want to understand how registered clinical psychologists and intern clinical psychologists experience working with victims of trauma and how they cope with this type of work.

Type of Research Intervention: This research will involve an interview that will take about one hour.

Participant Selection: You are being invited to take part in this research because we feel that your experience can contribute to our understanding of the research topic. You will be requested to refer the researcher to other participants in the same profession who work with victims of trauma.

Voluntary Participation

Your participation in this research is entirely voluntary. It is your choice whether to participate or not. If you choose not to participate there will be no negative consequences to you.

Procedures: If you agree to take part in the research, you will be asked to participate in an interview with Albertina Luaanda. During the interview, I will sit down with you in an environment that you will feel comfortable in. If you do not wish to answer any of the questions you may say so and I will move on to the next question. The entire interview will be recorded, but no-one will be identified by name in the recording. The information recorded is confidential, and no one else except Albertina Luaanda and Dr. Shelene Gentz will have access to the recordings. The recordings will be locked in a cupboard and destroyed after 6 months.

Duration: The research will take place in one day. During that time, I will visit you once for interviewing you and the interview will last for about one hour.

Risks: We are asking you to share some very personal and confidential information, and you may feel uncomfortable talking about some of the topics. You do not have to answer any question or take part in the interview if you don't wish to do so, and that is also fine. You do not have to give us any reason for not responding to any question, or for refusing to take part in the interview.

Benefits: There will be no direct benefit to you, however, the findings from this research may benefit professionals who work with victims of trauma.

Reimbursements: You will not be provided any incentive to take part in the research.

Confidentiality: The information that we collect from this research project will be kept private. Any information about you will have a number on it instead of your name. Only the researchers will know what your number is.

Sharing the Results: Nothing that you tell us today will be shared with anybody outside the research team, and nothing will be attributed to you by name. The thesis will be share

with you once it is finalised. We will publish the results so that other interested people may learn from the research.

Right to Refuse or Withdraw: You may stop participating in the interview at any time that you wish.

What will happen in the unlikely event of some form of emotional distress as a direct result of your taking part in this research study? Contact information about counselling services will be provided to you. The expenses that will result from these counselling services will be paid for by yourself as the university does not make provision for such cost.

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact Albertina Luaanda, 0812292425/albertinaluaanda@gmail.com.

PART II: CERTIFICATE OF CONSENT

Is there anything else that you should know or do?

This research has been reviewed and approved by the relevant Ethics Review Committee at the University of Namibia, which is a committee whose task it is to make sure that research participants are protected from harm.

a) You can contact the Centre for Research & Publications at research@unam.na if you have any further queries or encounter any problems.

b) You can also contact the Research Ethics Committee **at +264 061 2063061** **pclaassen@unam.na** if you have any concerns or complaints that have not been adequately addressed by the researcher.

Declaration by participant

By signing below, I ………………………………..………… agree to take part in a research study entitled "experiences and coping strategies of clinical psychologists and intern clinical psychologists working with victims of trauma in the Khomas region, Windhoek."

I declare that:

a) I have been notified that I will be audio taped during the interview and I consent to this.
b) I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
c) I have had a chance to ask questions and all my questions have been adequately answered.
d) I understand that taking part in this study is **voluntary** and I have not been pressurized to take part.
e) I may choose to leave the study at any time and will not be penalized or prejudiced in any way.

f) I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ....…........…………….. on (*date*) …………....……….. 20…...

…………………………………. ………………………………….

Signature of Participant Signature of Witness

Declaration by investigator

I declare that:

- I explained the information in this document to …………………………………..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above.
- I did not use an interpreter.

Signed at (*place*) ....…........…………….. on (*date*) …………....……….. 20…..

………………………….. ……………………………..

Signature of investigator Signature of witness

Appendix E: Semi-structured interview schedule

1. Introduction

This is a semi-structured interview schedule that will be used as a guide for obtaining information in the research titled "experiences and coping strategies of clinical psychologists and intern clinical psychologists working with victims of trauma in the Khomas region, Windhoek". This interview schedule is designed to be used flexibly with participants to provide the best opportunity for them to give free accounts of their experiences.

2. Interview questions/ topics:

2.1 What is your definition of a victim of trauma?

2.2 What motivated you to become involved in working with victims of trauma?

2.3 What is it like working with victims of trauma?

2.4 Please give examples of your experience(s) of working with victims of trauma that are significant to you?

2.5 Can working with victims of trauma have a positive impact?

2.6 Have you experienced any negative impact as a result of working with victims of trauma?

2.6.1 What is it like being negatively affected by this type of work?

2.6.2 Can you give examples of how working with victims of trauma has impacted you personally and/or professionally?

2.7 Have you received any training specific to trauma work?

2.8 How do you cope with the client's reactions to trauma?

2.8.1 Do you think that your current way(s) of coping with this type of work is/are effective?

2.8.2 Have you received training on coping with working with victims of trauma?

2.8.3 Do you think there is enough information available to help professionals cope with this type of work?

2.9 Can you give me the contact details of clinical psychologists or intern clinical psychologists

who work with victims of trauma?

2.10 Thank you for participating. Do you have any questions?

Appendix F: Socio-demographics form

Demographics form

Research titled: experiences and coping strategies of clinical psychologists and intern clinical psychologists working with victims of trauma in the Khomas region, Windhoek.

Participant no: _______

Gender: ☐male

☐female

Age: _______

Level of qualification: ☐Clinical psychologist

☐Intern clinical psychologist

Context of work: ☐State Psychiatric Department

☐Private clinical practice

Length of time doing therapy work______________________

Number of cases of trauma they work with per year__________________

Appendix G: Declaration of language editing

ACET Consultancy
Anenyasha Communication, Editing and Training
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9 March 2023

To whom it may concern

LANGUAGE EDITING – ALBERTINA P. LUAANDA

This letter serves to confirm that a **MASTER OF ARTS IN CLINICAL PSYCHOLOGY** thesis titled ***EXPERIENCES AND COPING STRATEGIES OF CLINICAL PSYCHOLOGISTS AND INTERN CLINICAL PSYCHOLOGISTS WORKING WITH VICTIMS OF TRAUMA IN THE KHOMAS REGION, NAMIBIA*** by ALBERTINA P. LUAANDA was submitted to me for language editing.

The thesis was professionally edited and track changes and suggestions were made in the document. The research content or the author's intentions were not altered during the editing process and the author has the authority to accept or reject my suggestions.

Yours faithfully

DR NELSON MLAMBO
PhD in English
M.A. in Intercultural Communication
M.A. in English
B. A. Special Honours in English – First class
B. A. English & Linguistics