WELL-BEING AND SECONDARY TRAUMATIC STRESS OF SOCIAL WORKERS IN NAMIBIA

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ABSTRACT

Social workers and other caregiver professions are at risk of becoming negatively affected by the nature of their work. However, many reports also indicate positive outcomes, such as personal growth and finding meaning through working with trauma victims. General mental well-being refers not only to a state of absence of pathology; it refers to optimal well-being in terms of self-perceived level of positive and negative affect, as well as satisfaction with life at a particular time in life (a dimension of emotional well-being); autonomy, environmental mastery, personal growth, positive relations with others, finding purpose in life and self-acceptance (dimensions of psychological well-being); and self-discovery, perceived development of one's best potential, a sense of purpose and meaning in life, investment of significant effort in pursuit of excellence, intense involvement in activities and enjoyment of activities as personally expressive (dimensions of eudaimonic well-being). Namibia, also being a post-war country, has many social problems which indicate severe and trauma-related conditions among the social workers' clients. Hence social workers are at risk of being negatively affected by the trauma in a vicarious form; a condition closely related to the DSM-IV posttraumatic stress disorder, and termed secondary traumatic stress. The aim of this research was to investigate the relationships between emotional well-being, psychological well-being, eudaimonic well-being and secondary traumatic stress in social workers of Namibia. A cross-sectional survey design was used with a sample population

of 116 social workers of Namibia. The measuring instruments used were the Satisfaction with Life Scale, which was used to measure emotional well-being; Psychological Well-being Scale; Questionnaire for Eudemonic Well-being; and the Secondary Traumatic Stress Scale; as well as a biographical questionnaire. Statistical analysis was conducted in terms of descriptive, factor, correlation, canonical, multiple regression and mediation analysis. It was confirmed that Namibian social workers experienced an average level of satisfaction with life, together with psychological well-being; both constructs measured higher than eudaimonic well-being and secondary traumatic stress. The results showed that secondary traumatic stress was negatively related to the emotional, psychological and eudaimonic well-being of social workers. Psychological well-being, and particularly one dimension thereof, namely environmental mastery, mediated the relationship between secondary stress and satisfaction with life.

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DEDICATION

I dedicate this study to my husband Christian and two children Alexander and Tatjana who assisted in each and every possible manner on a daily basis and took a lot of hardship and responsibilities upon themselves with a wife and mother spending many hours behind the computer. You looked after me when I was tired and grumpy, let me sleep longer when I worked during nights, prepared dinners, helped in cleaning, shopping, washed my car, studied on your own, created quiet time and space for me to work, assisted financially, loved me even when I was tired and lacked energy, soothed me, when I was down, made me laugh when I did not want to, and stood by me, when I needed you most. In so many big and small ways you have helped and cared so deeply for me to fulfil this dream. I am most grateful to you and proud of the way you managed it all!

DECLARATION

I, Martina Perstling, declare hereby that this study is a true reflection of my own research and that this work or part thereof has not been submitted for a degree in any other institution of higher education.

_____ _____

Martina Perstling Date

CHAPTER 1

INTRODUCTION

This thesis focuses on the emotional well-being, psychological well-being (PWB), and eudaimonic well-being (EWB), and secondary traumatic stress (STS) of social workers in Namibia.

Chapter 1 focuses on the orientation of the study, the problem statement, justification for the study, as well as research objectives and methodology.

1.1 BACKGROUND AND MOTIVATION FOR THE STUDY

Psychologists have long been concerned with the psychopathological underpinnings of suffering, ill health and deviance (Seligman, 2002), i.e. with the disease model (Peterson & Seligman, 2004). Well-being and optimal development were defined as the absence of distress and psychopathology (Seligman & Csikszentmihalyi, 2000). Decades of research focused on the disease model overshadowing efforts to enhance the states which make life worth living (Seligman, 2002).

Recently, the focus in mental ill-health shifted to mental well-being, more specifically to subjective[1], psychological and eudaimonic well-being (Gable & Haidt, 2005; Seligman, 2008; Seligman, Parks, & Steen, 2004; Waterman, 2008). Eudaimonic well-being constitutes two main pathways. One being hedonic, which is the immediate pleasure gratification. The other pathway is known as eudaimonic well-being, which is marked by experiencing deep satisfaction, frequently in the aftermath of a task or as a result of a way of living, and often in the form of finding purpose in life (Waterman, 2008).

Emotional, psychological, and eudaimonic well-being have an inverse relationship with environmental strain (Hope, 2006; Schiffrin & Nelson, 2010). The difference between perceiving the environment as stressful, or as a challenge, is determined by a complex transactional process correlating with the environmental demands in proportion to the resources (Dewe, 2004). Many causal relationships pertaining to job characteristics (i.e. role fulfilment, job demands, organisational demands, and interpersonal relationships) in relation to coping mechanisms and individual differences (i.e. personality, gender, and culture) in coping strategies (i.e. behavioural techniques, optimism, and self-

[1] The term *subjective* well-being is used to refer to an individual's judgment of his or her *feeling well* (which includes satisfaction with life, positive and negative affect and domain specific satisfaction). This is in contrast with subjective judgments of *living well* (which includes psychological and social well-being). Both *feeling* and *living* well as used in this study (and also in the research literature) are subjective judged by the participants. Therefore the term 'emotional well-being' will be used when referring to satisfaction with life, positive and negative affect and domain-specific satisfaction in this research (see also Keyes & Annas, 2009).

esteem) have been investigated (Anderson, 2004; Greenberg & Baron, 2008; Luthans, 2005). According to Frederickson (2004), positive affect serves as a protective shield against stressful conditions. Negative and positive are two opposed concepts, in which a correlation has been found between happiness and perceived stress has been found (Schiffrin & Nelson, 2010). Both positive and negative emotions have been found to be a reflection on experiences, or events, in the individual's life with either positive emotional consequences or negative emotional consequences (Diener, Kesebir, & Lucas, 2008). Studies on distress and well-being are contradictive in their outcome, yet they do confirm an inverse relationship between stressful life events and well-being (Schiffrin & Nelson, 2010). Lyubomirsky, King, and Diener (2005) confirm that positive emotions do influence work performance, health, personal relationships, creativity and problem solving.

Emotional well-being is linked to subjective well-being which refers to subjective judgments of how life is perceived by the individual, based on three domains, being cognitive, positive and negative affective experiences as well as the degree of satisfaction (Diener, et al., 2008; Sirgy & Wu, 2009). Experiencing satisfaction with life (SWL) and positive and negative affect is a self-perceived reality of the individual's own life in general and encompasses all life domains, including psychological and social well-being. *Psychological well-being* (PWB) is defined by six dimensions, namely finding purpose in life, personal growth and self-acceptance, good relationships with others,

environmental mastery, and autonomy (Ryff & Singer, 2008). PWB is also complemented by the theory of existentialism in finding meaning through suffering (Biswas-Diener, Kashdan, & King, 2009; Deci & Ryan, 2008; Jacobsen, 2007; Peterson, Park, & Seligman, 2005). Finding meaning and purpose in life is described as *eudaimonic well-being* (EWB) (Peterson et al., 2007; Seligman et al., 2004), which is a highly positive subjective experience (Waterman, 2008), also known as flourishing (Keyes & Annas, 2009). Dimensions of eudaimonic well-being are personal growth, self-knowledge and purposeful living (Ryff & Singer, 1998, 2008). Intrinsic motivation appears to be the most integral part of eudaimonia (Waterman, Schwartz, & Conti, 2008), and enhances feelings of autonomy, competence and self-esteem (Deci et al., 2001; Deci & Ryan, 2008).

Caregivers in the helping professions are emotionally challenged and struggle to maintain emotional balance owing to the high intensity of emotional involvement with primary trauma victims (Bride, Robinson, Yegedis, & Figley, 2003; Taubman-Ben-Ari & Weintroub, 2008) making them vulnerable to develop *secondary traumatic stress* (STS) (Bride et al., 2003; Hope, 2006, Huggard, 2003; Taubman-Ben-Ari & Weintroub, 2008). The essential difference between STS and posttraumatic stress disorder (PTSD) is that the caregiver has not experienced trauma him or herself, but has been exposed to the traumatic event through the experiences of the primary victim (Bride et al., 2003; Hope, 2006). Symptoms of caregiver and primary trauma victim also

differ in severity (Huggard, 2003; Taubman-Ben-Ari & Weintroub, 2008). Other than burnout, which is a separate construct to STS and a result of exhaustion, the onset of STS can develop abruptly without prior warning (Hope, 2006). Empathic engagement of the caregiver with a primary trauma victim together with their own emotional response and counter-transference (unconscious emotional reaction) are contributing factors to developing STS. STS in caregivers can cause impairment of normal functioning (Bride et al., 2003; Huggard, 2003).

Studies' outcomes on caregivers are contradictory in that helping professionals have also indicated high levels of personal growth (which is one of the dimensions of PWB and EWB), despite a stressful environment (Taubman-Ben-Ari & Weintroub, 2008), while others revealed high levels of chronic stress, burnout and exhaustion owing to a stressful environment (Collins, 2008; Naudé & Rothmann, 2003; Rothmann & Malan, 2003). Studies on societies in distress displayed a slightly elevated level of well-being, despite a stressful environment (Keyes, 2007; Ryff, Keyes, & Hughes, 2004). The various outcomes are explained in Hope's (2006) study on caregivers of primary trauma victims. She found that where there is a high level of STS, life satisfaction is low. As levels of STS increase, meaning in life decreases. On the other hand, higher scores on personal meaning reveal more well-being and lower disturbances when exposed to secondary trauma situations (Hope, 2006).

A contextually relevant study on PTSD by LeBeau (2005) in ex-fighters of the liberation struggle of Namibia indicated high levels of distress, and poor quality of life for both; perpetrator and victim; in the struggle owing to a past stressful environment. According to Eagle (2002), the influence on the individual of a larger system is a reciprocal process. On the one hand individuals collectively shape larger systems, e.g. war environments; on the other hand the same systems also influence the individual's thinking and behaviour e.g. the traumatic effect on the individual. Thus other community members, such as friends, family, co-workers and professional caregivers are indeed affected in a vicarious manner by the primary victim of trauma. PTSD is a result of traumatic experiences and especially intense in conditions of prolonged or intense past traumatic experiences, i.e. war or long-term abuse (Briere, 1998; Eagle, 2002; LeBeau, 2005). This may trigger associated symptoms in individuals such as depression, anxiety, substance abuse or dependency, disruptions in relationships and difficulty working, which are often not easily linked to the traumatic experience itself (Riggs & Foa, 2004). It has been found that these associated symptoms are also partially prevalent as a social need in the Namibian society (LeBeau, 2005; Ministry of Health and Social Services, 2009) which professional caregivers, such as social workers, are confronted with.

1.2 PROBLEM STATEMENT

Scientific information is needed regarding the well-being of Namibian social workers, since no prior research in terms of emotional well-being, consisting of satisfaction with life (SWL), positive and negative affect, PWB and EWB, could be traced, and the prevalence of STS in Namibian social workers is unclear. Scientific evidence is also needed regarding the relationship between STS and well-being (SWL, PWB and EWB) in the caregiver professions, seeing that the impact on community level as a consequence of STS may deplete well-being, and as a result cause poor functionality of social workers in Namibia.

Relevant to this study, is the investigation of possible inverse relationships between the dimensions of SWL, PWB, and EWB, on the one hand, and STS, on the other. The experience of meaningfulness (which is a dimension of PWB and EWB) is depleted when STS is present. Meaningfulness has been found to serve as a protector from STS (Hope, 2006). It is unclear how constructs and the specific dimensions of SWL, PWB and EWB relate to the presence or absence of STS. It has been found that certain dimensions serve as protectors against distress. For example, social relationships are a core component in treating PTSD victims (Riggs & Foa, 2004), and are integral to PWB in African cultures in which the primary obligation is to preserve and promote community (Ryff & Singer, 1998). High self-esteem seems to cause the stress hormone cortisol to return faster to baseline after exposure to a stressful event than in participants

with lower self-esteem (Ryff & Singer, 1998). Environmental mastery is challenged in Namibia in that 43% of the top ten needs of the country (Ministry of Namibia Health and Social Services, 2009) are also associated symptoms of PTSD (Riggs & Foa, 2004) which underpins the severity of emotional strain for caregivers (Collins, 2008; Taubman-Ben-Ari & Weintroub, 2008) and therefore the importance of general PWB in the caregiver professions.

Whether a traumatic experience becomes a challenge or a process of personal growth depends a) on the perception of the experience (e.g. cognitive appraisal) being a threat or a challenge b) the response to the challenge (e.g. environmental mastery) and c) the general outlook on life (e.g. purposeful living) (Bauer, McAdams, & Pals, 2008; Ryff & Singer, 1998). The response to a traumatic experience affects individuals' SWL, PWB and EWB. If STS and its influence on the emotional, psychological and eudaimonic well-being of social workers is not attended to, some individuals might languish or will not flourish (Keyes & Annas, 2009), which might impact on proximal outcomes (e.g., life satisfaction of social workers) and distal outcomes (e.g., lack of organisational commitment, turnover intentions, and low productivity).

Following from the above a general **research question** can be formulated:

What are the relationships between SWL, PWB, and EWB and STS of social workers in Namibia?

1.3 JUSTIFICATION FOR THE STUDY

It is important to investigate the SWL, PWB, and EWB as well as STS of Namibian social workers for the following reasons: First, in the past absence of mental ill-health was regarded as synonymous with well-being (Seligman & Csikszentmihalyi, 2000) and until recently well-being was rarely investigated (Gable & Haidt, 2005; Seligman, 2008; Seligman, Parks, & Steen, 2004; Waterman, 2008). In addition, the empirical distinction between STS and general PWB is merely modest (Slade, 2010) and needs further investigation. No studies pertaining particularly to well-being in terms of SWL, PWB and EWB in Namibian social workers could be traced.

Second, social relationships and support (Kasser & Ryan, 2008; Ryff & Singer, 1998), is a specific dimension of PWB and also integral to social work as the social worker provides support at the community level (Collins, 2008). The level of PWB the social worker is experiencing is important, as it reflects on the community through the nature of the social worker's occupation.

Third, EWB is experienced in the form of personal growth, self-knowledge and purposeful living through caring for primary trauma victims (Herman, 1992). SWL is related to the interpretation of an experience (Diener, 1994), which in turn relates to the degree of finding meaning through the event (Bauer et al.,

2008; Ryff & Singer, 1998). It is unclear whether Namibian social workers do indeed experience a sufficient degree of SWL, PWB and EWB.

Fourth, PWB is determined by positive emotions which protect against physical and emotional ill-health (Frederickson 2004; Ryff & Singer, 1998). The risk of workers in the caring professions of being affected by STS is significant because of high emotional demands intrinsic to those professions (Hope, 2006; Huggard, 2003; Taubman-Ben-Ari & Weintroub, 2008). Prior research, (Hope, 2006) has indicated an inverse relationship between general psychological well-being and STS making it justifiable to investigate the correlation between PWB and STS in Namibian social workers.

Fifth, in addition to the risk of developing STS because of the nature of the caregiver profession (Bride, et al., 2003), Namibia experiences high environmental demands in that one social worker is available for over 50 000 community members in the most affected post-war regions (Ministry of Namibia Health and Social Services, 2009). The community members are subject to a 15-20% risk of developing PTSD due to post-war conditions (LeBeau, 2005) and almost half of the top ten social needs at the same time are associated posttraumatic symptoms (Ministry of Health and Social Services, 2009). These conditions further support the necessity for investigating general psychological/mental well-being in Namibian social workers, and for assessing the presence or absence of STS and studying the correlation between the

constructs of well-being and STS. Helping professionals are able to experience eudaimonia not despite but *because* of challenging environmental conditions (Ryff & Singer, 1998; Taubman-Ben-Ari & Weintroub, 2008). Some evidence contradicts these observations and the risk of STS is just as realistic in the helping professions (Taubman-Ben-Ari & Weintroub, 2008), as demands are high, which may result in overexploiting resources (Anderson, 2004; Dewe, 2004; Greenberg & Baron, 2008; Luthans, 2004). Namibia as a post-war society is an emotionally demanding environment (Eagles, 2002; LeBeau, 2005). As environmental strain on social workers is high in working with traumatized clients, the risk of developing STS is significant (Bride et al., 2003).

1.4 AIM OF THE STUDY

Based on the above information, the aim of this study is to firstly investigate the current literature pertaining to well-being constructs as well as secondary traumatic stress, absence or presence, including the relationships between those constructs. Secondly, based upon literature review, the level of well-being constructs and STS needs to be ascertained in the Namibian social work population. Consequently the relationship between well-being constructs and STS needs to be investigated. A mediation effect should be investigated between the well-being constructs SWL and STS through PWB and EWB.

1.5 DEFINITION OF KEY TERMS

Emotional well-being is an umbrella term for happiness (Diener & Ryan, 2009) and serves as a self-assessment of pleasant moods and subjective emotional experiences in a person's life at any given moment in time. Emotional well-being includes three domains, namely cognitive, positive and negative affective experiences (Diener et al., 2008; Sirgy & Wu, 2009). For purposes of this study the focus will be on the cognitive component, namely satisfaction with life (SWL) (Diener, 1994).

PWB (psychological well-being) is based on Aristotle's "Nicomachean Ethics' (350BC) and orients itself through guidelines to live by in order to bring out the best in man (Ryff, 1989; Ryff & Singer, 2008). Positive and negative affect as a dichotomy, are integral to PWB (Ryff, 1989). In order to assess the individual's thriving to function positively, six dimensions have been identified by Ryff, namely autonomy, environmental mastery, personal growth, positive relations, purpose in life and self-acceptance.

EWB (eudaimonic well-being) also originates in Aristotle's 'Nicomachean Ethics' (350 BC) (Keyes & Annas, 2009; Ryff, 1989; Ryff & Singer, 1998). Eudaimonia is a dichotomy on a continuum which describes a way of living. On the one extreme is virtuous behaviour, based on spiritual good-will and benevolence towards others, and on the other is evil behaviour, based on self-

centred egoistical actions (Wills, 2009). *Eu* means “well-being”, or “good”, and *daimonia* means “demon” or “spirit” (Samman, 2007). Eudaimonia is also an important part of ’flourishing’, together with a general feeling of being complete, finding meaning in existence and dealing with the ultimate goal in life (Keyes & Annas, 2009). Eudaimonia strongly overlaps with three dimensions of PWB, namely, personal growth, self-knowledge/acceptance and purposeful living (Ryff & Singer, 1998, 2008). EWB is particularly defined by sustaining positive health, especially through times of hardship, negative feelings, struggles and pains (Ryff & Singer, 1998).

STS (secondary traumatic stress) is a syndrome of symptoms of posttraumatic stress disorder (PTSD). PTSD is the symptomological father of STS (Bride, Robinson, Yegidis, & Figley 2003; Hope, 2006). Earlier, less concrete descriptions of STS were vicarious trauma and compassion fatigue (Hermann, 1997). Different from PTSD, the diagnostic profile of STS is marked by a) the effort of the caregiver to become engaged in supporting primary victims, and b) by the caregiver acquiring the knowledge of horrific events through the disclosure of the primary victim. The symptom categories include avoidant responses, physiological arousal and intrusive imagery (Bride et al., 2003; Kanno, 2010; Hope, 2006), identical to PTSD, however less severe.

1.6 METHODOLOGY

1.6.1 Research design

This study is descriptive, cross-sectional and quantitative and utilises a survey to gather data regarding the emotional, psychological, and eudaimonic well-being as well as secondary traumatic stress of social workers as variables (Gravetter & Forzano, 2006).

1.6.2 Participants

The target population for this study was active social workers, including interns, of Namibia. Permission was granted by the Ministry of Health and Social Services and Ministry of Gender Equality and Child Welfare. The Ministries of Health & Social Services and Gender Equality and Child Welfare housed 161 registered social workers in June 2010 upon commencement of data collection. A convenience sample (n = 114) is taken from all the registered social workers within these two ministries throughout Namibia. Other organisations, such as Life Line Namibia, willing to participate were not omitted from this study, nor were any differentiations indicated between the abovementioned ministries or any other organisation that employs social workers. This sampling method selected participants on the basis of availability and willingness to respond (Gravetter & Forzano, 2006).

1.6.3 Measuring instruments

The *Satisfaction with Life Scale* (SWLS; Diener, 1994) is used to measure the cognitive component of emotional well-being. It is a five item scale, in which die participant subjectively assesses his or her perception of overall well-being. The scale is a 5-point Likert type scale. The scale ranges from 1 (strongly agree) to 5 (strongly disagree). The participant chooses which he or she finds most applicable (Diener, 1994).

The *Psychological Well-Being Scale* (PWBS; Ryff, 1989) is used to measure psychological well-being. The PWBS measured six dimensions of psychological well-being, namely autonomy, environmental mastery, personal growth, positive relations with others, purpose in life and self-acceptance. It is a self-report scale measuring the person's well-being at a particular time in each of these dimensions. The scale consisted of three to 12 items per scale, a total of 42 items. Individuals responded on a 6-point Likert-type scale. Participants choose between 1 *(strongly agree)* and 6 *(strongly disagree)* and participants choose the most appropriate score (Ryff, 1989).

The *Questionnaire for Eudaimonic Well-Being* (QEWB; Waterman et al., 2010) is used to measure eudaimonic well-being. The QEWB consisted of 21 items. Items respond to a 5-point Likert-type scale, and participants chose between 0 (*strongly disagree*) and 4 (*strongly agree*) Waterman et al., 2010). The

description of the individual scales and corresponding values are set out in detail in chapter 4.

The *Secondary Stress Syndrome Scale* (SSTS; Bride et al., 2003) is used to measure secondary stress syndrome scale. The scale consists of 17 items assessing frequency of intrusion, avoidance and arousal symptoms. Respondents indicated the frequency of being true of the items using a Likert-type scale where participants choose from 1 (*never*) to 5 (*very often*). The scale consists of three subscales for intrusion, avoidance and arousal respectively (Bride et al., 2003).

A *demographic questionnaire* is included to capture additional information and assess frequency. The demographic questionnaire consists of two parts. In part one personal information is retrieved, and the second part information about the nature of work of the participants.

1.6.4 Procedure

A cover letter explaining the purpose and emphasising the confidentiality of the research project accompanied the questionnaire. The researcher contacted the Ministry of Health and Social Services and Ministry of Gender Equality and Child Welfare respectively in order to obtain permission to conduct the research. Participation in the project was voluntary, whereby respondents had

the option to withdraw at any time. Questionnaires were administered inviting social workers to complete the questionnaire. The responses of participants were captured and converted to an SPSS dataset.

1.6.5 Data analysis

The data analysis was carried out with the PASW 18.0 programme (SPSS, 2010). Validity and reliability was assessed by exploratory factor analysis and Cronbach alpha coefficient (Clark & Watson, 1995). The relationship between variables was specified by Pearson product-moment correlation coefficients (Steyn, 1999). Canonical correlations determined the relationship between sets of variables (Tabachnick & Fidell, 2007). Regression analyses were used to investigate the relationships among secondary traumatic stress, psychological well-being, and eudaimonic well-being and emotional well-being. Mediation analysis was conducted to assess which constructs act as mediators between STS and SWL.

1.7 OVERVIEW OF THE THESIS

Chapter two entails a literature review on well-being and secondary traumatic stress, pointing out the work environment of the social worker as well as the influence of traumatic events on well-being. This is followed by chapter three, in which the research methods are discussed including participant selection and

description and rationale of the measuring instruments. Chapter four describes and interprets the data analysis in terms of descriptive statistics, correlations between constructs, canonical correlations, multiple regression and mediation analyses. Chapter five's focus is on the conclusion, limitations and recommendations as a result of this study.

1.8 CHAPTER SUMMARY

This chapter introduces the background and motivation for the study, statement of the problem, justification for the study, research objectives and definition of the relevant concepts. The research methodology was introduced, including a discussion on the research design, participants, relevant measuring, the procedure and anticipated data analyses. A brief overview of what can be expected in the following chapters was given.

CHAPTER 2

WELL-BEING AND SECONDARY TRAUMATIC STRESS

This chapter describes the individual theoretical constructs of well-being (emotional well-being, PWB and EWB) in detail, reviewing the respective empirical background and supportive research. Secondly, the development and criteria of STS will be discussed. Thirdly, the risk factor and currently researched status of the caregiver profession in general will be investigated. Fourthly, the focus will shift to the Namibian environmental factors relevant to social work, which is followed by a brief overview of a new phenomenon in positive psychology, namely posttraumatic growth. Finally, a discussion follows, focusing on the relatedness between the individual constructs of well-being and STS in terms of caregiver professionals.

2.1 CONCEPTS OF WELL-BEING

The focus of psychologists on mental ill health has by far exceeded studies on well-being and optimal development until recently (Seligman, 2002), when the focus moved to, in particular, emotional, psychological, and eudaimonic well-being (Gable & Haidt, 2005; Seligman, 2008; Seligman, Park, & Steen, 2004; Waterman, 2008). Even less literature has been found which particularly assesses the level of well-being in terms of emotional, psychological and

eudaimonic well-being in relation to secondary traumatic stress in the caregiver professions. Experiencing happiness has been integral to human kind and reports on it date back as far as Aristotle's scriptures (350BC) (Ryff & Singer, 2008; Samman, 2007; Waterman, 2008).

In this study, the well-being constructs investigated are emotional well-being (also referred to as subjective well-being; Diener, Kesebir, & Lucas, 2008); psychological well-being (PWB; Ryff & Singer, 2008); and eudaimonic well-being (EWB; Deci & Ryan, 2008; Waterman, 2008).

2.1.1 Emotional well-being

Emotional well-being describes a state in which the individual are experiencing frequent positive emotions, are generally highly satisfied with their lives, and experience only few negative emotions (Lyubomirsky, Schkade, & Sheldon, 2005). According to Diener and Ryan (2009), SWB refers to the self-perceived level of positive or negative affect an individual experiences at a particular time in life, and stems largely from the following theories:

a) Need-theories which suggest that individuals have an inborn need to seek a conscious goal to fulfil in order to feel good;

b) Top-down theory, suggesting that a person with a generally positive outlook in life will appraise an event as happier than a person with a more negative perspective;

c) Bottom-up theory suggests that positive and negative events are summed and an 'average' determines the level of emotional well-being;

d) Cognitive theories state that a happy individual is more likely to respond to positive stimuli, interprets events positively and remembers past events more favourable than people with low levels of emotional well-being, even if the events are neutral;

e) Evolutionary theories such as the 'broaden and build theory' suggest that positive emotions over time broadens the thought-action process and builds intellectual, psychological, social and physical resources;

f) Temperament and personality theories which determine a person's capacity for happiness, in which extraversion is known to predict positive affect and experience positive feelings more intensely than introverts;

g) Relative standards theories are based on the individual comparing between the actual condition and other components such as past events, others goals or ideals.

According to Diener and Ryan (2009), subjective well-being, which is synonymous with emotional well-being, has been adopted as an umbrella term for happiness. In other words, it refers to the assessment of pleasant moods and

subjective emotional experiences in an individual's life at any given moment in time. Emotional well-being refers to the conscious experience of feelings and cognitions of the individual, whether he or she perceives his or her life as a 'good life' (Diener & Suh, 1997), Emotional well-being is based on three domains, namely cognitive, which is measured against the degree to which an individual experiences satisfaction with life (SWL), as well as positive and negative affective experiences (Diener et al., 2008; Sirgy & Wu, 2009). Emotional well-being is measured against self-reports and indicates the state of happiness the individual evaluates him or herself to be in at a given period of time of their lives. In particular, SWL is measured through cognitive self-assessment. Although emotional well-being is contextually related to meaningful pursuits, and can therefore change over time, it is relatively enduring (Lyubomirsky, Schkade et al., 2005).

The degree of emotional well-being can be measured according to the degree of satisfaction, or dissatisfaction, with life (SWL), of how the person perceives his or her life in general, including external circumstances in different domains. It refers to the general self-assessment of life being good in general and in specific domains. Therefore SWL is the judgment of one's own life and its events (Diener et al., 2008). Emotional well-being is determined by (a) the person's own set-point, which is genetically determined and consistent over time; (b) circumstantial factors, which only contribute, at most, 15%, possibly due to hedonic factors facilitating the adaptation phase in contextual change; thus also

relatively stable over time; and (c) intentional activity, which is a deliberate effort to influence circumstances, and can be varied by the individual in order to avoid the new activity or circumstance becoming a boring routine; therefore retaining its potency and meaning (Lyubomirsky, Schkade et al., 2005).

A study of Linley et al. (2009) indicated that emotional well-being and PWB are closely related. It is debated whether or not emotional well-being is a prerequisite of PWB as it has been evident that positive affect indicated higher levels of meaning in life. Positive affect correlates positively with emotional well-being (Ryan & Deci, 2001), based on a study on the "big-five" personality traits in relation to emotional well-being, confirming that extraversion (which is characterised by positive affect) and agreeableness were consistently positively related to emotional well-being; while neuroticism (which is characterised by negative affect) was negatively related to emotional well-being. In addition it has been confirmed that emotional well-being and PWB measures do not vary according to biographic data such as gender, age and ethnic background (Linley et al., 2009). However, it does influence immune function and longevity (Lyubomirsky, Schkade et al., 2005).

High scores of emotional well-being also correlate positively with self-confidence, which in turn again particularly correlates positively with goal-achievements, warmth, leadership ability and sociability (DeNeve & Cooper, 1998; Diener & Ryan, 2009). De Neve and Cooper (1998) also found that

individuals who adopt a belief in a just world are excitement seeking, open to fantasy, feelings and values, are practical, radical, rule conscious, self-sufficient and sensitive; and seek social recognition. These individuals score low on emotional well-being. They further found that extroversion, as a personality trait, acts as a predisposition in experiencing emotional well-being, as well as happiness being a contributing factor towards certain personality characteristics. For example, people scoring high on extroversion naturally bond better with their social environment, and thus have a better social network as a consequence (DeNeve & Cooper, 1998).

High levels of emotional well-being cause individuals and societies to function better (Diener & Ryan, 2009). Lyubomirsky, King et al., (2005) indicate that people with a high positive state of mind benefit more from life domains such as social rewards, superior work outcomes, and higher activity, energy and flow. Although Diener and Ryan (2009) argue that a constant striving for high positive affect bears the danger of becoming engaged in risk-taking behaviour, such as illicit drug usage, in order to obtain and maintain a constant state of euphoria, other studies oppose this by pointing out that people high in emotional well-being have a higher ability of self-control and self-regulatory coping skills (Lyubomirsky, King et al., 2005).

Literature on what causes a person to be happy and how happiness facilitates certain characteristics is extremely comprehensive. In this study a number of

characteristics and factors have been mentioned which coincide with the topic. Satisfaction with life (SWL) is the degree to which people perceive their overall quality of life as good (Diener et al., 2008). Many debates have argued the causes for people being happy. Initially it was believed that wealth is the most influencing factor (Ahuvia, 2001; Andrews & Ingelhardt, 1979; Arthaud-Day & Near, 2005).

Who would not be happy when rich? SWL in terms of happiness has been a concept regularly researched and was already a relatively well-known area of research across western cultures three decades ago (Andrews & Ingelhardt, 1979). Differentiating between individualistic and collective cultures have opened a new dimension and it has been found that in both collective and individual cultures, SWL is positively linked to the level of consumable power when different countries are compared with one another (Andrews & Ingelhardt, 1979). However, upon comparison of individuals' SWL within the same countries, no difference could be attributed to the level of consumption once the basic human needs have been met (Ahuvia, 2001; Andrews & Ingelhardt, 1979; Arthaud-Day & Near, 2005). A significant difference was noted between individualist cultures and collective cultures in that the latter measured SWL against honour and meeting social obligations, whilst individualistic societies strive for personal happiness (Ahuvia, 2001). Studies on slums in Calcutta, India, revealed that social support and cohesion was significant in experiencing general psychological/mental well-being, and

participants indeed experienced meaningful lives despite very poor environmental conditions (Biswas-Diener & Diener, 2001). Social relationships do indeed increase SWL (Diener & Ryan, 2009). Individuals are simply happier when they have social support and, in general, married people have been found to be happier than unmarried ones.

Apart from social relationships, emotional well-being is also marked by general psychological/mental well-being in three additional areas of life, namely health and longevity, work, and societal benefits (Diener & Ryan, 2009). It has been confirmed that predominantly negative emotions are to a large degree responsible for triggering cardiovascular illness, since the autonomic nervous system is challenged continuously (Danner, Snowdon & Friesen, 2001). Positive emotions calm the autonomic nervous system and help it to remain at or return to baseline; thus promoting health. Even terminally ill people are better off when they experience fundamental happiness. Patients with illnesses such as cardiovascular diseases, strokes, bypass surgeries and HIV had a better prognosis and recovery rate when they had a positive state of mind (Seligman, 2008). It was found, especially under aversive conditions, that positive emotions undo negative emotions (Frederickson, 2004) and are subject to psychological factors such as hardiness and self-esteem, outlook on life and social factors such as emotional support (Ryff & Singer, 1998). Furthermore, neurophysiological research has revealed that in the realm of stressful encounters, the body down-regulates neuroendocrine, which prevents

impairment in the feedback system for the glucocorticoid cascade, which is caused by high cortisol. This serves as a powerful protector against cardiovascular diseases (Ryff & Singer, 1998).

People with high levels of emotional well-being tend to live longer (Danner, Snowdon, & Friesen, 2001). According to Danner et al. it has been found that participants who displayed more positive emotions in their young adulthood years lived longer than those who did not. In 1930, nuns with an average age of 22 years, who took their final vows at the time, were asked to give a brief sketch of their lives. Coders were used to code words in order to differentiate between positive, negative and neutral emotions. Accomplishments, amusement, contentment, gratitude, happiness, hope, interest, love and relief were categorized as positive emotions, whilst negative emotions were categorized as anger, contempt, disgust, disinterest, fear, sadness and shame, and neutral emotions were characterized as surprise. Sixty years later it was confirmed that those nuns, who expressed more positive wordings in their brief autobiography, were found to exceed the age of 75 to 95, while, those expressing more negative emotions, had died before reaching 75 years of age (Danner et al., 2001).

In the occupational domain, people who experience high levels of emotional well-being have been observed to be more productive, dependable and creative (Diener & Ryan, 2009). They are known for high quality work and higher organizational citizenship, which is the likelihood of doing tasks not required,

such as helping colleagues. Society as a whole benefits from individuals with high levels of emotional well-being in that they are more likely to become engaged in altruistic activities (Diener & Ryan, 2009). Such people are generally trusting, co-operative and adopt a pro-peace attitude with confidence in democracy and tolerance towards immigrants and racial groups. A society experiencing elevated levels of SWL is expected to be a stable, productive and effectively functioning society.

2.1.2 Psychological well-being (PWB)

PWB originates from Aristotle's 'Nicomachean Ethics' (350 BC in Ryff, 1989; Ryff & Singer, 2008). According to Aristotle's, finding meaning in life is based on virtue and ethics. At the time of Aristotle's purpose was less to define happiness, but rather a guideline to live by, and while doing so to bring out the best in the person. It is a delicate balance between good and evil. Synonymous with positive and negative affect these two concepts, as a dichotomy, are integral to PWB (Ryff, 1989). Goal orientation and having purpose in a person's action in order to grow into the true best nature of man, a life of justice, intellectual virtues, friendship and higher purpose by acting for others instead of the self – those were the core aspects of Aristotle's concern in his studies (Ryff & Singer, 2008).

PWB is linked to earlier developmental theories, such as early lifespan development of Erikson and Neugarten as well as the self-actualising theories such as those of Maslow and Rogers, and analytic psychology such as that of Jung (Ryff, 1989). PWB is also strongly related to the self-determination theory (SDT) of Ryan and Deci (2000, 2001), which proposes three innate psychological needs to be met, being the need for competence, the need for autonomy and the need for relatedness. Ryan and Deci argue that these needs are integral to achieving psychological growth, integrity and well-being and are based on intrinsic motivation. Well-being is arrived at by maximising one's potential, and if any of these three psychological needs are thwarted, PWB is in jeopardy (Samman, 2007).

In particular, intrinsic motivation is strongly related to good relationships, community well-being (Kasser & Ryan, 1996), personal growth, through attributing meaning to recollections of the past (Bauer, McAdams, & Pals, 2008), as well as feelings of autonomy (Deci et al., 2001; Deci & Ryan, 2008). Intrinsic motivation refers to the reason for engaging in an activity, and in finding pleasure and reward in the task itself because it enhances feelings of joy, intense involvement and mastery, kindles interest and is personally expressive (Baumgardner & Crothers, 2010). Intrinsic motivation has been found to be the underlying motivational factor for people functioning well in occupational and societal roles. Usually these people are committed and engaged in their tasks and are prepared to make more effort to reach a goal. In

order to find meaning in a task, research has found that certain intrinsic rewards are critical, being sense of meaning and purpose, sense of choice, sense of competence and sense of progress (Chalofsky & Krishna, 2009). Extrinsic motivation on the other hand, is finding joy in the end-result and not the process itself (Baumgardner & Crothers, 2010).

Ryff (1989) developed a multi-dimensional approach to PWB and managed to distil six psychological dimensions which assess the individuals' thriving to function positively. These six dimensions are autonomy, environmental mastery, personal growth, positive relations, purpose in life and self-acceptance (Biswas-Diener, Kasdan & King, 2009; Deci & Ryan, 2008; Peterson, Park & Seligman, 2005; Ryff & Singer, 2008; Seligman et al., 2004).

2.1.2.1 Autonomy

Autonomy, also referred to as self-determination or independence, is a form of behaviour regulated from within (Ryff, 1989). It refers to internal locus evaluation in which the individual is not solely dependent on the norms of the external environment, but evaluates oneself by personal standards (Chirkov & Ryan, 2001; Ryff & Singer, 2008). Autonomy is strongly related to self-actualizing abilities referring to the degree of resisting blindly following others' opinions, views and certain collective social norms. Autonomy refers to a certain personal freedom in finding distance from collective fears, beliefs, and

social laws. Autonomy is also interwoven in life-span development theories and described as the process of turning inwards, making choices based on own personal standards (Ryff, 1989).

People with an impaired level of autonomy, are extremely concerned with the expectations and evaluations of others. They rely on others' judgment to make decisions and conform easily to social pressure. Individuals on an optimal level of functioning are independent and self-determined. They can resist social pressure and regulate their behaviour from within. Their self-evaluation is based on their own personal standards and not societal norms (Ryff & Singer, 2008, p. 26).

An environment of autonomy, flexibility, empowerment, continuous learning, risk taking and creativity kindles intrinsic motivation (Chalofsky & Krishna, 2009). A comparative study on performance and well-being amongst Russian and American students confirmed that intrinsic motivation is weakened in a controlling environment, whilst an autonomy supportive environment facilitates intrinsic motivation and, through this, increases the level of SWB and PWB (Chirkov & Ryan, 2001).

2.1.2.2 Environmental mastery

The ability to create an environment, which is in coherence with the psychic condition attributed to mental health, is referred to as environmental mastery (Ryff, 1989). According to lifespan theories, environmental mastery includes manipulating and controlling complex environmental conditions, including the capacity to act and change the environment to suit the individual's personal needs (Ryff, 1989; Ryff & Singer, 2008). Keyes (2005) distinguishes flourishing students from languishing students and found that PWB in flourishing students is indeed positively related to performance in terms of mastery, goal orientation, lower procrastination and higher self-control. The study of Keyes is also evident for high levels of well-being being associated with high levels of self-regulated learning. Flourishing students portrayed high scores on goal orientation and mastery, which again determines a high degree of adaptability.

Environmental mastery is coupled with living for a goal which in the occupational domain is supported by the demand-control model which postulates that, amongst others, personal growth is influenced by the degree of psychological demands of the work situation and the degree of control the employee has over the situation. High levels of psychological demands coupled with high levels of control facilitate learning and personal development, whilst high demands and a low probability to meet them result in elevated levels of

strain, which hampers personal development resulting in poor environmental mastery (Taris & Kompier, 2004).

Individuals on an impaired level of environmental mastery have difficulty managing their daily affairs, and are unable to change or improve their surroundings. They lack awareness in environmental opportunities and have little sense of control over their environment. On the optimal level, these people are competent in managing their environment optimally, control external activities, and make sufficient use of environmental opportunities. They are able to create and choose contexts which suit their personal needs and values (Ryff & Singer, 2008, p. 25).

Howell (2009) found that well-being is inversely related to mastery-avoidant goal orientation, indicating that decreased levels of well-being indicate increased levels of mastery-avoidant behaviour. Ryff and Singer (1998) indicate that low scores of environmental mastery can cause a person wanting to avoid triggering a (further) negative outcome, a feeling of helplessness dawns, and consequently this may result in symptoms of depression.

Shock beyond control, over a prolonged period of time, causes an expectation. Expectation then serves as a mediating effect, and can result in the subject to perceive the situations to be uncontrollable. Consequently the subject will display a pattern of helplessness. Experimental studies have shown that even

when the external environment is manipulated, making it possible to exercise control or avoid the shock, the research subject remains helpless (Peterson, Maier, & Seligman, 1993). The demand-control model (Taris & Kompier, 2004) supports the study of Peterson et al. in that it postulates that if the psychological demands are high, and control over the situation low, environmental mastery is hampered. However, this theory does not acknowledge the influence of expectation as a mediating effect, nor does it take positive emotions into account.

Predictability and controllability, together with impact and duration, under severe stressful circumstances are key determinants of health outcomes in stress victims. The mediating effect determines the behavioural outcome. For example, an environmental disaster is perceived as a *lack* of control, while a technological disaster is perceived as *loss* of control.The distinction between both evenly dangerous, uncontrollable and potentially lethal, disasters is based on the *expectation* of technology not to fail while environmental disasters are perceived as a catastrophe of nature, beyond human control (Schwarzer & Schulz, 2003).

Other variables such as positive emotions strongly influence the likelihood of apprehension regarding the future under aversive circumstances. Normally aversion is associated with negative emotions. However, when this negative feeling is approached with confidence in believing that the future will be better,

which in turn is generating an internally positive state, the prolonged negative affect is eliminated. Practically this increases the ability to identify difficult circumstances as a challenge and not to surrender in defeat (Danner et al., 2001).

2.1.2.3 Personal growth

Personal growth is a positive, dynamic and continual process of developing one's own potential, which includes openness to experience and confrontation of challenges in different stages in life (Ryff & Singer, 2008). Personal growth is related to strengths such as zest, engagement and the ability to reflect on life, having a clear comprehension of life, and a sense of directedness and intentionality (Ryff, 1989; Ryff & Singer, 2008).

On the impaired level, these individuals feel personal stagnation and boredom, lack sense of improvement and expansion over time and have little interest in life. They have little or no ability to develop new attitudes or behaviours. On the optimal level these individuals feel a continuous development, see themselves as constantly growing and expanding, and are open to new experiences. They have a sense of realising their own potential, and see improvement in themselves and their behaviour over time (Ryff & Singer, 2008, p. 25).

Personal growth is experienced by caregiver professionals through enhanced personal resources (Taubman-Ben-Ari & Weintroub, 2008). Reports such as greater appreciation for life, redefined priorities, self-esteem, better coping skills and greater appreciation in life in the aftermath of aversive conditions do indeed trigger a sense of directedness and intentionality (Herman, 1992; Ryff & Singer, 2008). Clinicians, who experienced personal growth through working with trauma victims, only reported short- termed experiences of intrusion, while others fit into the profile of secondary traumatic stress. Working with trauma victims, changes personality in clinicians, and reports confirmed a higher level of sensitivity, compassion, insight, tolerance, more appreciation, greater resilience and spirituality all towards personal growth. Therapists, medical personnel and other caregivers confronted with trauma victims have reported on various occasions how these experiences have made them grow in terms of being more mindful in their own lives, knowing what they live for, and finding fulfilment in their own lives (Herman, 1992; Slade, 2010; Taubman-Ben-Ari & Weintroub, 2008).

2.1.2.4 Positive relations with others

In many of the person-centred theories it is found that self-actualisers have also positive relations with others since they are strong in conveying emotions such as empathy, warmth, affection, capacity to love, deep friendships and close relationships with others (Ryff & Singer, 2008). Emotions play the key role in

bridging negative and positive experiences in PWB. Good relationships specifically are a reciprocal process of lead-and-follow (Diener & Seligman, 2004). Based on adult developmental stage theories, the ability to love is central to well-being, nourishes friendship and enhances identification with others (Ryff, 1989).

Individuals with an impaired level of positive relationships with others have few close or trusting relationships, find it difficult to be open and feel frequently isolated as well as frustrated in interpersonal relationships. They are not willing to compromise in order to maintain important or close relationships with others. People who have an optimal level of positive relationships with others are known to be warm and trusting towards others, concerned about others' welfare and are capable of strong feelings of empathy, affection and intimacy. They understand the give-and-take principle of human relationships (Ryff & Singer, 2008, p. 25).

Social support correlates positively with physical health in terms of a healthy cardiovascular system. A study of students has confirmed that loneliness has a negative effect on the immune system. Other studies have found that the impact, for example of a divorce, depends on the nature of the past relationship and that social support has an inverse relationship with symptoms of anxiety (Ryff & Singer, 1998). Social support is one of the most important key determinants of the success in trauma therapy (Riggs & Foa, 2004).

In an investigation of marginalised people of Calcutta, being sex workers, slum and pavement dwellers, astounding results were obtained confirming that being happy is not linked to material possessions. As a matter of fact the marginalised people of Calcutta capitalize and find meaning in non-material resources such as rewarding social relationships, family relations and morality and religion, they regard themselves as 'good' people (Biswas-Diener & Diener, 2001).

A study on burnout in social workers of South Africa confirmed that the degree of sense of cohesion experienced by the social worker is inversely related to the degree of burnout the social worker may experience (Rothmann & Malan, 2003), and a South African study in the policing service identified seeking for social support to be an active coping strategy (Pienaar & Rothmann, 2003).

2.1.2.5 Finding purpose in life

Finding purpose in life is defined by clearly comprehending one's sense of directedness and intentions, which gives a sense of meaningfulness (Ryff, 1989). Fundamental to finding purpose in life, are life-span theories and the theory of existentialism in creating meaning and direction in life, through living an authentic life (Ryff & Singer, 2008). In some theories this may be achieved through suffering or dedicating a life to helping those who suffer. In this process of experiencing or witnessing suffering, the value lies in 'finding

purpose through suffering' such as elaborated on in Frankl's theory of existentialism (Meyer, Moore, & Viljoen, 1997; Ryff & Singer, 2008). Purpose of life is based on having a goal or aim which gives an individual the feeling of achieving or contributing something meaningful to life (Ryff, 1989).

On the impaired level individuals who have no or little purpose in life lack a sense of meaning and. as a result, have very few goals, little sense of direction, see no purpose in past events and have no meaningful outlooks or beliefs in life. On the optimal level these individuals experience having a goal and sense of direction in life, find meaning in present and past, hold purposeful beliefs and have clearly defined goals for which they live (Ryff & Singer, 2008, p. 25).

The marginalized in the slums of Calcutta found meaning in the challenges of hardship they faced (Biswas-Diener & Diener, 2001). Distressing living conditions in the form of marginalisation and oppression of minority groups, past political regime of apartheid and poor economic circumstances have apparently no direct influence on well-being, as studies indicate that those populations actually score higher in well-being than comparatively stable populations (Keyes, 2007; Ryff et al., 2004; Wills, 2009). Summerfield (1991) argues that post-war societies are indeed suffering from a pseudo-condition of trauma, reframing the experiences of war to make it understandable; to arrive at finding meaning in the experience.

Well-being in the form of finding meaning and experiencing personal growth particularly can be experienced *as a result* of challenging conditions (Ryff & Singer 1998; Taubman-Ben-Ari & Weintroub, 2008), by utilising own goals and strengths, and finding meaning and purpose through reframing to a valued social identity (Slade, 2010). This is supported by psychotherapists who dealt with primary trauma victims specifically and, as a result, experienced higher self-awareness and personal growth (Herman, 1992). A sense of meaning and personal growth has been found in paediatric nurses and physicians exposed to different levels of mortality of their patients (Taubman Ben-Ari & Weintroub, 2008).

2.1.2.6 Self-acceptance

Self-acceptance is defined by knowing the self, own actions, motivations and feelings and also the need for positive self-regard (Ryff & Singer, 2008). These aspects are also fundamental to many person-centred theories, such as Maslow's self-actualization, Roger's optimal functioning and Allport's maturity and Frankl's contemplation of the meaning and purpose of human existence through suffering (Biswas-Diener et al., 2009; Deci & Ryan, 2008; Jacobsen, 2007; Meyer et al., 1997; Peterson et al., 2005; Ryff & Singer, 2008; Seligman et al., 2004) as well as life-span theories in which the importance of acceptance of the self and past life is emphasized (Ryff, 1989). In his analytic theory Jung elaborates on self-actualization as the 'dark side', which a person must also

come to terms with, in order to gain the ability of self-awareness through acceptance of personal strengths and weaknesses (Meyer et al., 1997; Ryff & Singer, 2008).

Individuals with an impaired level of self-acceptance typically feel dissatisfied with themselves, disappointed about past occurrences, troubled about specific personal qualities and wish they were different from who they are. On the optimal level, these individuals experience a positive attitude towards themselves, accept their good and bad qualities equally and feel positive about their past (Ryff & Singer, 2008, p. 25).

Self-acceptance includes the desire for autonomy, personal growth and self-esteem. It has been found that people who predominantly strive for extrinsic goals such as wealth, social status, social recognition or physical appearance, experience lower levels of well-being (Kasser & Ryan, 1996).

2.1.3 Eudaimonic well-being (EWB)

The concept of *eudaimonia* originates from Greek philosophy, based on Aristotle's (350 BC) first systematic exposition of ethics, "Nicomachean Ethics" (Keyes & Annas, 2009; Ryff, 1989; Ryff & Singer, 1998). Eudaimonia is a dichotomy on a continuum which describes a way of living. On the one extreme is virtuous behaviour based in spiritual good-will and benevolence

towards others, and on the other, evil behaviour, based on self-centred egoistical actions (Wills, 2009). *Eu* means "well-being", or "good", and *daimonia* means "demon" or "spirit" (Samman, 2007). Aristotle believed that the inner spirit drives the human being towards a constructive world, in which the inner spirit leads the person to pursuing goals or actions being 'right for them'. Aristotle explains that acting in accordance with the daimon is constructively leading to the facilitation of well-being of the self as well as others, while living against the daimon, would lead to ill-being. Aristotle emphasises that well-being of the individual heavily influences the well-being of communities (Linley, Joseph, & Seligman, 2004). Although eudaimonia is a sense of pleasing the self and the external environment through virtuous actions, there is a distinction between pleasure in the sense of satisfying directedness and satisfying the need for immediate gratification.

In terms of virtuous and pleasurable acts, Aristotle distinguishes once again. This time between eudaimonic pleasure and hedonic pleasure, which are interlinked (Samman, 2007). *Eudaimonic pleasure*, according to Aristotle, is the pleasure derived from finding a higher purpose and meaning through an act, which does not guarantee personal gratification. *Hedonic pleasure*, on the other hand, is an 'immediate need gratification', and is arrived at through the principle to maximise pleasure and minimize pain (Samman, 2007), such as eating ice cream to satisfy a craving for sweets.

Eudaimonic well-being has been defined by Waterman, (2008, p. 236) as "…a set of subjective experiences, as a highly positive affective condition". Eudaimonia is the subjective experience of being true to the inner self; an existential quest in life in which purpose is found by, for example, creating, loving, parenting and observing; to be involved in something larger than the self over a specific time period – this all with the central aspect of meaning, being that the purpose in life has been fulfilled. EWB reflects, once again, in the life-span development theories of Neugarten, Erikson and Buhler, and in the humanistic theories, such as existentialism of Frankl, person-centred approach of Rogers, and self-actualization of Maslow (Ryff, & Singer, 2008). Today we also refer to eudaimonia, also as 'flourishing', together with a general feeling of being complete, finding meaning in existence and dealing with the ultimate goal in life (Keyes & Annas, 2009). Eudaimonia strongly overlaps with three dimensions of PWB, namely, personal growth, self-knowledge/acceptance and purposeful living (Ryff & Singer, 1998, 2008).

EWB complements both PWB and emotional well-being, and distinguishes itself in that EWB transcends beyond what has already been explained in terms of emotional well-being and PWB in terms of finding ultimate meaning in life (Waterman et al., 2010).

Other than PWB, eudemonia is not that much concerned with the positive affect as such, but to the degree to which a person might feel to be fully functional or

not (Ryan & Deci, 2001). Eudaimonia satisfies multi-faceted needs; consequently experiencing a deep feeling of satisfaction, for example working on a community project alleviating poverty (Samman, 2007). EWB supports inner growth and so differentiates from hedonic well-being, which is merely a fulfilment of subjective desires as a momentary act of pleasure, and also believed to be harmful to human growth (Ryan & Deci., 2001).

Intrinsic motivation, as opposed to extrinsic motivation, seems most integral to eudaimonia. Intrinsic motivation can be described as being faithful to the inner self in terms of fulfilment of a deep, often virtuous desire, and may be experienced as 'flow' usually exceeding societal expectations (Csikszentmihalyi, 1999). In addition intrinsic motivation contributes positively to social self-actualisation, and is marked by what the individual wants to achieve by him or herself (Ahuvia, 2002). Intrinsic motivation is an aim to strive towards excellence and self-actualization (Ryff & Singer, 2008). On the contrary, extrinsic goals are subject to what is expected from the external world such as financial success, social recognition and physical appearance (Ahuvia, 2007).

EWB is further defined by six inter-related categories being self-discovery (know thyself); perceived development of one's best potentials (learning thy upper limitations); a sense of purpose and meaning in life (direct thy talent into personal meaningful goals); investment of significant effort in pursuit of

excellence (fulfilment in self-realization); intense involvement in activities (engagement/flow); and finally, enjoyment of activities as personally expressive (doing things not to impress others but to find joy for one-self) (Waterman et al., 2010).

A significant overlap between PWB and EWB has been noted. According to Ryan and Deci (2001), EWB is also rooted in the self-determination theory (SDT) which underlies the concept of eudaimonia, or self-realisation, as being central to well-being. Similar to PWB, self-determination theory also regards autonomy as a need for well-being. However, it adds the need for competence and the need for relatedness as integral to achieve psychological growth, integrity and well-being in terms of life satisfaction and psychological health and the experience of vitality and self-congruence.

EWB is not a concept of living exclusively with positive emotions and not to experience negative events. EWB is particularly defined by sustaining positive health especially through times of hardship, negative feelings, struggles and pains. It is about the engagement in living even when living gets extremely difficult. Eudaimonia, may also be marked by, but is not exclusive to, negotiating its way through trauma and, by doing so, preserving mental health and well-being, facilitating personal growth and finding a personal meaning (Ryff & Singer, 1998).

The differentiation between eudaimonia and, in particular, purposeful living in PWB is not clearly defined, as these two constructs overlap in terms of personal growth and attributing meaning to life. Keyes (2002) argues that a complete state of mental health is neither languishing nor flourishing. She found in her study, that pure languishing is prevalent to depression and associated with psychosocial impairment, absenteeism, and limited daily activities. Flourishing is associated with resilience and acts as a buffer against stressful events and life changes. Strümpfer (2006) further elaborates by saying that finding meaning through suffering is a form of stimulating and utilising personal strengths such as resilience and as such steeling the individual.

A high awareness in well-being resulted in taking well-being into consideration in cases of mental ill-health (Slade, 2010). According to Keyes (2005), languishing participants, who were free of mental disorder, experienced greater dysfunctions in terms of goal formation and resilience than non-languishing participants with mental disorders. Keyes consequently states that absence of well-being is in itself dysfunctional.

People throughout history have achieved a state of deep personal growth and meaning in life through extreme distressing environmental conditions and have achieved excellence, for example deaf Beethoven and long-term imprisoned Mandela. One may not forget holocaust survivors and war survivors, once having been ‘ordinary’ people, formed through extraordinary hardships in life

(Strümpfer, 2006). Psychotherapists and medical staff have reported eudaimonic experiences such as personal growth, self-knowledge and purposeful living, after prolonged exposure to traumatised and terminally ill patients and death (Taubman Ben-Ari & Weintroub, 2008). It is matter of an innate tendency to utilise personal and learned strength to overcome extraordinary demands, facing challenges, threats, adversity and suffering and growing out of and beyond it (Keyes 2002; Strümpfer, 2006).

2.2 SECONDARY TRAUMATIC STRESS (STS)

In order to better conceptualise STS, which is another construct of measure to this study, it is important to elaborate somewhat on posttraumatic stress disorder (PTSD), which is the precursor, and symptomological 'father' of STS (Bride, Robinson, Yegidis, & Figley 2003; Hope, 2006).

2.2.1 Posttraumatic stress disorder (PTSD)

PTSD has officially been recognised by the American Psychiatric Association (APA) in 1980 as a psychological pathology, and subcategory of Anxiety Disorders and was included in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994). The profile of PTSD is based on neurotic conditions soldiers experienced during war. It has been labelled throughout history as 'soldiers heart', 'shell shock', 'combat neurosis'

and ‘operational fatigue’. Most commonly it is recognised in victims of assault, rape, war, technical and natural disasters.

According to the “Synopsis of Psychiatry” (Sadock & Sadock, 2007), criteria to develop PTSD are described as follows:

Table 2.2.1.1

Symptoms of PTSD

Criterion A ***Both elements must be present:***		
o Incident of experiencing or witnessing an event which is life-threatening or in danger of serious injury, either actual or threatened to happen o Feelings of intense fear, horror, helplessness		
Criterion B		
Intrusion	***Avoidance***	***Arousal***
Re-living the traumatic event in <u>at least one</u> of the following ways:	*Avoidance of trauma-related stimuli and emotional numbness in <u>at least three</u> or more ways:*	*Symptoms of hyper arousal not present before event, <u>at least two</u> must be present:*
Intrusive thoughts or images	Avoids to remember event-related feelings, conversations or thoughts	Insomnia
Repeated distressing dreams	Avoids activities, places and people that recall event	Outburst of anger / irritability
Flashbacks or hallucinations	Forgot important features of the event	Decreased concentration
Internal/external cues	Loss of interest in activities important to him or her	Excessive vigilance
Physical reactions	Feelings of detachment and isolation	Increased startled response

Symptoms of PTSD (continued)

Intrusion	***Avoidance***	***Arousal***
	Restricted feelings of love or other strong emotions	
	Believes life to be short and unfulfilling	
The above symptoms lasted at least one month.		
The symptoms cause distress, impair work, social or personal functioning.		

Symptoms may develop within months after the traumatic events or sometimes years after the event. Often victims experience feelings of guilt, rejection and humiliation and may describe dissociative states, panic attacks, illusions and hallucinations. Associated symptoms may include aggression, violence, poor impulse control, depression and substance-related disorders (Sadock & Sadock, 2007).

According to the diagnostic profile, PTSD is based on a precipitating factor of first-hand experience encounter with trauma. Hence it cannot be diagnosed as such, if criterion A is not satisfied. Hermann (1997) initially argued that professional caregivers, for example trauma therapists, are also witnesses. The relationship resembles a triangulation of the visible victim, the invisible perpetrator and the therapist as a third party. Hermann supported this argument with observations of trauma therapists who identified with the victim's feeling of fear and fury, evoking feelings of fear in the therapist him or herself, which in turn caused distrust and avoidance of close relationships in the therapists and

consequently loss of confidence in treatment methods, adopting a rescuing or advice-giving position resulting in disempowerment of the victim. Therefore Hermann suggested that posttraumatic stress disorder is ‘contagious’.

2.2.2 From posttraumatic stress disorder to secondary traumatic stress

That what Hermann (1997) righteously has linked, as the consequence of engagement with primary victims, to posttraumatic stress symptoms in 1997, has received increasing attention in the caregiver professions. This phenomenon has been accepted as a vicarious form of stress arrived at through compassionate involvement with a primary trauma victim. It has been termed ‘secondary traumatic stress’, since the condition could not fulfil all the criterion of PTSD. Nevertheless, the relation is obvious. STS differs from PTSD in that firstly the victim is exposed to the traumatic event through a primary victim and secondly the symptoms are believed to be less severe (Bride et al., 2003; Hope, 2006; Schiffrin & Nelson, 2010).

STS is a negative consequence of empathetically caring for a trauma victim (Hope, 2006; Huggard, 2003), which, as such, is an affront to all person-centred theories and humanism, in which empathy is widely promoted. Furthermore, it has been brand-marked as an ‘occupational hazard’ for all caregiver professionals, particularly pointing out social workers (Bride et al., 2003).

STS is a syndrome of symptoms almost identical to PTSD. The diagnostic profile of STS is marked by a) the effort of the caregiver to become engaged in supporting primary victims, and b) by the caregiver acquiring the knowledge of horrific events through the disclosure of the primary victim. The symptom categories include avoidant responses, physiological arousal and intrusive imagery (Bride et al., 2003; Kanno, 2010; Hope, 2006), identical to PTSD symptoms, as set out in table 1 of this chapter. Sufferers of STS may experience symptoms such as emotional numbing, physiological somatic problems, hyper-vigilance and functional impairment (Kanno, 2010). Although STS is not classified as a DSM-IV-revised psychopathology, Kanno (2010) argues that STS is not less important than any other pathological condition. Apart from the impact on the sufferer of STS, Kanno (2010) further points out that STS is also responsible for a substantial proportion of staff turnover in caregiver professions, resulting in a high number of inexperienced and young staff members as the majority in caregiver organisations. Other researchers (Bride et al., 2003; Hope, 2006; Huggard, 2003) support Kanno (2010) in emphasising the sacrifice in well-being in professional caregivers, resulting from elevated levels of STS. According to Kanno (2010), STS should formally be recognized in the DSM-V as diagnostic criteria. This should increase awareness amongst professional caregivers and lead to means of early identification, intervention, treatment- and training programs. STS should not be accepted as ‘a part of the job’ in the caregiver professions.

2.2.3 The downside of caring

The difference in responding to a challenge is determined by the individual's outlook on life. Each challenge or confrontation starts with an initial perception, or appraisal, determining whether the individual perceives this as a challenge or a potentially harmful encounter, or even a severe threat (Ryff & Singer, 1998). Response to stress may be acute in terms of experiencing horror or intense fear as a result of a shocking or horrific experience and is normally of short duration, or it may be chronic in terms of continuity and builds up over time.

Attention is increasingly given to caregiver professions as they are very demanding as a result of emotional involvement with traumatised people (Bride et al., 2003; Taubman-Ben-Ari & Weintroub, 2008). Researchers disagree about the experience of positive emotional consequences by professional caregivers (i.e. Hope, 2006; Naudé & Rothmann, 2003; Rothmann & Malan 2003) as some indicate the probability of general PWB through personal growth and finding meaning (Collins, 2008), and others state that, in particular, social workers are vulnerable to ill-health conditions such as burnout (Rothmann & Malan, 2003) and STS (Bride et al., 2003; Huggard, 2003). Caregivers are at increased risk of developing anxiety and depression symptoms and STS. Symptoms of posttraumatic stress have been noted in caregivers working with soldiers as early as 1974. What was known as compassion fatigue or vicarious traumatisation was in actual fact the result of empathetic engagement with

victims of war, sexual abuse, disability, serious illness, holocaust victims and terminally ill patients (Bride et al., 2003; Huggard, 2003).

Social workers in the UK reported the field of work to be taxing and exhausting (Collins, 2008) and STS in social workers has been found to be prevalent in south-east of the United States (Bride et al., 2003). Studies from South Africa confirm that social workers experience high incidents of burnout (Rothmann & Malan, 2003), and emergency workers experience chronic stress (Naudé& Rothmann, 2003). Two of the most intense stressors for nurses in South Africa were to perform painful procedures and to watch patients suffer. However, social cohesion seemed to minimise burnout (Van der Colff & Rothmann, 2009). As moderating factors, good interpersonal relationships and length of service acted as buffers and made caregivers more resilient against the trauma (Taubman-Ben-Ari & Weintroub 2008).

Social workers function and simultaneously influence on community level (Collins, 2008). Decreased levels of EWB in particular indicate lower productivity and higher vulnerability to mental or physical illness (Keyes & Annas, 2009; Keyes et al., 2008) and would hamper the effectiveness of the social worker, underpinning the importance of investigating well-being in terms of SWL, PWB, and EWB as opposed to STS. This would be in the interest of the community as well as the profession.

Cameron and Payne (2011) have found that as the scope of suffering increases, the degree of compassion decreases; thus if an individual is exposed to high numbers of trauma victims, or alternatively to a high frequency of trauma victims, affective returns are diminished; a state of psychophysical numbing takes place and a collapse of compassion may be the result. Cameron and Payne attribute this to the intensity of emotion a person may experience towards one victim which, however, becomes too overwhelming when the numbers of victims increase dramatically. In order to regulate the intense feeling of compassion towards masses of victims, emotions of compassion are prevented or eliminated, as a measure of self-preservation.

An inverse relationship between general psychological well-being and perceived stress (Schiffrin & Nelson, 2010) has been found. More precisely, in terms of primary caregivers, it has been found that increased general psychological/mental well-being indicates absence of STS, and presence of STS indicates depleted general psychological/mental well-being (Hope, 2006). Little is known about the inverse relationship between SWL, PWB, and EWB in relation to STS.

The risk of developing STS in the caregiver profession is significantly high, since caregivers are exposed to trauma through the primary victim (Hope, 2006; Huggard, 2003). Bride (2003) found that in the United States of America 97% of social work clients have experienced trauma and 70% of the social workers

have at least experienced one of the STS symptoms in the week before, and 55% met the criteria for at least one of the core symptoms being intrusion, avoidance and arousal. More than half of the social workers acknowledge the influence of secondary trauma on their personal lives. Caregivers are known to experience feelings of shame, guilt, anxiety, and despair when they are affected by STS symptoms (Harrison & Westwood, 2009), consequently risking isolation from others. Furthermore, the nature of the client-caregiver relationship is essentially a non-reciprocal therapeutic process. Therefore the caregiver discourages the client from adopting a care-giving role in the relationship and, other than in any other social relationship, does not expect anything in return from the client which could soothe the emotional burdens put upon the caregiver by the horrific experiences of the client.

The status of the helper as an 'auditory witness' has been defined and indeed, as a negative consequence, can impair the functionality of the caregiver (Bride et al., 2003; Hope, 2006; Kanno, 2010). Since stress is accumulative in principle, the frequency of exposure to stressful events over a prolonged period of time coincides with the observations of learned helplessness, in being a further determinant of the health outcome for the individual (Peterson et al., 1993; Schwarzer & Schulz, 2003). Peterson et al. further emphasize that an individual can learn to become helpless by observing others being helpless; thus does not need to experience an undesirable event. Witnessing it, may be sufficient. The latter statement may reflect upon the Namibian social work clientele, not

exclusively traumatic, but infiltrated by poverty, substance dependency, disability, relationship problems and unemployment (Ministry of Health and Social Services, 2009).

2.2.4 Distressing environmental factors for the social worker

A demographically relevant study on social workers is South Africa indicates the complexity of the nature of the job in relation to the personal resources (Rothmann & Malan, 2003). The particular study investigated the level of burnout in social workers of South Africa, resulting in cynicism and emotional drainage. Consequently the social worker is not in the emotional condition to fully take care of the additional emotionally taxing client, and takes comfort in having fulfilled the basic elements of the tasks necessary. Moreover, the studies founds on social work within the context of stress, concentrate on stress-related conditions such as burnout. They do not take the severity and additional risk of dealing with traumatised population into account as a separate and additional phenomenon, which is not part of the average professional's experiences when working in the general service industries (Newell & MacNeil, 2010).

Namibian social workers are challenged by traumatic conditions and frequently exposed to primary trauma victims i.e. HIV/AIDS victims and orphans as well as domestic violence and rape victims, amongst others (Ministry of Health and Social Services, 2009), thereby risking STS. No measure of STS in Namibian

social workers could be traced and it can thus not be established with certainty whether Namibian social workers do indeed suffer from STS.

According to LeBeau (2005), in her study on ex-fighters of Namibia's liberation struggle, the prognosis of developing PTSD at some point in time is 15-20% in a post-war society, depending on further environmental stressors the person may experience. The Essential Indicators of 2006-2007 (Ministry of Health and Social Services, 2009), apart from HIV/AIDS and disabilities, constitute the top ten needs of Namibia. Difficulty with working, alcohol/drug abuse, domestic violence and relationship problems make up almost half the problems that need to be attended to, and at the same time these are also associated symptoms of PSTD (Riggs & Foa, 2004). These are the social domains in which social workers of Namibia have to function.

Taking into consideration the political past of Namibia, together with the present high degree of abuse and violence, one may wonder whether the wording in posttraumatic stress disorder may be adequate to explain the circumstances many clients of social workers find themselves in. Becker (1995) disagrees with the term 'post' and argues that one cannot claim that the victims suffer only in the aftermath, since many of these victims are traumatized while still experiencing traumatic situations. Secondly Becker queries the term 'disorder'. This term indicates that the *victim* is classified as being abnormal rather than to understand that the *circumstances* are the true abnormality. The

social worker's emotional involvement is thus not merely hearing about a 'past' traumatic situation and he/she cannot consolidate him/ herself by acknowledging that the client *has* experienced something really bad, in the past, however *is* safe in the present moment. The social worker needs to emotionally deal with the trauma of the victim, *knowing* that the victim is *not* safe and also knowing that it is his/her *responsibility* to help alleviate or resolve the situation the client is in. Together with the 'shock' of the traumatic event, the social worker bears a great responsibility in alleviating and not worsening the traumatic situation of the client in which timing also may be crucial. The increased number of victims together with the professional obligation to help substantially increases the risk of emotional disengagement (Cameroen & Payne, 2011). Becker points out that the impact of trauma is extremely severe to those who are emotionally involved with the victim. For better understanding, Becker has found that very small children, who are not able to cognitively understand what their parents have lived through by being victims of war atrocities, have been found to be haunted by 'ghosts'. Deep fears of the parents have seemingly been transferred to the very young child, even if the incidents had happened before the child was born, or was an infant. The potential harmful and deep impact on the human's psyche, of being a second-hand witness to trauma, can hardly be explained more clearly.

2.2.5 Posttraumatic growth

Literature reports on the detrimental effects of trauma have been so vast that negative consequences have officially been classified as psychological pathology since 1980 (Sadock & Sadock, 2007). Recent research in positive psychology, however, showed that traumatic experiences could also lead to growth. This may then be referred to as 'posttraumatic growth' (Tedeschi & Calhoun, 2004). Joseph (2009) conducted a study on survivors of disasters and found a surprising 43% of respondents reporting that their lives had changed for the better, and not for the worst, as expected, while an almost equal number, namely 46% found their lives had changed for the worst. Posttraumatic growth is rooted in the person-centred theories, more particularly in the organismic valuing theory of growth (OVP), postulating the individual's innate ability to identify what is important and integral for a fulfilled life. It is based on the intrinsic motivation to grow into a positive direction. Three broad dimensions of posttraumatic growth have been found, first, improved social relationships in increasingly valuing friends and family; secondly, a greater sense of resilience and increase in personal strengths; and lastly, positive change in life philosophy in terms of renegotiations in what really matters and in general, an increase in appreciation (Joseph, 2009; Tedeschi & Calhoun, 2004). Communalities amongst survivors of trauma are that they have an increased sense of their own capability to prevail, that self-disclosure results in them becoming more comfortable with intimacy, and that a greater sense of compassion develops.

Posttraumatic growth is not determined by the traumatic incident as such. It is the positive result of the individual's intense effort to find meaning through the traumatic event in the aftermath (Tedeschi & Calhoun, 2004).

It may be debated whether posttraumatic growth indeed leads to well-being (Hobfoll et al., 2007) or whether it merely deletes the horror experience, and therefore stands as the absence of pathology, such as potentially consequential PTSD, depression or anxiety. Several studies claim traumatic encounters of any nature have the potential for dichotomous outcomes. For one, they may result in a poor attempt to cope, by becoming emotionally disengaged or, in a worst case scenario, lead to a state of psychological pathology (Huggard, 2003; Bride et al., 2003). If, in the aftermath of trauma, the cognitive shift in finding meaning as a result of having experienced a traumatic event, is turned into action, and does not merely remain at the cognitive level of reframing the event into a meaningful experience, but in addition is used to translate this cognitive realisation into growth-related actions, then actual posttraumatic growth happens, resulting in well-being (Hobfoll et al., 2007). Actively leading a meaningful deeper life is understood as 'posttraumatic growth' and creates a new dimension of well-being (Tedeschi & Coulhahn, 2004), in terms of emotional well-being, PWB and EWB.

Identical to the strong relationship between PTSD and STS (Kanno, 2010), the concept of EWB and posttraumatic growth are related in a similar way. Both

result in transcending beyond a presently unsatisfactory condition towards a deeper, more meaningful life and experiencing personal growth in the process (Tedeschi & Coulhahn, 2004), with the fundamental difference between EWB and posttraumatic growth being that posttraumatic growth is subject to having experienced a traumatic event. The construct of posttraumatic growth agrees with EWB's finding purpose in life through suffering, which is rooted in the theory of existentialism (Ryff & Singer, 2008). Although posttraumatic growth, equal to EWB, leads to a life on a deeper level of fulfilment and meaning and higher awareness, this cannot be understood to be equal to a happy, care-free life (Ryan & Deci, 2001; Tedeschi & Calhoun, 2004).

2.3 INTEGRATION: STS AND WELL-BEING

As an analogy to emotional traumatic experiences one may think of an earthquake, which rips apart the earthy environment, causing confusion in its structure, leaving next to nothing the same as it has been before. Similarly, the fundamental assumptions of the individual that the world is a safe and structured environment, a traumatic experience overthrows the feeling of safety and structure (Goldblatt, 2009), and leaves behind insecurity, vulnerability and downright fear of survival resulting in emotional chaos. Just as nature has to reconstruct itself in order to produce a new vegetative landscape again, the individual needs to reconstruct his or her basic assumptions of life (Goldblatt, 2009). With time, a new perspective about values and meaning of life is

constructed resulting from such a painful and severely threatening event (Tedeschi & Calhoun, 2004) which is synonymous with EWB. With reference to STS, one may imagine to be a witness of an earthquake happening in the same city – close enough to be a serious threat, but far enough to not induce physical danger at that particular moment in time, but what about the next earthquake? If it could be this close that it can be seen, can it not happen right here too? Dealing with a traumatised population may raise negative emotions in the caregiver in direct relation to the indirect effect of the traumatising event (Bride et al., 2003; Hope, 2006; Kanno, 2010).

Exposure to trauma changes the cognitive schema and personality (Kanno, 2010). On the one side there is the newly acquired stress-inducing knowledge about a horrific event, on the other side the caregiver experiences willingness to help the victim (Carmel & Friedlander, 2009). Helping professionals dealing with domestic violence victims may experience overwhelming feelings of helplessness, psychological numbness, and even aversive emotions in order to protect the self from falling into despair. The self-belief of a safe world is scattered, the insight gained that nobody is immune to abuse results in deep fears about the own and their children's safety (Goldblatt, 2009). Emotional insecurities and spill-over into the personal life may be experienced when dealing with disabilities, HIV/AIDS, poverty and murders. As a rule the social worker is constantly challenged through dealing with exceptionally taxing to severely traumatic life circumstances of others, who seek their help; witnessing

trauma so closely, consequently risking emotional engagement and decrease of well-being to their own detriment. Caregiver professionals exposed to primary trauma victims (Bride et al., 2003) are at increased risk to misdiagnose, deliver poor judgments and ineffective treatment planning, and even display abusive behaviour towards their clients; therefore impairing their functionality and may even cause harm. According to Kanno (2010), STS is not merely a risk for the helping professional, it is an *unavoidable consequence* for caregivers who support victims of violence and crime.

Traumatic experiences have a deep impact on the psyche (Becker, 1995). Hope (2006) advocated that the inverse relationship between well-being and STS in caregivers results from empathic engagement with traumatized population. The necessity of positive emotions in terms of empathic engagement in the helping professions is made clear by Huggard (2003) in that only a deeper level of empathy creates a path of insight beyond that of the client into the clients' circumstance. In order to moderate the risk of developing STS, it has in the past been believed that distance and disengagement within the client-caregiver relationship may be a useful technique. However, it is known to impair empathic engagement.

Although empathetic engagement with the client is integral to the helping professions, empathy has been seen as the defining criterion to develop what was initially known as vicarious trauma (Bride et al., 2003). To take this one

step further, the frequency of traumatic encounters due to a large number of clients, together with the professional obligation to help the victim, has another implication altogether.

Cameroen and Payne (2011) investigated the phenomena of increased escaping effect, similar to emotional numbing in STS, as the number of victims increases. Individuals are often more touched by an unknown individual's death than mass deaths. Thus compassion decreases as the number of victims increase. Numerous victims may appear psychologically overwhelming, to such a large degree, that a psychologically protective response in the form of emotional numbing sets in, creating emotional distance. The experimental study of Cameroen and Payne resulted in finding that the degree of compassion was not affected when the participants were not expected to become involved in terms of assisting the victims. However, when compassion came with a cost and it was expected of the individual to help, the degree of compassion decreased as the number of victims increased.

In opposition to disengagement (Tedeschi & Calhoun, 2004), it has been found that the process of growth out of traumatic events, as theorized by Frankl's existentialism (Meyer et al., 1997), includes cognitive engagement in which the individual reflects upon the lack of fit between the schemata of the self and environment, and the actual happening and consequence. Huggard (2003) suggests an approach for caregiver professionals to monitor own emotions

together with increased self-awareness about disturbing emotions, in order to identify and accept emotional responses and to work towards coping strategies such as seeking support and supervision. It has been established that helping behaviour is predicted by higher levels of social and personal responsibility as well as moral reasoning (Jost & Jost, 2009). Whether traumatic encounters result in a difficult challenge to surrender to, or a process of personal growth, depends at large on the perception of the experience; thus the cognitive appraisal (Ryff & Singer, 1998), in addition to fundamental personality pre-dispositions such as for example self-confidence, positively influences relationships with others (DeNeve & Cooper, 1998), and the level of intrinsic motivation (Ahuvia, 2002; Csikszentmihalyi, 1999; Ryff & Singer, 2008). Social cohesion in turn is responsible for experiencing meaning through a life of hardship (Biswas, Diener, & Diener, 2001). Meaning, according to Herman (1992), Ryff and Singer (1998), Slade (2010), Summerfield (1991) and Taubman-Ben-Ari and Weintroub (2008), is arrived at through experiencing challenges in life, creating higher self-awareness and personal growth by achieving a state of understanding the event and so finding meaning through the challenge, which initially may have been perceived as an aversive condition (Summerfield, 1991).

During this process of overcoming traumatic encounters and arriving through posttraumatic growth at a state of SWL, PWB and EWB a realisation dawns within the individual that certain beliefs are no longer valid and goals no longer

attainable and that some formerly existing schemas do not reflect accurately what actually is in that present moment. A reframing of the current reality needs to take place. This is not a pathway to what is known as a cheerful living condition. It bears the implication that cognitive memories of loss experienced causes painful memories (Tedeschi & Calhoun, 2004).

Whether it was loss of a loved one, or loss of fundamental trust in humankind, either way, some change has happened in the individual, which causes periodic distressful memories. This creates a pathway towards a state of deeper, more mindful living; thus a state of EWB at the same time undergoing some transformation in terms of PWB's personal growth and finding purpose in life, leading to a general feeling of SWL.

Based on the premise of personal growth through traumatic experiences it has been documented in philosophical terms that witnessing, or experiencing, trauma causes change in religious, spiritual and existential components of the individual and results in a sophisticated philosophy of life in life becomes satisfying and meaningful (Tedeschi & Calhoun, 2004). Personal growth is arrived at by finding meaning in the traumatic experience (Bauer et al., 2008) evoking a sense of directedness and intentionality (Herman, 1992; Ryff & Singer, 2008).

Social workers are working for the community. Their well-being directly impacts the well-being of the community they work with; hence PWB's dimension of how to relate to others plays a significant role. The manner of how social workers engage with their clients is determined by psychological availability based on creating an environment of trust, portraying genuine care and concern. The capability of empathetic engagement induces optimal betterment in their clients' condition. To underpin the necessity of social workers individual well-being and its effect on the community, a study undertaken in the United Kingdom serves as an example of the importance of emotional engagement in the client's often complex and distressing needs.

Negative views about social workers were made clear in the United Kingdom, when geriatric clients described social workers to maintain an unhelpful attitude, are uninterested, deliver poor service quality, being too slow or unresponsive altogether. Others again reported social workers to be caring, helpful, trustworthy and responsive. In general, elderly clients describe it to be a 'lottery' in finding a good social worker. On the one hand, social workers experience a high societal demand, and on the other, they suffer limited resources. What seems to lack most in the geriatric clientele was recognition of emotions and worries. Yet, limited time and pressure to perform fast and effectively does not allow the time needed, sensitivity, and emotional engagement necessary, to build a satisfying caregiver-client relationship (Manthorpe et al., 2008).

It has been documented that caregivers who do not fit the diagnostic profile of STS may indeed progress through phases of experiencing STS symptoms. However, they undergo a change in personality in the form that the levels of sensitivity, compassion, insight, tolerance and spirituality increase, leading to PWB and EWB in terms of, amongst others, personal growth and finding meaning in life (Herman 1992; Slade, 2010; Taubman-Ben-Ari & Weintroub, 2008). Interestingly some social workers were able to build a satisfying caregiver-client relationship even though environmental and work-related challenges appeared equal for all social workers in this particular investigation (Manthorpe et al., 2008). They successfully managed to create a reciprocal process. By uplifting the emotional state of the client, they simultaneously experienced the benefits of dimensions of PWB and EWB. PWB dimensions, in particular to find purpose in life and experiencing personal growth, together with EWB in terms of finding meaning in life, have been noted in caregivers who empathetically engage with their traumatized clientele (Herman, 1992). Those caregivers have experienced reframing into a new valued social identity (Slade, 2010) and in the process increased their level of self-awareness (PWB) (Herman, 1992) and meaning in life (EWB) through virtuous actions (Taubman- Ben-Ari & Weintroub, 2008). This way a state of having found purpose in life is arrived at through remaining true to the inner self and being engaged by something larger than the self (Ryff & Singer, 2008) by helping others.

The role of empathy as part of PWB's dimension pertaining to positive relationships with others, is a significantly large contributor towards well-being in the caregiver professions, and should not be underestimated. It has been found that social worker-client relationship in dealing with male sex offenders is crucial as this at large determines the betterment of the client. Ideally the social worker needs to empathetically separate the violent acts from the identity of the client in order to give the client the room to feel remorse and induce a meaningful change. Dealing with sex-offenders is a challenging task and many social workers report emotional exhaustion and hardening, and become cynical and pessimistic. It has been found that social workers with a high score on STS leave this niche at some stage, while social workers who are capable of experiencing high-degree compassion satisfaction build a strong caregiver-client relationship (Carmel & Friedlander, 2009).

In terms of PWB's environmental mastery, a study on nurses dealing with domestic violence victims have found that, as a result the boundaries between the professional and private domain of the nurses are blurred. Once home after a day of domestic abuse victims, nurses have been found to remunerate mentally about their clients as well as their own involvement questioning their capabilities and actions in the process. In this process an invasion into the private life takes place and these women consequently have reported to struggle with their life domains as women, mothers and wives. Emotional confusion takes place, resulting in feelings of terror and emotional draining in extremely

violent cases, in which abused women are emotionally and physically severely battered, losing their identity as women in the process. Nurses report to empathetically identify to such a large degree with the victim that the experiences and embodiment of the patients' miserable condition is reflected into their own body, seeing themselves in the physical and emotional condition of the victim (Goldblatt, 2009).

Caregivers with a high degree of compassion satisfaction are defined by their willingness to help and feelings of confidence in their ability to contribute to others' well-being (Carmel & Friedlander, 2009) and relate well to the construct of PWB's positive relations with others. Numbness and emotional distance on the other hand, which relates to symptoms of STS, interfere with empathetic caring. To overcome emotional distance, social cohesion in terms of support of others, including maintaining a balance between personal and professional life is recommended. Another dimension of PWB plays a significant role in surpassing challenging phases is environmental mastery in terms of attaining a state of awareness in terms of realistic expectations about the environmental conditions in general. The individual's belief in his/her own ability to endure and transform pain, can assist in understanding the dynamics of trauma and maintain a hopeful and optimistic outlook (Harrison & Westwood, 2009). Personal growth (PWB) is experienced through increased sensitivity, compassion, insight, tolerance and more appreciation for life..

Posttraumatic growth is not controlled for in this thesis. However, it is used in this discussion since it is parallel in its characteristics to the PWB dimensions of experiencing personal growth, finding purpose in life, increased self-awareness and adaptive ability to the new environment. Posttraumatic growth also includes finding meaning through the traumatic experience, which in turn leads to a deeper, more mindful way of living, by attributing meaning to the event as a new structure (Tedeschi & Calhoun, 2004). Similar, EWB is characterised by a close to objective conditions forsaking pleasures based upon immediate gratification, and rather leading a life of contemplation and virtue, balancing between skills and challenges including a vast degree of self-realizing values (Waterman, 2008).

Individuals who conquer serious life challenges have a few characteristics in common, namely an increased sense of their capacity to survive and prevail, feel more comfortable with intimacy, are more compassionate and find increased value in smaller things of life (Tedeschi & Calhoun, 2004). Similar to actual trauma experiences, the self-belief of the helping professional, perceiving the external world is a safe place is scattered by the realisation that abuse and trauma can happen to anybody; thus needing constant affirmation regarding the their own intact domestic reality. Clinicians and caregivers (Herman, 1992) reported work with traumatized clients as very rewarding and their own lives being more fulfilling. They stated to be more self-conscious, more appreciative towards small things in life, more aware of their daily experiences and

experiencing frequent feelings of gratitude; in sum they experienced dimensions of emotional well-being, PWB and EWB.

It takes a conscious attempt to separate between the roles of work with trauma victims and the home environment, where some learn to focus on preserving a sense of self-control over their life domains and focusing on the positive aspects of their own domestic life including feelings of gratitude (Goldblatt, 2009). It has been found that caregivers should disengage from identifying with the victim, but not disengage in terms of empathetic caring. Harrison and Westwood (2009) state that caregivers who practice self-insight into the nature of their own emotions, are able to differentiate between their own needs and those of the client, possess conceptual ability and the ability to express empathy, experience a lower level of anxiety, are able to disengage from identifying with the client, experience greater well-being and are more effective in their professions.

2.4 CHAPTER SUMMARY

This chapter is based on literature review, and primarily introduces and interprets the theoretical background of the well-being constructs, being PWB, EWB and emotional well-being measured by SWL as well as STS and explains and debates these constructs within the parameter of existing research. Furthermore, the dark side of the caregiver profession is discussed and argued

followed by a description of challenges resulting from environmental factors of social workers as well as the phenomena of posttraumatic growth. Finally, a comprehensive discussion about the effects of STS on well-being is provided of how the individual concepts are intertwined with each other and at the same time relate to each other.

CHAPTER 3

RESEARCH METHODOLOGY

In this chapter the empirical study will be discussed. Firstly the focus will be on the objectives and consequential hypotheses formulation. This will be followed by the general research approach, secondly the characteristics of the participants, which include biographical information and the nature of work of the Namibian Social Workers. Thirdly, an explanation of the relevant measuring instruments used in this study will follow. Fourthly, the data analysis and procedure will be described.

3.1 RESEARCH OBJECTIVES

Based on the literature review the specific research objectives are as follows:

- To investigate STS and well-being as well as the relationship between these concepts from the literature;
- to determine the levels of STS, SWL, PWB and EWB in social workers in Namibia;
- to study the relationships between STS and well-being in social workers in Namibia; and

- o determine whether PWB and EWB mediate the relationship between STS and satisfaction with life of social workers in Namibia.

3.2 HYPOTHESES

Based on the objectives, the research hypotheses guided this research by investigating the levels of SWL, PWB, EWB and STS and predicting possible correlation, causal and mediating relationships in the interrelationship of the well-being constructs and STS of social workers of Namibia. Literature study served as a basis to formulate the following hypotheses:

Hypothesis 1: A significant correlational relationship exists between the well-being constructs (SWL, PWB and EWB) and STS in social workers of Namibia.

Hypothesis 2: A significant predictive relationship exists between and within the well-being constructs (SWL, PWB and EWB) and STS in social workers of Namibia.

Hypothesis 3: PWB and EWB significantly mediate the relationship between STS and SWL in social workers of Namibia.

3.3 RESEARCH APPROACH

This study is descriptive, cross-sectional and quantitative and utilised a survey to gather data regarding the emotional, psychological, and eudaimonic well-being as well as secondary traumatic stress of social workers as variables.

Descriptive designs involve investigating variables as they occur naturally. Not necessarily for investigating relationships between variables, being a weakness of the design, but rather to utilise the strength of the design in describing and understanding natural phenomena. The advantage of cross-sectional design is that it gives room to measure different groups at one point in time based on pre-existing variables. Therefore data can be collected in a short period of time. A weakness of cross-sectional designs is that it does not give an indication of one particular individual's development over time (Gravetter & Forzano, 2006).

The survey design was used to gather large amounts of information and to obtain a comprehensive description of the sample population. In the demographic section of this particular thesis a mixture of open-ended and restricted questions were used. For example "please describe the nature of traumatic experiences you are working mostly with" (leaving open space to respond), and "level of education" (giving a choice of three answers to respond to). In addition a semantic differential scale was also used, for example "How severely traumatised did you find this client" (giving a choice between 'little',

‘moderate’ or ‘severe’). The advantage of using open-ended questions was that the participants were allowed greater flexibility to answer the questions. Two disadvantages of the survey design were that some answers were difficult to compare or summarize and secondly are based upon subjective interpretation; therefore difficult to analyse. Restricted questions held the advantage of being easily summarised and analysed, provided a good opportunity for quantitative information. However, in-depth information could not be retrieved. The semantic differential scale presented a set of adjectives (little, moderate, severe) to describe their clientele’s emotional state. This provided the opportunity to position each response on an equal-sized category of interval scale that represents the observed degree of severity by the respondent. This way a variety of observations could be measured and computed to describe differences. This scale is normally easy to understand and to respond to and gives a comprehensive overview. The measuring instruments were all rating scale questions, more particularly the Likert-type rating scale. This rating scale is a sophisticated rating system with equal spacing between different choices to respond to, known as interval measurements (Gravetter & Forzano, 2006). The distance between each point, e.g. strongly disagree and disagree for example, is equivalent to one point difference, this applies for each distance between each two possible responses. A noted disadvantage is that respondents are hesitant to answer to the anchoring points or have a tendency to answer all questions the same way, called ‘response set’. A mixture of positive and negative statements and alternate phrasing of the same statement normally controls for this risk

since respondents are challenged to move back and forth between the anchoring points.

The quantitative approach was used firstly, to objectively establish a statistical data-base of well-being on social workers in Namibia and, secondly, to statistically assess the different levels of well-being and STS in this occupational field. Quantitative measures allowed for collecting large amounts of data in a relatively short period of time. It can easily be analysed and computed for the purpose of describing and assessing the current status, investigating relationships between variables as well as identifying those variables which serve as causal and mediating factors. Quantitative measures provide the opportunity to convert raw data into numerical values which are computed into sophisticated statistical analysis. This allows generalisation, protects against selective bias and subjective interpretation of the researcher. A general disadvantage of the quantitative approach is that it does not allow for detailed descriptions or identifying influential variables as an exception to the rule, and is not fit to study rare and unusual events (Gravetter & Forzano, 2006; Gravetter & Wallnau, 2007).

3.4 PARTICIPANTS

Table 3.4.1 shows the characteristics of participants in this study. A convenience sample of 116 social workers of Namibia is represented herein.

The respective response rates in terms of percentages were as follows: education = 99.1%; position in organization = 100%; years of service in social work: region of occupation = 94%; age = 94.8%; gender = 100%; marital status = 98.3%; number of dependants on one household = 100%; nationality of respondents = 98,3%, ethnicity = 99.1% and language = 96.6%.

Table 3.4.1

Characteristics of the Participants

Item	**Category**	**Frequency**	**%**
Education	Social Work Intern	34	29.3
	University degree in Social Work	73	62.9
	Post-graduate degree in Social Work	8	6.9
Position in Organisation	Intern Social Worker	34	29.3
	Fully qualified Social Worker	82	70.7
Years of service in social work	≤ 1 year	25	30.2
	1-2 years	16	13.8
	3-9 years	21	18.1
	10-19 years	20	17.2
	≥ 20 years	19	16.4
Region of occupation	Khomas	37	31.9
	Hardap	8	6.9
	Karas	10	8.6
	Erongo	5	4.3
	Omaheke	4	3.4

Characteristics of the Participants (continued)

Item	Category	Frequency	Percentage
Region of occupation continued	Otjizondjupa	9	7.8
	Oshana	10	8.6
	Kunene	3	2.6
	Oshikoto	4	3.4
	Ohangwena	3	2.6
	Okavango	4	3.4
	Caprivi	7	6.0
	Omusati	5	4.3
Age	≤24 years	24	20.7
	25-35 years	33	28.4
	36 – 45 years	30	25.9
	≥ 46 years	23	19.8
Gender	Male	16	13.8
	Female	100	86.2
Marital status	No partner	72	62.1
	Other	42	36.2
Dependants	None	34	29.7
	At least one	82	70.7
Nationality	Namibia	86	74.1
	Non-Namibian	28	24.1
Language	Afrikaans	32	27.6
	English	7	6.0
	Oshiwambo	22	19.0

Characteristics of Participants (continued)

Item	Category	Frequency	Percentage
Language continued	Herero	3	2.6
	Nama	1	0.9
	Tswana	7	6.0
	Other	30	25.9
	Damara	10	8.6

Table 3.4.2 gives an overview of the nature of work of social workers in Namibia in terms of frequency, severity and nature of events classified into two categories In terms of frequency, 8.6% social workers have not seen any traumatised clients within the past six months. Forty-four percent have seen at least one to nine trauma cases, 22.4% have seen at least ten to 29 trauma cases and 19% were confronted with over thirty trauma cases within the past six months. In summary, 44% of the Namibian social workers had at least one encounter with a traumatic case, while 41.7% had at least 10 encounters with traumatic cases in the past six months.

In terms of how long ago the last traumatic case was seen, 8.6% social workers reported that they had encountered a traumatic case the same day, 25.9% reported two to 14 days ago, 6% reported two to four weeks ago, 23.3% reported one to two months ago, 6.9% reported three to six months ago and 7.8% reported the last traumatic case seen to be over six months ago. In summary, 34.5% of Namibian social workers were confronted with traumatic

cases at least once within fourteen days and 55.2% reported to have seen at least one traumatic case within two months.

In terms of perceived severity of the last most traumatised seen, 37.9% of the social workers perceived the client to be severely traumatised, 45.7% perceived the client to be moderately traumatised and only 3.4% perceived their last traumatised client to only have been traumatised a little.

In terms of perceived severity of traumatised clients seen in general, 17.2% perceived their clients to be severely traumatised, 57.8% perceived their clients in general to be moderately traumatised and 12.1% perceived their clients to be slightly traumatised.

The nature of events has been classified into two main categories, namely physically abused clients and psychologically distressed clients, whereby one should bear in mind that physical abuse does not rule out psychological distress.

Physical abuse is defined by emotional and physical distress encountered through physical injury such as sexual abuse/rape, incest, child neglect, physical violence, domestic violence, physical assault with or without a weapon, physical and psychological self-injury induced by alcohol/substance dependency and abuse, suicide attempts and murder. A total of 12.9% of participants is dealing with physically abused children, 36.2% with physically

abused adults and 16.4% with children as well as adults who have been physically abused.

Psychological distress is defined as the state in which people find themselves when witnessing in court against someone, for instance children against their perpetrator, or in the case of orphans, adoptions, juvenile criminals, marriage/relationship/family conflict, emotional/verbal abuse, financial distress/poverty, disabilities/medical patients, HIV/AIDS patients, trauma victims experiencing extreme horror, psychiatric patients and bereavement. A total of 51.7% of social workers deals with psychologically distressed clients. Less than 1% of Namibian social workers deal with children who are only psychologically distressed and not physically abused as well. Only 1.7% of social workers deal with psychologically distressed adults and children.

The respective response rates in terms of percentages were as follows: How many trauma cases in past six months = 94%; how long ago was last trauma case seen = 78.4%; severity of trauma case last seen = 87.1%; general severity of trauma cases = 87.1%; physical abuse = 81.9% and psychological distress = 81.9%.

Table 3.4.2

Nature of Work

Item	Category	Frequency	%
How many trauma incidents in past 6 months	No longer working with clients	10	8.6
	1-9 cases	51	44.0
	10 – 29 cases	26	22.4
	≥ 30 cases	22	19.0
How long ago was last trauma case seen	Same day	10	8.6
	2 - 14 days ago	30	25.9
	2 - 4 weeks ago	7	6.0
	1 – 2 months ago	27	23.3
	3 – 6 months ago	8	6.9
	≥ 6 months ago	9	7.8
Severity of trauma case last seen	Little	4	3.4
	Moderate	53	45.7
	Severe	44	37.9
General severity of trauma cases	Little	14	12.1
	Moderate	67	57.8
	Severe	20	17.2
Physical abuse cases	Not working with physical abuse	19	16.4
	Child physical abuse	15	12.9
	Adult physical abuse	42	36.2
	Both (child & adult physical abuse)	19	16.4
Psychological distress	Not working with psych. Distress	32	27.6
	Child psych. Distress	1	0.9
	Adult psych. Distress	60	51.7
	Both (child & adult psych. distress)	2	1.7

No statistically significant changes could be confirmed, based on demographic data.

3.5 MEASURING INSTRUMENTS

Four measuring instruments were used in the current study, being the Satisfaction with Life Scale (SWLS), Psychological Well-being Scale (PWBS), Questionnaire for Eudaimonic Well-being (QEWB), Secondary Traumatic Stress Scale (STSS) and a demographic questionnaire consisting of a combination of characteristics of participants and nature of the work.

3.5.1 The Satisfaction with Life Scale (SWLS)

3.5.1.1 Rationale and description

The *Satisfaction with Life Scale* (SWLS; Diener, 1994) was used to measure the cognitive component of emotional well-being. The SWLS is a global assessment of life satisfaction at a particular time (Diener, 1994; Diener, Emmons, Larsen & Griffin, 1985). It is based on how a person assesses his/her satisfaction with life according to his/her own individual standards and not those of a researcher, excluding affect items (Diener et al., 1985).

Initially the SWLS was a 48-item scale relating to the individual's satisfaction with life. The scale was not intended to measure affect; thus all positive and negative affection items and items with loading less that 60% were omitted, resulting in 10 items being left. Due to high similarity in meaning of the questions, five more items were deleted, resulting in five-item scale measuring satisfaction with life.

The SWLS consists of five items which measure the individual's evaluation of satisfaction with life in general (e.g. "I am satisfied with my life" and "If I could live my life over, I would change almost nothing"). Respondents are asked to select one of seven options they find most applicable, ranging from "strongly disagree" to "strongly agree" for each question. Responses are then averaged to provide a total life satisfaction score. Research has established acceptable psychometric properties for the SWLS (Diener, 1994). Reliability by means of consistency is satisfactory within a population with a correlation coefficient of 0.82 and coefficient alpha of 0.87 (Diener, Emmons, Larsen & Griffin., 1985).

3.5.1.2 Administration, scoring and interpretation

Responses are averaged to provide a total life satisfaction score (Diener, 1994; Diener et al., 1985). The SWLS gives a subjective overall assessment of how the participant in general perceives his or her life as satisfactory in the domains

of school, family, friends, leisure and personal development. The scale gives a general overview of the degree of satisfaction a person may experience at a particular time in life. It is a very short scale and easy to administer. The scale is a 7-point Likert-type scale, ranging from the lowest score being 1 “strongly disagree” to 7, being “strongly agree”. Low scores indicate dissatisfaction with life, and high scores indicate satisfaction with life (Diener, 2006).

If the scale is used as an individual measure and compared to global norms of individual measure, (Diener, 2006), participants who score between 30 and 35 are highly satisfied with life. Although life is not perfect, they perceive life as good as it can get. Scores between 25 and 29 indicate that they feel their lives are mostly good in the major domains of life, e.g. work/school, family, friends, leisure and personal development. Scores between 20 and 24 are categorized as average, indicating these individuals to be generally satisfied but find the need for some life changes in order to improve towards a higher level. Scores between 15 and 19 indicate that participants are slightly below average in life satisfaction and have small but significant problems in several domains or significant problems in one of the life domains; this may be acute or chronic. Participants scoring between 10 and 14 are fundamentally dissatisfied in either all domains or have one or two domains which are in a disastrous state; this may be acute, for example after a divorce or it may be chronic, in which case counselling may be recommended as normal functioning may be hampered. Participants scoring between 5 and 9 are extremely dissatisfied with life and

may be the consequence of losing a spouse, unemployment or chronic conditions such as substance abuse. Whether the high degree of dissatisfaction is due to a traumatic incidence or a chronic state, in either case professional assistance may be recommended.

3.5.1.3 Reliability and validity

Reliability by means of internal consistency was satisfactory within a population of 167 participants, 67 of which were re-tested after one month with a correlation coefficient of 0.82 and coefficient alpha of 0.87 (Diener et al., 1985).

Validity has been confirmed with moderately strong correlations (except the Affect Intensity Measure (AIM) as this scale measured intensity of emotional experience), found between scores on SWLS and scores on selected personality measures, such as the self-esteem scale (0,54); symptom checklist similar to Hopkins Inventory (-0.41); the neuroticism scale of Eyseneck's Personality Inventory (-0.48), emotionality (-0.25), activity (0.08), sociability (0.20), and impulsivity (-0.03). Measuring instruments used for this purpose were: Self-Anchoring Ladder (SAL), D-T scale, Single Item Measure of Happiness, Semantic Differential-Like Scale, Affect Balance Scale, Well-Being subscale of the Differential Personality Questionnaire, Affect Intensity Measure (AIM), Self-esteem scale, a Symptom Checklist similar to Hopkins Inventory, the

neuroticism scale of Eysenck's Personality Inventory, Ratings of Life Satisfaction in 10 key life domains and finally the Marlowe-Crowne scale of Social Desirability (Diener et al., 1985).

A principal component analysis which was carried out for purposes of this study showed that one factor (eigenvalue = 2.48), which explained 50% of the variance, could be extracted. The item loadings were as follows (communalities are given in brackets): Item 1 = 0.57 (h^2 = 0.33); Item 2 = 0.79 (h^2 = 0.63); Item 3 = 0.74 (h^2 = 0.54); item 4 = 0.72 (h^2 = 0.51), and item 5 = 0.69 (h^2 = 0.47). The item loadings were acceptable, although the communality of item 1 did not compare well with the guideline of 0.50 (Hair, Black, Babin, & Andersen, 2010).

3.5.1.4 Motivation for inclusion

The SWLS is a short measuring instrument which gives a clear overall view of how individuals, in this case social workers of Namibia, subjectively assess his or her life to be satisfactory in the most prominent domains, being work/school, family, friends, leisure and personal development. The scale can be used as a global measure of emotional well-being by an individual of his or her life (Pavot & Diener, 1993). The SWLS has been widely used, also in studies transcending demographic barriers, such as age comparing between college students and geriatrics (Diener et al., 1985), and investigating culture and

socioeconomic factors, for example the study on well-being in the slums of Calcutta (Biswas-Diener & Diener, 2001). Discriminant validity in terms of positive and negative affect, optimism and self-esteem has been confirmed in the study of Lucas, Diener and Suh (1996). Furthermore, the SWLS has been recommended as a supplementary scale to assess psychopathology or emotional well-being (Pavot & Diener, 1993). It has been selected particularly to indicate the over-all level of well-being in social workers due to the implications secondary traumatic stress may cause in terms of well-being. Relevant to this thesis, the SWLS has been used in the study of Hope (2006) on the well-being of caregivers of primary trauma victims.

3.5.2 The Psychological Well-being Scale (PWBS)

3.54.2.1 Rationale and description

The *Psychological Well-Being Scales* (PWBS) (Ryff & Singer, 1998) was used to measure psychological well-being. Ryff's PWBS was developed to measure six theoretical constructs of psychological well-being. Those six dimensions are autonomy (independence and self-determination), environmental mastery (the ability to manage one's life), personal growth (being open to new experiences), positive relations with others (having satisfying and high quality relationships), purpose in life (the belief that life is meaningful) and self-acceptance (positive attitude towards oneself and the past life). It is a self-report scale measuring the

person's well-being at a particular time in each of these dimensions. The original instrument included 120 items, 20 for each dimension, of which the inter-correlations among factor scores for the six dimensions ranged from 0.32 to 0.76. It was later shortened to a 42- item scale, consisting of negative affect items and positive affect items in each of the six dimensions (Abbott et al., 2006). Reliability in terms of internal consistency of the PWBS is reported with a coefficient alpha for the composite score of 0.81 (Waterman et al., 2010). Validity is confirmed when the PWBS was measured against the General Health Questionnaire (GHQ-28) with a correlation coefficient of -0.45, except environmental mastery with a correlation coefficient of -0.52 (Abbott et al., 2006).

In this study three items were used to measure each dimension of psychological well-being. The dimensions are autonomy (A), environmental mastery, (E), personal growth (G), positive relations (R), purpose in life (P) and self-acceptance (S). Questions are ordered by dimensions, but negative and positive questions are randomly distributed within the dimensions As an example of positive and negative affect questions, within the dimension of autonomy, a negative affect question would be formulated as follows: "I tend to worry what other people think of me", and a positive affect question would be formulated in the following manner: "My decisions are not usually influenced by what everyone else is doing" (Abbott et al., 2006; Ryff & Singer, 1998). Participants and individuals respond to a 6-point Likert-type scale, whereupon participants

are instructed to choose between 'strongly disagree' and 'strongly agree', whichever they find most applicable to each question (Ryff & Singer, 1998).

3.5.2.2 Administration, scoring and interpretation

The PWBS measures, in particular, six most important domains influenced by the positive or negative affective state of the individual (Ryff & Singer, 2008) which indicates a state of emotional well-being, or ill-being, which in turn determines the overall functionality as well as the functionality within various dimension of life. High and low scores are identified in each dimension (one being strongly disagree and 6 being strongly agree) in which high scores would indicate positive affect while low scores indicate negative affect (Ryff & Singer, 2008)

3.5.2.3 Reliability and validity

Reliability in terms of internal consistency of the PWBS was reported in another study with a coefficient alpha for the composite score of 0.81 (Waterman, et al., 2010). In terms of dimensions, Ryff (1989) reported the internal consistency coefficient alpha to be as follows: for autonomy $\alpha = 0.86$; environmental mastery $\alpha = 0.90$; growth $\alpha = 0.87$; positive relations with others, $\alpha = 0.91$; purpose in life, $\alpha = 0.90$ and self-acceptance $\alpha = 0.93$.

Validity could be confirmed when the PWBS was measured against the General Health Questionnaire (GHQ-28) which measures severity of psychological distress, when measured one year apart, with a strong negative association with a correlation coefficient of -0.45, except environmental mastery with a correlation coefficient of -0.52 (Abbott et al., 2006).

A principal component analysis was carried out on the 42 items of the PWB which were selected for purposes of this study. The results showed that six factors, which were 65.17% of the total variance, could be extracted. A principal axis factor analysis was carried out with a direct oblimin rotation extracting six factors. The pattern matrix showed that all items loaded as expected on the six dimensions measured by the PWB.

3.5.2.4 Motivation for inclusion

The PWBS is used in this study to assess the emotional well-being and functionality of social workers in the six dimensions of well-being. It has been debated which factors may influence well-being and, amongst others, trauma disclosure and caring have been indicated to influence well-being (Ryff & Singer, 2008) either being a causal factor of partial or total impairment of functionality in one or more dimension, or to facilitate personal development in terms of personal growth and leading a meaningful life. The PWBS has been used in conjunction with the Beck Depression Inventory Second Edition, Beck

Anxiety Inventory scales and Hopkins Symptom Checklist-21 (Harari, Waehler, & Rogers, 2005) and resulted in the PWBS total score probably being useful as a screening measure for mental health and has the added advantage compared to other mental ill-health measuring instruments, in that it also focuses on positive attributes.

3.5.3 The Questionnaire for Eudaimonic Well-being (QEWB)

3.5.3.1 Rationale and description

The *Questionnaire for Eudaimonic Well-Being* (QEWB; Waterman et al., 2010) was used to measure eudaimonic well-being. The QEWB was developed in order to measure a true reflection of the philosophical understanding of eudemonia and which transcends existing studies of well-being in the measurement of quality of life.

The QEWB is based on the philosophic theories of eudaimonic well-being, and has been developed to investigate eudaimonic functioning in terms of philosophical literature, for example pursuit of excellence and self-realization, and also eudaimonic subjective experiences, for example becoming engaged in activities and creativity (Waterman et al., 2010).

The QEWB provides a basis to identify social conditions which may facilitate or jeopardize eudaimonic functioning. Furthermore, it has been assessed in conjunction with the PWBS to investigate positive and negative psychological functioning, and in comparison with SWL and PWB to measure identity, commitment and positive and negative functioning (Waterman et al., 2010).

The QEWB is a composition of six inter-related categories, being self-discovery, perceived development of one's best potentials, a sense of purpose and meaning in life, investment of significant effort in pursuit of excellence, intense involvement in activities and enjoying of activities as a personally expressive. The questionnaire consists of 21 items. Items respond to a 5-point Likert-type scale, and participants choose between 0 "strongly disagree" and 4 "strongly agree", whichever they find personally applicable to each statement. Fourteen items are written in the affirmative, and seven in the negative direction indicating high and low EWB respectively (Waterman, et al., 2010),

3.5.3.2 Administration, scoring and interpretation

Fourteen items are written in a positive wording, and seven in the negative wording, indicating high and low EWB respectively. An example for a statement in positive wording would be: "I believe I have discovered who I really am", and a negatively phrased statement would read: "Other people usually know better what would be good for me to do than I know myself". The

negative direction questions imply absence of EWB and need to be reversely scored. The scale is a 5-point Likert-type scale with 0 indicating to "strongly disagree" and 4 indicating to "strongly agree" (Waterman et al., 2010).

3.5.3.3 Reliability and validity

The QEWB has a good internal consistency with an alpha coefficient of 0.86 (Waterman et al., 2010). Reliability was tested by comparing two sample populations of 1728 and 5606 college and university students respectively, in which demographical variations regarding gender, age, ethnicity, family income and family structure were assessed with a geographic distribution across the United States of America. In both the samples the effect size did not exceed 3% of variability in terms of gender, age and ethnicity, family income and family structure.

In terms of validity, the EWBS was assessed against the following scales: The 5th scale of the Erikson Psychosocial stage Inventory (EPSI) concerned with assessing identity versus role confusion was used, and showed a strong positive correlation ranging from 0.50 to 0.69 ($p \leq 0.001$) with the QEWB (Waterman et al., 2010). Commitment making was measured with the Dimensions of Identity Development Scale (DIDS) correlated negatively with QEWB ranging from -0.41 to -0.53 ($p \leq 0.001$). In terms of well-being, the QEWB scores correlated with the Satisfaction with Life Scale (SWLS) 0.47 ($p \leq 0.001$) and

Psychological Well-being Scale (PWBS) 0.63 ($p \leq 0.001$). Correlation between personality traits and QEWB were assessed by the Arnett sensation seeking scale (ASSS), ranging from 0.01 – 0.05 ($p \leq 0.001$), and the Mini-International Personality Item Pool Five-factor Model (Mini-IPIP), agreeableness and conscientiousness with 0.28 ($p \leq 0.001$), extraversion 0.20 ($p \leq 0.001$), intellect/imagination 0.29 ($p \leq 0.001$) and neuroticism -0.20 ($p \leq 0.001$) and were significantly lower than the correlation between SWLS and PWBS and QEWB. Positive and negative psychosocial functioning in the QEWB correlated with the Rosenberg Self-Esteem Scale (RSES) ranging from 0.63 to 0.65 ($p \leq 0.001$), and internal locus of control correlated with the Locus of Control Scale (LOCS) ranging from 0.37 to .40 ($p \leq 0.001$). Correlations in symptoms of general anxiety were measured by the Beck Anxiety Inventory (BAI) ranging from -0.35 to -0.37 ($p \leq 0.001$); social anxiety symptoms were measured by the Social Interaction Anxiety Scale (SIAS) ranging from -0.47 to -0.43 ($p \leq 0.001$); and depressive symptoms were assessed by Center for Epidemiologic Studies Depression Scale (CES-D) ranging from -0.35 to -0.32 ($p \leq 0.001$).

3.5.3.4 Motivation for inclusion

The EWBS was used in this thesis to assess the eudaimonic well-being of social workers in Namibia, since past investigations indicate that positive ending in addition to closure of a difficult/traumatic life circumstance may also serve as a

precipitating factor for personal development and growth in finding meaning from the experience (Bauer, McAdams, & Pals, 2008).

3.5.4 The Secondary Traumatic Stress Scale (STSS)

3.5.4.1 Rationale and description

The Secondary Traumatic Stress Scale (STSS) was designed in order to measure the level of vicarious traumatic stress in professionals who have a professional relationship with traumatised clients, and was initially tested on a sample population of registered social workers. The scale is based on the symptoms of posttraumatic stress disorder (Bride et al., 2003).

The original scale was based on the three clusters of posttraumatic stress disorder, as stipulated in the DSM – IV (American Psychiatric Association, 1994), namely, intrusion, avoidance and arousal respectively. A 36 item Likert-type scale was initially developed, which was expanded to a 65 item Likert-type scale, and later reduced to a 50 item version for reasons after deleting items which were not clear, relevant, too long or performed poorly. This procedure was repeated and a 17 items Likert-type scale was finally developed, which was measured against related symptoms of anxiety and depression, as well as frequency of experiences with traumatised clients and degree of the experience (Bride et al., 2003).

The STS scale consists of 17 items (Bride et al., 2003) assessing frequency of intrusion, avoidance and arousal symptoms. Respondents indicate the frequency of being true to, for example, a question being "It seems I was relieving the trauma(s) experienced by my client(s)", using a 5-point Likert-type scale ranging from 1 (*never*) to 5 (*very often*). The STS scale consists of three subscales for arousal, intrusion and avoidance respectively. Items of the full scale and each subscale are scored by summing the items in each category and adding them up to obtain the full scales score.

3.5.4.2 Administration, scoring and interpretation

The STSS is based on the criteria for PTSD (Bride et al., 2003), which is related to STS; thus fundamental to the diagnostic criteria and assesses the categories of PSTD with the exception that the questions are phrased in such a manner that it is possible to distinguish between the negative effect of trauma and the response to traumatised clients. Therefore Items 2, 3, 6, 10, 12, 13, 14 and 17 were designed such that the traumatic stressors were identified as the exposure to clients, while items 1, 4, 5, 7, 8, 9, 11, 15 and 16 were characteristic of the negative effects of traumatic stress and synonymous with the DSM-IV criteria for PTSD.

3.5.4.3 Reliability and validity

Reliability was measured in a sample population of 287 licensed social workers, by measuring internal consistency with an alpha level of at least 0.80 resulting in STSS Means, standard deviations, and alpha levels for the STSS and its sub-scales were as follows: Full STSS (α = 0.93), Intrusion (α = 0.80), Avoidance (α = 0.87), and Arousal (α = 0.83) (Bride et al., 2003).

Validity was tested based on the assumption that an increase in traumatised clients would lead to an increase in STS symptoms as well as the notion that there is co-morbidity between traumatic stress and symptoms of depression and anxiety. Convergent validity was supported with respondent ratings of the *extent* to which their client population is traumatised (Mean = 3.19, *SD* = 0.87), the *frequency* with which their work with clients addresses traumatic stress (Mean = 3.49, *SD* = 0.93), and the severity of *depression symptoms* (Mean = 1.74, *SD* = 0.79) and *anxiety symptoms* (Mean = 0.88, *SD* = 0.85) experienced in the past week. Scores on the STSS were unrelated to variables of age, ethnicity and income; thus discriminant validity was confirmed (Bride et al., 2003). Convergent, discriminant and factorial validity was found against a measure for posttraumatic stress disorder in a sample of social workers (Bride et al., 2003).

Item analysis for purposes of this study showed that nine items of the STSS (SSTS2, SSTS4, SSTS6, SSTS10, SSTS11, SSTS12, SSTS13, SSTS14, SSTS15 and SSTS17) were suitable for use. A principal component analysis which was carried out on the 10 items showed that two factors (with eigenvalues of 4.47 and 1.16. respectively), which explained 56.30% of the total variance could be extracted. A principal axis factor analysis with a direct oblimin rotation was used to extract the two related factors (r = 0.59). The factors were labelled Arousal (six items) and Intrusion (four items).

3.5.4.4 Motivation for inclusion

The STSS of Bride et al. (2003) is based on the PTSD diagnostic criteria and has been developed for caregiver professionals, and has initially been used to assess the level of secondary traumatic stress in social workers due to their high involvement with primary trauma victims. Furthermore, no empirical relationship between symptoms of secondary stress and demographic variables such as age, ethnicity and income could be demonstrated. Based on the diagnostic criteria deriving from PTSD, the similarity of the sample population in which the STSS was initially used as well as the high convergent and discriminant validity makes the STSS adequate for this particular study.

3.5.5 DEMOGRAPHIC QUESTIONNAIRE

Part one of the demographic questionnaire, consisted of personal information pertaining to education, position in organisation, years of service in social work, region of occupation, region of residence, age, gender, marital status, number of dependents per household, nationality and language. The second part of the demographic questionnaire entailed questions regarding the nature of work, such as how many trauma incidents were seen in the past six months, how long ago was last trauma case seen, severity of trauma case last seen *(severe, moderate, little)*, general severity of trauma cases *(severe, moderate, little)* and number of physical and psychological abuse cases respectively seen.

3.6 PROCEDURE

As target population, registered and active social workers, including interns, of Namibia were sought but private organisations were not excluded. Two Government institutions, employing the largest number of social workers were approached. Social workers from non-governmental organisations (NGOs) were also invited to participate in this study, for example Life Line of Namibia. One of the most determinant challenges with NGO's was that the number of social workers employed varied between one and five social workers only, who were not necessarily full-time employees. Hence the largest active and registered proportion of social workers derived from two Ministries of Namibia, namely

the Ministry of Health and Social Services (MoHSS), and the Ministry of Gender Equality and Child Welfare MGECW). Both ministries have been approached to officially grant approval for this study, and approval has been obtained, see appendix 1 and 2 respectively. MoHSS requested regular progress reports, attached as appendices 1(a), 1(b) and 1(c).

At the time of commencement of the study it was recorded that the two ministries, MoHSS and MGECW, combined had 161 registered, active and intern social workers in their employ. A convenience sample (n = 114) of social workers were identified. This sampling method selected participants on the basis of availability and willingness to respond (Gravetter & Forzano, 2006).

No particular differentiation was made or indicated between the ministries or NGOs as it was not the aim of the study to compare between social workers ministries or NGOs, but rather to obtain a general overview of the Namibian situation pertaining to the individual well-being of the social workers of Namibia.

One hundred and fifty questionnaires were printed, together with an electronic lay-out for electronic distribution, and distributed. Questionnaires were sent out per post or per courier, or via telefax to the remotest regions of Namibia. The risk of losing questionnaires, or questionnaires not reaching the destination at all or questionnaires remaining unattended was too high. Therefore the rationale

was to rather have more questionnaires available than actually needed, so that availability of the measuring instruments was guaranteed. This proved extremely beneficial, especially in personal contact sessions in which the respective social workers had reported to have received a questionnaire, but not completed at the time. They were then handed a second copy of the questionnaire, occasionally upon request, which they had the option to complete. The personal pin prevented duplication. In personal contact sessions, when social workers of Namibia were handed a second questionnaire at presentations, many found value in the study and completed the questionnaires often accompanied by sincere verbal apologies and displaying real interest in the study. In total, 116 completed and usable questionnaires were returned and utilized for this study. The initial aim was to acquire a minimum of 114 participants. The number was exceeded by two questionnaires; thus all 116 questionnaires, attached and indicated as "Appendix 3", were used.

One hundred and fifty questionnaires were distributed in the following manners, of which 116 were completed and returned:

i) Telephonic contact was made with the regional directors or head social workers respectively, information of the study was given verbally, consequently questionnaires were faxed, or e-mailed, to the regions with the request to return the questionnaires once completed either via fax, e-mail, courier or by snail mail.

ii) Personal contact was made either one to one, by physically visiting the respective offices, after obtaining telephonic consent to do so, brief introductions to the research topics were given and questionnaires were handed out, and completed questionnaires were collected again within an agreed timeframe.

iii) Airtime was granted at an official function of the MHSS where the study was briefly introduced, and social workers who had not completed the questionnaire at that point in time were encouraged to do so. Once again, a time was agreed on which to collect the questionnaires.

On the organisational level, the ministries, as well as NGO's which were approached, but not specifically identified, were extremely supportive in making the data collection of this research project not only possible, but also successful. On the organisational level, the regional directors and head social workers of the ministries gave their approval and supported the data collection. Individual participants, in general, responded positively and with great interest in the research project. Consequently questionnaires were returned rather swiftly.

Inquiries were made relating to feedback on the outcome of the study. Individual social workers approached the researcher on informal occasions

during and after data collections, communicating their interest and curiosity regarding this project. No incentives were offered in return for completion of questionnaires. Instead, an approach of willingness to communicate the results was offered. After completion of this research project and having obtained relevant permission, where necessary, feedback sessions will be given by the researcher, if the interest prevails.

3.7 DATA ANALYSIS

The analysis was carried out with the PASW 18.0 programme (SPSS, 2010). Exploratory factor analyses and Cronbach alpha coefficients were used to assess the validity and reliability of the constructs measured in this study (Clark & Watson, 1995). Means, standard deviations, skewness and kurtosis describe the data. Pearson product-moment correlation coefficients were used to specify the relationship between the variables. In terms of statistical significance, the value was set at a 95% confidence interval level ($p \leq 0.05$). Effect sizes (Steyn, 1999) were used to decide on the practical significance of the findings. A cut-off point of 0.30 (medium effect, Cohen, 1988) was set for the practical significance of correlation coefficients. Canonical correlation was used to determine the relationships between sets of variables (Tabachnick & Fidell, 2007).

Furthermore, regression analyses were used in this to investigate the relationships between secondary traumatic stress, psychological well-being, and

eudaimonic well-being and satisfaction with life.

3.8 CHAPTER SUMMARY

In this chapter the empirical study was discussed, focusing on the objectives, hypotheses and the research approach as well as procedure of data collection, characteristics of the participants inclusive of demographic data pertaining to personal information and work-related information. The individual measuring instruments, namely SWLS, PWBS, QEWB and STSS have been described, the rationale of the development of the individual instruments has been mentioned and the procedure of administering, scoring and interpreting, reliability and validity of the scales and a motivation for including these scales in the research was provided. The data analysis procedures were given which will be used in this study.

CHAPTER 4

RESULTS AND DISCUSSION

In this chapter first the descriptive statistics, in which internal consistency, through the alpha coefficient, central tendency, by means of mean and standard deviation, and distribution, in terms of skewness and kurtosis, will be interpreted. SWLS scores will be compared to international norms. An analysis of correlations follows between the various constructs, being Secondary Traumatic Stress (STS), Psychological Well-Being (PWB), Eudaimonic Well-being (EWB) and Satisfaction with Life (SWL). The results of the canonical and multiple regression analyses are reported and discussed.

4.1 DESCRIPTIVE STATISTICS

In Table 4.1.1 the descriptive statistics of the STS, PWB, EWB and SWLS are reported in terms of means, standard deviations, Cronbach alpha coefficients, skewness and kurtosis, with the respective standard errors.

Table 4.1.1

Descriptive Statistics

Item		**Mean**	***SD***	**Range**	**α**	**Skewness z-scores**	**Kurtosis z-scores**
STS	Arousal	1.98	0.76	1-5	0.82	4.52**	2.26*
	Intrusion	2.10	0.79	1-5	0.74	4.57**	3.00**
PWB	Autonomy	4.55	0.94	1-6	0.59	-1.43	-1.96*
	Mastery	4.21	1.06	1-6	0.72	-3.43**	0.00
	Growth	4.94	0.94	1-6	0.63	-4.52**	2.78*
	Positive relations	4.07	1.15	1-6	0.61	-0.39	-1.93
	Purpose	4.91	0.99	1-6	0.76	-4.39**	1.76
	Self-acceptance	4.72	0.98	1-6	0.64	-4.04**	1.80
EWB		2.97	0.35	0-4	0.69	-1.50	-0.21
SWLS		4.36	1.10	1-6	0.74	0.04	-0.96

*Statistical significance of z-score ≥ 1.96 equals $p = \leq 0.05$
**Statistical significance of z-score ≥ 2.58 equals $p = \leq 0.01$

Table 4.1.1 shows that, in terms of reliability, the following scales had acceptable internal consistencies with a value above the cut-off point of 0.70: SWLS (α = 0.74), the PWBS dimensions environmental mastery (α = 0.72) and purpose in life (α = 0.76), the STSS dimensions of arousal (α = 0.82) and intrusion (α = 0.74).

In terms of central tendency the results show that social workers in Namibia experience relatively high levels of SWL and PWB compared to EWB, intrusion (STS) and arousal (STS). The highest mean scores, were found in the following items: growth (PWB) (Mean = 4.94, *SD* = 0.94), with a maximum score of 6, closely followed by purpose (PWB) (Mean = 4.91, *SD* = 0.99) with a maximum score of 6. The highest cluster of scores around the mean is found in EWB (*SD* = 0.35) and the lowest cluster of scores around the mean is found in the PWB dimension, positive relations (*SD* = 1.15).

The skewness and kurtosis values have been transformed to z-scores with a cut-off point of ≥1.96 ($p \leq 0.05$) and ≥ 2.58 ($p \leq 0.01$). Statistically significant positive skewness has been found on the PWB dimensions, mastery (-3.43, $p \leq 0.01$), growth (-4.52, $p \leq 0.01$), purpose (-4.39, $p \leq 0.01$) and self-acceptance (-4.04, $p \leq 0.01$), whilst statistically significant negative skewness has been found in the STS dimensions, arousal (4.52, $p \leq 0.01$) and intrusion (4.57, $p \leq 0.01$). Statistically significant flat kurtosis has been found in the PWB dimensions autonomy (-1.96, $p \leq 0.05$) and growth (2.78, $p \leq 0.05$). Statistically significant peaked kurtosis has been found in the STS dimensions being arousal (2.26, $p \leq 0.05$) and intrusion (3.00, $p \leq 0.01$).

Table 4.1.2

SWLS Scores Compared with International Norms (N = 112)

	Category	**Frequency**	**%**
Extremely dissatisfied	1	0	0
Dissatisfied	2	10	8.6
Slightly dissatisfied	3	27	23.3
Average	4	39	33.6
High score	5	26	22.4
Very high score	6	10	8.6

The most frequent score is score 4, comprising 33.6% of social workers in Namibia which experience average SWL. According to Diener (2006, p.1), "[t]he average of life satisfaction in economically developed nations is in this range – the majority of people are generally satisfied, but have some areas where they very much would like some improvement. Some individuals score in this range because they are mostly satisfied with most areas of their lives but see the need for some improvement in each area. Other respondents score in this range because they are satisfied with most domains of their lives, but have one or two areas where they would like to see large improvements. A person scoring in this range is normal in that they have areas of their lives that need improvement. However, an individual in this range would usually like to move to a higher level by making some life changes."

Between score 3 (slightly below average) and score 5 (high) there is an almost equal score, being 23% and 22% respectively. According to Diener (2006), people who score high are defined by the feeling that their life is mostly good, enjoyable and growth and challenge resulting from dissatisfactions might be partial reasons for satisfaction. Those people scoring slightly below average, might have experienced a recent significantly problematic event, and should improve over time, or they might have chronic significant problems, possibly ranging from too high expectations, experiencing distraction and unpleasant-ness. Some changes in life may be needed in order to improve this condition.

An equal percentage of social workers (8.6%) experience very high satisfaction with life, or are dissatisfied with life. According to Diener (2006), individuals who score very high are highly satisfied with life, love their lives and feel that this is how good life can get. Those who are dissatisfied with life may have a number of domains in life not going well. This level of SWL might be as a result of bereavement, divorce or significant work or home problems. If this is the case, improvement will occur over time. Should this be a chronic condition, it may be the result of dysfunctional attitudes, patterns of thinking and counterproductive activities. Positive change may be beneficial, possibly with professional guidance.

4.2 CORRELATIONS BETWEEN THE CONSTRUCTS

Table 4.2.1

Pearson Correlations of the Scales

	1	2	3	4	5	6	7	8	9
1. Intrusion	-	-	-	-	-	-	-	-	-
2. Arousal	0.60^{**++}	-	-	-	-	-	-	-	-
3. Autonomy	-0.15	-0.29**	-	-	-	-	-	-	-
4. Mastery	-0.27**	-0.24**	0.26*	-	-	-	-	-	-
5. Growth	0.01	-0.10	0.29**	0.24*	-	-	-	-	-
6. Positive relations	-0.13	-0.24*	0.14	0.03	0.08	-	-	-	-
7. Purpose	-0.25**	-0.49^{**+}	0.36^{**+}	0.27**	0.30^{**+}	0.23*	-	-	-
8. Self-acceptance	-0.27**	-0.40^{**+}	0.33^{**+}	0.34^{**+}	0.33^{**+}	0.24*	0.27**	-	-
9. EWB	-0.26**	-0.35^{**+}	0.36^{**+}	0.35^{**+}	0.21*	0.20*	0.57^{**++}	0.51^{**++}	-
10. SWLS	-0.28**	-0.38^{**+}	0.22*	0.49^{**+}	0.22*	0.08	0.32^{**+}	0.23**	0.36^{**+}

$^{*}p \leq 0.05$ statistically significant; $^{**}p \leq 0.01$ statistically significant

$^{+}r > 0.30$ (practically significant, medium effect) $^{++}r > 0.50$ (Practically significant, large effect)

Table 4.2.1 shows the correlations between the constructs STS, being intrusion and arousal, PWB, being autonomy, mastery, growth, positive relations, purpose and self-acceptance, EWB and SWL.

The relationships between the variables, as indicated in Table 4.2.1, have been investigated, using Pearson product-moment correlation coefficient. In terms of statistical significance, the value was set at a 95% confidence interval level ($p \leq 0.05$). However, the findings are statistically significant at the value of 99% confidence interval level ($p \leq 0.01$). A cut-off point of 0.30 (medium effect, Cohen, 1988; Steyn, 1999) was set for the practical significance of correlation coefficients.

The constructs correlated as follows:

- Arousal (STS) is statistically and practically significantly negatively related to the following dimensions of PWB: purpose (r = -0.49, medium effect) and self-acceptance (r = -0.40, medium effect), as well as to EWB (r = -0.35, medium effect) and SWLS (r = -0.38, medium effect).

- SWLS is statistically and practically significantly positively related to the PWB dimensions mastery (r = 0.49, medium effect), and purpose (r = 0.32, medium effect) as well as to EWB (r = 0.36, medium effect).

- EWB is statistically and practically significantly positively related to the PWB dimensions autonomy (r = 0.36, medium effect); mastery (r = 0.35, medium effect), purpose (r = 0.57, large effect) and self-acceptance (r = 0.51, large effect).

In the first hypothesis, significant relationships between the well-being constructs (SWB, PWB and EWB) and STS were predicted. As shown in Table 4.2.1, arousal was inversely related to the PWB dimensions purpose (r = -0.49, medium effect); and self-acceptance (r = -0.40, medium effect), as well as to EWB (r = -0.35, medium effect) and SWLS (r = -0.38, medium effect); SWL correlated positively with the PWB dimensions mastery (r = 0.49, medium effect), purpose (r = 0.32, medium effect) as well as with EWB (r = 0.36, medium effect). EWB correlated positively with the PWB dimensions autonomy (r = 0.36, medium effect); mastery (r = 0.35, medium effect), purpose (r = 0.57, large effect) and self-acceptance (r = 0.51, large effect). Hence the hypothesis was accepted in that it was confirmed when Namibian social workers experience higher levels of STS (arousal) they experienced lower levels of PWB (purpose and self-acceptance), EWB and SWL. If they experienced higher levels of SWL, they would also experience increased levels of PWB (mastery and purpose) and EWB. Furthermore, if they experienced increased levels of EWB, they would also experience increases in the PWB dimensions, autonomy, mastery, purpose and self-acceptance. The first hypothesis was accepted.

4.3 CANONICAL CORRELATION

Canonical correlation was performed between PWB and SWL on the one hand and STS on the other. Shown in Tables 4.3.1 and 4.3.2, are correlations between the variables and canonical variates, standardized canonical variate coefficients, within-set variance accounted for by the canonical variates (percent of variance), redundancies and canonical correlations. Only canonical correlations higher than 0.30 are interpreted here (Tabachnick & Fidell, 2007). The percent of variance is a measure of how well a given canonical variable represents the original variance in that set of original variables. The redundancy measures the percent of the variance of the original variables of one set that is predicted from a canonical variable from the other set. High redundancy means high ability to predict. In particular, the researcher is apt to be interested in how well the independent canonical variate predicts values of the original dependent variables.

The first canonical correlation in table 4.3.1 was 0.60 (36% overlapping variance). The other canonical correlation was 0.20. With both canonical correlations included $F(14, 178) = 3.55$, $p < 0{,}0001$, the second F-test [$F(6, 90) = 0.61$, $p < 0.0001$] was not statistically significant.

With a cut-off correlation of 0.30, the variables in the well-being set that correlated with the first canonical variate were purpose (-0.83), self-acceptance (-0.75), mastery (-0.57), autonomy (-0.46), positive relations (-0.36), and satisfaction with life (-0.62). Among

the secondary traumatic stress set, intrusion (0.64) correlated with the first canonical variate.

Table 4.3.1

Canonical Correlation PWB, SWL and STS

	Correlation	**Coefficient**
Well-being		
Autonomy	**-0.46**	-0.17
Mastery	**-0.57**	-0.24
Growth	-0.19	0.10
Positive relations	**-0.36**	-0.14
Purpose	**-0.83**	-0.45
Self-acceptance	**-0.75**	-0.27
SWLS	**-0.62**	-0.29
Percent of variance	0.33	-
Redundancy	0.12	-
STS		
Intrusion	**0.64**	0.08
Arousal	0.10	0.95
Percent of variance	0.26	-
Redundancy	0.71	-
Canonical correlation	0.60	

The first canonical correlation in table 4.3.2 was 0.46 (22% overlapping variance). The other canonical correlation was 0.10. With both canonical correlations included $F(4,$

182) = 6.12, $p < 0{,}0001$, the second F-test [$F(1, 92) = 0.86$, $p < 0.0001$] was not statistically significant. Only canonical correlations higher than 0.30 are interpreted here (Tabachnick & Fidel, 2007). With a cut-off correlation of 0.30, the variables in the well-being set that were correlated with the first canonical variate were EWB (0.86) and SWL (0.74). Among the STS set, intrusion (-0.66) and arousal (-0.99) correlated with the first canonical variate. Therefore, in further support of the first hypothesis, social workers who measured high levels of well-being in terms of EWB and SWL showed significantly lower levels of intrusion (a dimension of STS).

Table 4.3.2

Canonical Correlation: EWB, SWL and STS

	Correlation	**Coefficient**
Well-being		
EWB	**0.86**	0.70
SWL	**0.74**	0.54
Percent of variance	0.65	-
Redundancy	0.14	-
STS		
Intrusion	**-0.66**	-0.07
Arousal	**-0.99**	-0.96
Percent of variance	0.16	-
Redundancy	0.71	-
Canonical correlation	0.46	

4.4 MULTIPLE REGRESSION ANALYSES

Next, a series of multiple regression analyses were performed. Table 4.4.1 shows the results of a multiple regression analysis with SWL as the dependent variable and intrusion and arousal the independent variables.

Table 4.4.1

Multiple Regression Analysis with SWL as the Dependent Variable and Intrusion (STS) and Arousal (STS) the Independent Variables

Variable	**Unstandardised Coefficients**		**Standar-dised Coefficients**	***t***	***p***	***F***	R^2
	B	SE	B				
(Constant)	27.82	1.68		16.57		7.20**	0.13
Intrusion	-0.16	0.18	-0.11	-0.91	0.37		
Arousal	-0.40	0.18	-0.28	-2.29*	0.02*		

* $p \leq 0.05$ ** $p \leq 0.01$

The results in Table 4.4.1 indicate that two dimensions of STS, being intrusion and arousal, explain 13% of the variance in the SWLS ($F = 7.20$, $p \leq 0.01$). The regression coefficient of one dimension of the STS, namely arousal ($\beta = -0.28$, $p \leq 0.05$), was statistically significant.

Table 4.4.2 shows multiple regression analysis with STS and PWB as the independent variables and SWL the dependent variable.

Table 4.4.2

Multiple Regression Analysis with Intrusion (STS), Arousal (STS) and PWB as the Independent Variable and SWL the Dependent Variable

Variable		**Unstandardised Coefficients**		**Standardised Coefficients**	***t***	***p***	***F***	R^2
		B	SE	B				
Step 1							6.57**	0.13
	(Constant)	27.80	1.75		15.90	0.00		
	Intrusion	-0.20	0.19	-0.13	-1.07	0.29		
	Arousal	-0.37	0.18	-0.26*	-2.06	0.04*		
Step 2							4.21**	0.16
	(Constant)	10.60	5.83		1.81	0.07		
	Intrusion	-0.56	0.18	-0.04	-0.31	0.76		
	Arousal	-0.17	0.20	-0.11	-0.83	0.41		
	Autonomy	0.19	0.20	0.09	0.94	0.35		
	Environmental mastery	0.56	0.18	0.33**	3.17	0.00**		
	Growth	0.09	0.19	0.05	0.49	0.63		
	Positive relations	-0.16	0.15	-0.10	-1.04	0.30		
	Purpose	0.30	0.23	0.16	1.23	0.20		
	Self-acceptance	0.01	0.24	0.01	0.04	0.97		

* $p \leq 0.05$ ** $p \leq 0.01$

The results in Table 4.4.2 show that the two dimensions of the STS, namely arousal and intrusion, predicted 13% of the variance in SWL ($F = 6.57$, $p \leq 0.01$). The regression

coefficient of arousal (β = -0.26, $p \leq 0.05$) was statistically significant. With PWB added, dimensions resulted in a statistically significant increase of 4% ($p < 0.01$) in the prediction of the variance in SWLS (F= 4.21, $p \leq 0.01$). The regression coefficient of one dimension of PWB, namely mastery (β = 0.33, $p \leq 0.01$), was statistically significant.

A principal component factor analysis was performed on the PWB dimensions (see Table 4.4.3). The individual measures from the PWB sub-scales, being autonomy, environmental mastery, growth, positive relations, purpose and self-acceptance, have been combined to form one scale. All factors loaded on the first component, eigenvalue ≥ 1.00 (Tabachnik & Fidell, 2007). The six dimensions of PWB explained 41% of the total variance with an initial eigenvalue of 2.46. Loadings exceeding 0.71 (50% overlapping variance) are regarded as excellent, 0.55 (30% overlapping variance) are good, 0.32 (10% overlapping variance) are considered poor (Tabachnik & Fidell, 2007). In Table 4.4.3 the variables are ordered by size loading to facilitate interpretation. The highest loadings were seen in the dimension self-acceptance (0.80), closely followed by the dimension purpose (0.79). Positive relations showed the lowest loading (0.40).

Table 4.4.3

Factor Analysis of PWB Dimensions

Items	**Component 1**	***h*2**
Self-acceptance	0.80	0.65
Purpose	0.79	0.63

Factor Analysis of PWB Dimensions (continued)

Autonomy	0.62	0.39
Growth	0.57	0.33
Environmental mastery	0.55	0.31
Positive relations	0.40	0.16

Table 4.4.4 shows the results of regression analyses with intrusion, arousal and PWB as the independent variables and SWLS the dependent variable.

Table 4.4.4

Multiple Regression Analyses with Intrusion (STS), Arousal (STS) and PWB as the Independent Variables and SWL as the Dependent Variable

Variable		**Unstandardised Coefficients**		**Standar-dised Coefficients**	***t***	***p***	***F***	R^2
		B	SE	B				
Step 1							6.57**	0.13
	(Constant)	27.80	1.75		15.90	0.00		
	Intrusion	-0.20	0.19	-0.13	-1.07	0.29		
	Arousal	-0.37	0.18	-0.26*	-2.06	0.04		
Step 2							7.20**	0.20
	(Constant)	12.23	5.93		2.06	0.04		
	Intrusion	-0.19	0.18	-0.18	-1.05	0.30		
	Arousal	-0.13	0.20	-0.09	-0.64	0.53		
	Psychological well-being	0.16	0.06	0.31**	2.74	0.01		

* $p \leq 0.05$ ** $p \leq 0.01$

The results in Table 4.4.4 showed that the two dimensions of secondary traumatic stress, being arousal and intrusion, predict 13% of the variance in satisfaction with life (F = 6.57, $p \leq 0.01$). The regression coefficient of arousal is statistically significant (β = -0.26, $p \leq 0.05$). Adding PWB as independent variable (in step 2) resulted in a statistically significant increase of 7% in the prediction of the variance in satisfaction with life (F= 7.20, $p \leq 0.01$). The regression of coefficient of PWB is statistically significant ($\beta = 0.31$, $p \leq 0.01$).

Table 4.4.5 shows the results of a multiple regression with intrusion and arousal (as measured by the STS) as the independent variables and PWB (as measured by PWBS) the dependent variable.

Table 4.4.5

Multiple Regression Analysis with Intrusion (STS) and Arousal (STS) as the Independent Variables and PWB the Dependent Variable

	Unstandardised Coefficients		**Standar-dised Coefficients**	***t***	***p***	***F***	R^2
	B	SE	B				
						21.41**	0.32
(Constant)	90.86	3.06		32.28	0.00		
Intrusion	-0.11	0.32	-0.04	-0.34	0.74		
Arousal	-1.52	0.30	-0.54**	-5.03	0.00		

* $p \leq 0.05$ ** $p \leq 0.01$

The results in Table 4.4.5 show that arousal and intrusion predict 32% of the variance in psychological well-being ($F = 21.41$, $p \leq 0.01$). The regression coefficient of arousal is statistically significant ($\beta = -0.54$, $p \leq 0.01$).

Table 4.4.6 shows the results of a multiple regression analysis with PWB as the independent variable and SWL the dependent variable.

Table 4.4.6

Multiple Regression Analysis with PWB as the Independent and SWL the Dependent Variable

Variable	**Unstandardised Coefficients**		**Standar-dised Coefficients**	***t***	***p***	***F***	R^2
	B	SE	B				
						26.31**	0.21
(Constant)	3.53	3.59		0.98	0.33		
Psychological well-being	0.22	0.04	0.46**	5.13	0.00		

* $p \leq 0.05$ ** $p \leq 0.01$

The results in Table 4.4.6 show that psychological well-being predicts 21% of the variance in satisfaction with life ($F = 26.31$, $p \leq 0.01$). The regression coefficient of psychological well-being is statistically significant ($\beta = 0.46$, $p \leq 0.01$).

Table 4.4.7 shows the results of multiple regression analyses with intrusion and arousal (as measured by the STS) and the PWB dimensions autonomy, mastery, growth,

positive relations, purpose and self-acceptance as the independent variables and SWLS the dependent variable.

Table 4.4.7

Multiple Regression Analyses with STS and PWB as the Independent Variables and SWL the Dependent Variable

		Unstandardised Coefficients		Standardized Coefficients	*t*	*p*	*F*	R^2
		B	**SE**	**Beta**				
1							5.20**	0.10
	(Constant)	24.53	3.52		6.97	0.00		
	Intrusion	-0.16	0.18	-0.11	-0.90	0.37		
	Arousal	-0.36	0.18	-0.25*	-1.97	0.05		
	Autonomy	0.21	0.19	0.11	1.08	0.29		
2							10.41**	0.12
	(Constant)	17.58	3.11		5.66	0.00		
	Intrusion	-0.04	0.17	-0.03	-0.22	0.83		
	Arousal	-0.32	0.17	-0.22	-1.90	0.06		
	Environmental mastery	0.63	0.18	0.37**	3.84	0.00		
3							5.63**	0.02
	(Constant)	23.67	3.41		6.93	0.00		
	Intrusion	-0.21	0.18	-0.14	-1.14	0.26		
	Arousal	-0.37	0.18	-0.25*	-2.04	0.05		
	Growth	0.28	0.19	0.14	1.48	0.14		
4							4.58**	0.06
	(Constant)	29.45	2.77		10.63	0.00		
	Intrusion	-0.14	0.18	-0.10	-0.81	0.42		
	Arousal	-0.43	0.19	-0.30*	-2.32	0.02		
	Positive relations	0.12	0.16	0.08	0.79	0.43		

Table 4.4.7 (continued)

		Unstandardised Coefficients		Standardized Coefficients	*t*	*p*	*F*	R^2
		B	SE	Beta				
5							6.14**	0.03
	(Constant)	20.73	4.01		5.17	0.00		
	Intrusion	-0.17	0.18	-0.12	-1.00	0.32		
	Arousal	-0.25	0.19	-0.17	-1.28	0.20		
	Purpose	0.38	0.20	0.21	1.93	0.06		
6							5.09**	0.09
	(Constant)	24.33	4.03		6.03	0.00		
	Intrusion	-0.19	0.18	-0.13	-1.03	0.30		
	Arousal	-0.32	0.19	-0.22	-1.63	0.11		
	Self-acceptance	0.20	0.21	0.10	0.97	0.34		

$^{*}p \leq 0.05$ $^{**}p \leq 0.01$

The results in Table 4.4.7 show that the only statistically significant PWB dimension predicting SWL when STS (arousal and intrusion) was controlled for, was environmental mastery ($\beta = 0.37$, $p \leq 0.01$).

Table 4.4.8

Multiple Regression Analysis with STS and EWB as the Independent Variables and SWL the Dependent Variable

		Unstandardised Coefficients		**Standar-dised Coefficients**	***T***	***p***	***F***	R^2
		B	SE	B				
Step1							6.47**	0.12
	(Constant)	27.78	1.79		15.20	0.00		
	Intrusion	-0.16	0.19	-0.11	-0.84	0.40		

Table 4.4.8 (continued)

		Unstandardised Coefficients		Standar-dised Coefficients	*T*	*p*	*F*	R^2
	Arousal	-0.40	0.18	-0.28*	-2.20	0.03		
Step 2								
	(Constant)	17.73	5.75		3.08	0.00	5.55**	0.03
	Intrusion	-0.17	0.19	-0.11	-0.91	0.36		
	Arousal	-0.28	0.19	-0.20	-1.47	0.14		
	EWB	0.14	0.08	0.20	1.84	0.07		

* $p \leq 0.05$ ** $p \leq 0.01$

The results in Table 4.4.8 showed that arousal and intrusion (STS) predicted 12% of the variance in SWLS (F = 6.47, $p \leq 0.01$). The regression coefficients of arousal ($\beta = -0.28$, $p \leq 0.05$) was statistically significant. Adding EWB as independent variables (in step 2) resulted in a statistically significant increase of 3% in the prediction of the variance in SWLS (F= 5.55, $p \leq 0.01$). However, the regression coefficient of EWB is not statistically significant.

In the second hypothesis a significant predictive relationship between the well-being constructs and STS was postulated. As shown in Table 4.4.1 and 4.4.2, STS explained 13% of the variance in SWL, adding the PWB dimensions resulted in an increase of 4% variance in SWL, in which environmental mastery was significant. In Table 4.4.4 PWB as an independent variable resulted in a 7% increase of variance in SWL. As shown in

Table 4.4.5, STS resulted in a 23% variance in PWB and PWB predicted SWL with 21%, and the only statistically significant PWB dimensions predicting SWL when STS was controlled for were environmental mastery with 6% and purpose with 3%. Table 4.4.8 shows that EWB increased SWL levels by 3%. However, the regression coefficients were not statistically significant even though correlational analysis showed that EWB correlated statistically significantly with all constructs. Hence the second hypothesis was accepted to a large degree seeing that when social workers experienced STS this would influence the variances in experiencing SWL and PWB in which environmental mastery made a significant difference and PWB influenced SWL. Environmental mastery and purpose alone also influenced SWL. However, EWB had no significant effect on SWL, which compromised the full acceptance of this hypothesis.

4.5 MEDIATION ANALYSES

Next, the mediation effects of a) PWB on the relationship between arousal and SWL, and b) Environmental mastery between arousal and SWL were investigated using the procedure recommended by Baron and Kenny (1986). First, the relationship between the independent and dependent variables was assessed. Second, the relationship between the independent variable and mediator was assessed. Third, the relationship between the mediator and the dependent variable was computed. The relationship between the independent variable (entered in the first step of a regression analysis), mediator (entered in the second step of the regression analysis) and dependent variable was finally studied. The procedure to determine mediation effects, as explained by Preacher and

Hayes (2008), was followed to compute the bootstrap estimated indirect effects of PWB and environmental mastery on STS and SWL. Two-sided 95% bias corrected confidence intervals (5000 trials) and the statistical significance of indirect effects was computed. The significance of the indirect effects was assessed in terms of zero versus non-zero coefficients rather than in terms of statistical significance only (Preacher & Hayes, 2004).

Regarding the mediation effect of PWB on the relationship between arousal and SWL, the results in Table 4.4.1 showed that arousal and intrusion predicted 13% of the variance in SWL ($F = 6.57$, $p \leq 0.01$), and that the regression coefficient of arousal ($\beta = -0.26$, $p \leq 0.05$) was statistically significant. Table 4.4.2 showed that arousal and intrusion predicted 32% of the variance in PWB ($F = 21.41$, $p \leq 0.01$), and that the regression coefficient of arousal was statistically significant ($\beta = -0.54$, $p \leq 0.01$). Table 4.4.6 showed that psychological well-being predicted 21% of the variance in SWL ($F = 26.31$, $p \leq 0.01$). Table 4.4.4 showed that PWB statistically significantly predicted SWL ($\Delta R^2 = 7\%$) when arousal was controlled for ($F= 7.20$, $p \leq 0.01$), and that PWB was the only statistically significant predictor of SWL ($\beta = 0.31$, $p \leq 0.01$). The indirect effect of arousal on SWL through PWB was -0.26 ($p < 0.01$, SE = 0.08). The 95% confidence intervals varied from -0.50 to -0.05.

Regarding the mediation effect of environmental mastery on the relationship between arousal and SWL, the results in Table 4.4.1 showed that arousal and intrusion predicted

13% of the variance in SWL ($F = 6.57$, $p \leq 0.01$), and that the regression coefficient of arousal ($\beta = -0.26$, $p \leq 0.05$) was statistically significant. A multiple regression analysis showed that arousal predicted 9% of the variance in environmental mastery ($F = 10.60$, $p \leq 0.01$), and that the regression coefficient of arousal ($\beta = -0.30$, $p \leq 0.05$) was statistically significant. A multiple regression analysis showed that environmental mastery predicted 24% of the variance in SWL ($F = 33.84$, $p \leq 0.01$). Table 4.4.7 showed that environmental mastery statistically significantly predicted SWL ($\Delta R^2 = 12\%$) when arousal was controlled for ($F= 10.41$, $p \leq 0.01$), and that environmental mastery, of all the PWB dimensions, was the only statistically significant predictor of SWL ($\beta = 0.37$, $p \leq 0.01$). The indirect effect of arousal on SWL through environmental mastery was -0.16 ($p < 0.01$, SE = 0.06). The 95% confidence intervals varied from -0.34 to -0.05.

Table 4.5.1

Indirect Effects of STS (Arousal) on SWL via PWB and Environmental Mastery

	Estimates	**SE**	**95% CI**
PWB	-0.26	0.08	-0.50 to -0.05
Environmental mastery	-0.16	0.06	-0.34 to -0.05

Table 4.5.1 shows that 95 percent bootstrap confidence intervals (5000 trails) for all indirect effects do not include zero (Preacher & Hayes, 2004). Therefore it is concluded that STS (arousal) had an indirect effect via PWB on SWL. STS (arousal) had an indirect effect via mastery on SWL.

The third hypothesis predicted mediation in the relationship between STS and SWL through EWB, PWB and environmental mastery. Table 4.5.1 showed that arousal (STS) influences SWL through PWB and environmental mastery but not through EWB. Therefore the third hypothesis was only partially accepted in terms of PWB and environmental mastery mediating the relationship between arousal (STS) and SWL, but not EWB.

4.6 DISCUSSION

The purpose of this study was to investigate well-being, secondary traumatic stress and relationships between these constructs, in social workers of Namibia. Namibia, as a post-war society (LeBeau, 2005), faces unique social challenges (Ministry of Health and Social Services, 2009).

The work environment of social workers in Namibia seems to be psychologically taxing. More than half (55.2%) of the social workers in Namibia have seen at least one traumatized client within two months. In general, over half the social workers (57.8%) perceived their clients to be moderately traumatized while 17.2% perceive their clients as severely traumatized. Furthermore, 36.2% of Namibian social workers deal with physically abused adults and 51.7% deal with psychologically distressed clients. Taking trauma-related work environment of the Namibian social workers into consideration (Ministry of Health and Social Services, 2009), these findings agree with the

environmental challenges as set out by the Ministry of Health and Social Services (2009).

The circumstances under which Namibian social workers function and are confronted with on a daily basis include HIV/AIDS victims, orphans, domestic violence and rape. The harshness of the Namibian environment is further confirmed by the Essential Indicators of 2006-2007 which documented the country's ten most urgent needs, being financial and material assistance (23%); orphans and other vulnerable children (21%); foster care placement (11%); alcohol and drug abuse (9%), HIV/AIDS/STD/TB-related (8%); maintenance grant for single mothers (6%); marital and relationship problems (6%); juveniles in conflict with the law (6%), domestic violence (5%) and uncontrollable behaviour in children (5%) (Ministry of Health and Social Services, 2009), of which half of them are also associated symptoms of PTSD (Riggs & Foa, 2004). Apart from this, one Namibian social worker is liable at the lowest for a population of 13 856 or at the most for a population of 91 652 (Ministry of Health & Social Services, 2009).

Three psychological well-being scales were used to assess the well-being of Namibian social workers and one scale to measure the levels of secondary traumatic stress. Acceptable internal consistencies have been found for the following scales: Satisfaction with Life Scale ($\alpha = 0.74$), the psychological well-being scales, namely environmental mastery ($\alpha = 0.72$) and purpose in life ($\alpha = 0.76$), the Secondary Traumatic Stress Scale dimensions of arousal ($\alpha = 0.82$) and intrusion ($\alpha = 0.74$) and the Questionnaire for

Eudaimonic Well-being just below the cut-off point with $\alpha = 0.69$ (Gliem & Gliem, 2003).

Upon investigating the level of well-being in terms of satisfaction with life in Namibian social workers, it has been found that social workers in Namibia experience higher levels of satisfaction with life and psychological well-being than eudaimonic well-being, intrusion (secondary traumatic stress) and arousal (secondary traumatic stress). When satisfaction with life scores were compared to international norms, the most frequent score was that 33.6% of social workers in Namibia experienced an average level of life satisfaction. According to Diener (2006), to score on average is a normal rate in economically developed nations and indicates a general satisfaction in most areas of life, but leaves room for the desire to improve in some domains. Interestingly it has been found that almost equal numbers score either one score below (23%) or one score above (22%) average. According to Diener (2006), those who score below average have either experienced recent significant problems, or alternatively have chronic significant problems, possibly resulting from too high expectations or too many distractions. Those scoring above average perceive their life as mostly good, and experience joy and growth.

Correlation analyses revealed that satisfaction with life correlates positively (medium effect) with psychological well-being's dimensions purpose in life and environmental mastery, and eudaimonic well-being. Eudaimonic well-being again correlates positively with the psychological well-being dimensions autonomy, environmental mastery,

purpose in life and self-acceptance. Social workers of Namibia who experienced increased levels of satisfaction with life also experience increased levels of psychological well-being, particularly purpose in life and environmental mastery, as well as eudaimonic well-being. Those social workers who experienced higher levels of eudaimonic well-being also experienced higher levels of psychological well-being, in particular the dimensions autonomy, environmental mastery, and a very strong increase in purpose in life and self-acceptance. This also is in agreement with the findings of Hope (2006) in which the personal meaning scale (PMP) measures meaning in life and if increased, satisfaction with life also increases.

The psychological well-being dimension, personal growth does not correlate with any other well-being construct, even though the psychological well-being dimensions self-acceptance/knowledge, purpose and personal growth overlap with eudaimonic well-being (Ryff & Singer, 2008). Here one should also refer to several studies on well-being in terms of flourishing marked by increased satisfaction with life and well-being in which it has been confirmed that depleted well-being and low satisfaction with life may lead to mental ill-health (Keyes, 2007), which has been confirmed by the inverse relationships of well-being constructs and secondary traumatic stress.

In this study it has been found that the secondary traumatic stress dimension arousal does in actual fact correlate negatively with the psychological well-being dimension (purpose and self-acceptance) as well as eudaimonic well-being and satisfaction with life. Therefore Namibian social workers who experienced higher levels of secondary

traumatic stress (arousal) at the same time experienced lower levels of psychological well-being, particularly purpose in life and self-acceptance, as well as lower levels of eudaimonic well-being and satisfaction with life. These findings are also supported by Hope's (2006) study on social workers in the United States in which a negative correlation between secondary traumatic stress and satisfaction with life has been confirmed. Furthermore, Hope's study confirmed the current findings in that increase in secondary traumatic stress results in decrease of personal meaning in life, similar to the psychological well-being dimension purpose in life and eudaimonic well-being. Specifically within the field of social workers, research has revealed that the outcome of well-being or ill-being is not clearly distinguished (Bride et al., 2003; Collins, 2008; Rothmann & Malan, 2003). However, an inverse relationship between psychological well-being and perceived stress, particularly secondary traumatic stress in caregiver professions, has been confirmed (Hope, 2006; Schiffrin & Nelson, 2010).

Canonical analysis made it evident that a strong negative relationship exists between the secondary traumatic stress dimension intrusion and eudaimonic well-being, psychological well-being, except personal growth, and satisfaction with life. Hence social workers who experience high levels of intrusion, experience low levels of eudaimonic well-being, psychological well-being and satisfaction with life. The strength of the relationship between secondary traumatic stress and well-being constructs have been supported by various studies, for example the risk of empathetic engagement leading to secondary traumatic stress symptoms in the caregiver (Huggard, 2003), being so high, that some researchers recommend to emotionally detach from the client

altogether. Initially known as compassion fatigue and later termed secondary traumatisation, is marked by the symptoms of re-living the traumatic events of the clients as intrusive memory, depleting well-being in the process (Taubman-Ben-Ari & Weintroub, 2008).

The seriousness and magnitude of the relationship of secondary traumatic stress in relation to well-being is confirmed by the results of the studies of Hope (2006) and Goldblatt (2009). These studies showed that the encounter with trauma victims does indeed negatively influence the private lives of nurses working with abused women, interfering with their intimate relationships, parenthood, gender attitude and distortions of their self-perception as women. Personal growth, on the other hand (Taubman Ben-Ari & Weintroub, 2008), happens as a result of emotional suffering, producing change in the personality of the caregiver, such as increased sensitivity, greater resilience, increased awareness, insight and spirituality, to name but a few and is supported by Joseph (2009), arguing that positive psychological changes happen as a result of adversity.

The results of hierarchical multiple regression analyses showed that increased levels of arousal (a dimension of secondary traumatic stress) predicted decreased levels of satisfaction with life and psychological well-being, which is supported by Hope (2006), stating that increased levels of secondary traumatic stress do in fact negatively impact well-being, and secondary traumatic stress having been brand-marked as an occupational hazard for caregiver professionals (Bride et al., 2003) depleting well-being

to the level of psychopathology similar to posttraumatic stress disorder (Bride et al., 2003; Hope, 2006; Schiffrin & Nelson, 2010).

Increased levels of psychological well-being predicted increased levels of satisfaction with life. This is supported in that the psychological well-being scale was tested against the Life Satisfaction Index (LSI) (Ryff, 1989) measuring the individual's evaluation of the own well-being on five items, being zest versus apathy, resolution versus fortitude, congruence versus desired and achieved goals, positive self-concept and mood tone, making this prediction plausible. Furthermore, it has been established that social support, a psychological well-being dimension, predicts satisfaction with life (Diener & Ryan, 2009). Studies of the slums in Calcutta, India, confirmed that emotional well-being is a precursor for finding life meaningful (Biswas-Diener & Diener, 2001).

When secondary traumatic stress was controlled for, increased levels of environmental mastery predicted increased levels of satisfaction with life. This is supported in that environmental mastery is defined by the capacity to act and change the environment; therefore exercising healthy control over it (Ryff, 1989; Ryff & Singer, 2008) resulting in a higher degree of adaptability (Keyes, 2005). This is supported by fundamental close relationship between the constructs psychological well-being and satisfaction with life, to the degree that satisfaction with life should be assessed as a prerequisite of psychological well-being (Linley, Maltby, Wood, Osborne, & Hurling, 2009). Finally, these findings also agree with studies in various societies in which one of the psychological well-being dimensions, being relationships, serve as a predictor for

satisfaction with life (Taubman-Ben-Ari & Weintroub, 2008; Uchida, Norasakkunkit, & Kitayama, 2004).

The results of the mediation analyses showed that psychological well-being and also environmental mastery transferred the effect of arousal (secondary traumatic stress) to satisfaction with life. Therefore social workers experiencing arousal may experience decreased levels of satisfaction with life because of decreased levels of psychological well-being and environmental mastery. On the other hand, if social workers experience arousal and decreased levels of psychological well-being and environmental mastery they also experience decreased levels of satisfaction with life through psychological well-being and environmental mastery.

These results are in line with the finding of Hope (2006) in which the personal meaning profile served as predictor for the relationship between secondary traumatic stress and satisfaction with life. It is noteworthy that particularly the dimension environmental mastery influences satisfaction with life. The assumption of satisfaction with life being predicted by certain dimensions have been investigated on a global scale by Uchida et al. (2004) and it has been found that in North American cultures satisfaction with life has been predicted particularly by self-esteem, while in East Asian cultures satisfaction with life is predicted by social relationships.

4.7 CHAPTER SUMMARY

In this chapter the empirical findings were discussed and interpreted. First, the descriptive statistics were reported. These, included the assessment of the mean, standard deviation, and alpha coefficients, kurtosis and skewness. Correlation, canonical analysis and hierarchical multiple regression analyses were reported on. One hypothesis of three has been fully accepted, the second and third have been compromised due to eudaimonic well-being not having served as a predictor for satisfaction with life. Lastly, a discussion followed in which the findings were partially confirmed or supported by previous and related empirical findings.

CHAPTER 5

CONCLUSIONS, LIMITATIONS AND RECOMEMNDATIONS

In this chapter the conclusions of the research are made based on the specific objectives. Limitations of the study are discussed. Finally, recommendations are made to solve the research problem as well as for future research.

5.1 CONCLUSION

Next, the conclusions of the research are drawn, based on the research objectives.

The first objective was to investigate secondary traumatic stress, well-being and the relationship between these concepts from the literature. In summary, researchers started to break away from the disease model, as it more and more became evident that positive emotions and psychological processes are huge contributing factors to compensate in difficult life circumstances to resort to coping strategies and relying on personal strengths and so help to overcome aversive conditions (e.g. Danner, Snowden, & Friesen, 2001; Diener & Ryan, 2009; Frederickson, 2004; Ryff & Singer, 1998; Seligman, 2008). It has been found that satisfaction with life, psychological well-being and eudaimonic well-being are indeed strongly related. Satisfaction with life is based on a self-assessment of the own perception whether or not life is good (Diener, Kesebir, & Lucas, 2008). A brief debate whether satisfaction with life is a prerequisite of

psychological well-being followed. Reason being the close relationship of these constructs based on evidence that positive affect (as measured in satisfaction with life), indicates a certain degree of meaningfulness in life (as measured in psychological well-being) (Linley, Maltby, Wood, Osborne, & Hurling, 2009).

The relatedness between psychological well-being and eudaimonic well-being is probably most evident in that both stem from Aristotle's 'Nicomachean Ethics' (350 BC in Ryff, 1989) and both reflect in the life-span theories of Neugarten and the self-actualization theory of Maslow (Ryff, 1989; Ryff & Singer, 2008) with strongly overlapping dimension, being personal growth, self-knowledge/acceptance and purposeful living. The relationship between satisfaction with life and secondary traumatic stress has been investigated by Hope (2006) and an inverse relationship was found. No evidence could be traced of a relationship between psychological well-being and secondary traumatic stress, or emotional well-being and secondary traumatic stress.

The second objective was to determine the levels of secondary traumatic stress, satisfaction with life, psychological well-being and eudemonic well-being in social workers of Namibia. Descriptive statistics revealed that Namibian social workers experienced elevated levels of satisfaction with life and psychological well-being and decreased levels of eudaimonic well-being and secondary traumatic stress.

Global comparison of satisfaction with life indicated that social workers of Namibia experience an average level of well-being. The Namibian environment, apart from the

ten most prominent needs of potential social work clients, (Ministry of Health and Social Service, 2009) being related to posttraumatic stress disorder, is unique in the sense that a contributing factor to hardship on the Namibian society is that Namibia is a post-war society (LeBeau, 2005). In theory, the prognosis of LeBeau is that 15 – 20% of the ex-fighters of Namibia, who served in the armed Forces in their struggle for independence, are potential victims of posttraumatic stress disorder, depending on future critical life events. In total, 48 000 Namibian soldiers were demobilised in 1989, as a result of the end of the war. Consequently this makes family and community members in close contact with the ex-fighters vulnerable to vicarious trauma, apart from professional caregivers. The risk of being vicariously affected by empathetic engagement with trauma victims has been recognised as early as 1974, and symptoms are strongly related to symptoms of posttraumatic stress disorder (Bride, Robinson, Yegedis, & Figley, 2003; Huggard, 2003). Given that in 2011, according to the U.S. Census Bureau (2011), Namibia has an estimated population of two million people comprise, ex-soldiers comprise 2.5% of the Namibian population.

Of the total number of 585 ex-soldiers during LeBeau's study in 2005 expressed their primary needs either for money and jobs or housing, implying that their basic needs were not met at the time and it may be questionable how this impacts on family life. This serves as an additional complication for the Namibian social worker compared to social workers in other countries with no war-ridden past. Demographic data confirmed that close to 60% of the social workers of Namibia perceive their clients in general as moderately traumatized. Unfortunately it is difficult for a bystander to conceptualise the

severity of impact, even in the absence of pathology, when dealing with trauma cases on a regular basis. However, various researchers (Bride et al., 2003; Cameroen & Payne, 2011; Collins, 2008; Huggard, 2003; Keyes & Annas, 2009; Keyes et al., 2008; Naude & Rothmann, 2003; Taubman-Ben-Ari & Weintroub, 2008) acknowledge the severity and hardship caregivers undergo by dealing with trauma. In general it has been found that the training curriculum of social workers does not leave time to adequately prepare social workers for the emotional and psychological risk involved when treating vulnerable populations, especially when it comes to traumatized individuals. Another global concern (Newell & MacNeil, 2010) is that general stress-related conditions such as burnout are most predominantly researched, also in the caregiver professions. Burnout is a condition targeting any population in the service industry and is related to three domains, being emotional exhaustion, depersonalization and reduced sense of personal accomplishment, while secondary traumatic stress is based on the pathological picture of posttraumatic stress disorder and particularly addresses the risk for the caregiver resulting from empathetic engagement with primary trauma victims.

The third objective was to study the relationships between secondary traumatic stress and satisfaction with life, psychological well-being and eudaimonic well-being. It has been found that a positive relationship exists between satisfaction with life, psychological well-being (purpose and environmental mastery) and eudaimonic well-being; and between eudaimonic well-being and psychological well-being (autonomy, environmental mastery, purpose and self-acceptance). Social workers experiencing increased levels of satisfaction with life also experience higher levels of psychological

well-being and eudaimonic well-being, and when experiencing increased levels of eudaimonic well-being, they experience higher levels of psychological well-being, except personal growth. Prediction was investigated through multiple regression analysis and it was found that elevation in psychological well-being predicted elevation in satisfaction with life, especially the dimension environmental mastery predicted satisfaction with life. Various researchers confirm (Herman 1992; Manthorpe et al., 2008; Slade, 2010; Taubman-Ben-Ari & Weintroub 2008) that social workers who experience eudaimonic well-being and psychological well-being seem to be resilient, but not emotionally distant, to their clients' trauma. This enables them to cope better with other environmental challenges in the profession and in turn also uplift their clients, which again increases their own positive state, a cyclic phenomenon.

It has been found that elevated levels of secondary traumatic stress predict deflated levels of satisfaction with life and psychological well-being. An inverse relationship was found between secondary traumatic stress and the well-being constructs eudaimonic well-being and satisfaction with life, and the psychological well-being dimensions purpose and self-acceptance. A practical example of social workers losing purpose when dealing with sex-offenders (Carmel & Friedlander, 2009) is their leaving this niche at some stage due to the high levels of secondary traumatic stress. This causes a decreased capability to separate the deed from the person. As a result those caregivers are not longer able to remain consistently empathetic towards the offender (Carmel & Friedlander, 2009). However, finding meaning or purpose is strongly linked to the ability to be empathetic (Herman, 1992). Another example is the study on nurses

working with abused women, losing their identity as women; therefore sacrificing their self-acceptance (Goldblatt, 2009).

Canonical analysis showed that a strong relationship between the well-being constructs and secondary traumatic stress does indeed exist. The seriousness and magnitude of the relationship with secondary traumatic stress in relation to well-being is underpinned once more by the study of Hope (2006) as well as the study of Goldblatt (2009). In both studies it was found that the encounter with trauma victims does indeed negatively influence the private lives of caregivers. Goldblatt found that when nurses worked predominantly with abused women, this would interfere with their intimate relationships, parenthood, gender attitude and cause distortions of their self-perception as women. Another supporter is the study of Newell and MacNeil (2010) in which the urgency of investigating secondary traumatic stress in caregiver professions, particularly social workers, is made clear based on the high risk of being vicariously affected by primary trauma victims.

Contrary to expectations, no significant relationship has been found between personal growth (psychological well-being) and eudaimonic well-being, although the psychological well-being dimensions, purpose in life and self-acceptance, show a strong relationship with eudaimonic well-being. This is somewhat of a mystery, especially when taking into consideration that the three dimension altogether overlap with eudaimonic well-being (Ryff & Singer, 2008). It may be that social workers of Namibia do not experience suffering to such a degree that personal growth (Taubman Ben-Ari &

Weintroub, 2008), takes place. One should take into consideration that existentialism explains personal growth as a result of emotional suffering, only in the aftermath producing change in the personality of the caregiver, such as increased sensitivity, greater resilience, increased awareness, insight and spirituality, to name but a few. This is supported by Joseph (2009), arguing that positive psychological changes take place as a result of adversity. Possibly, the adversity social workers of Namibia are experiencing is not of such a vast degree that it produces a change in their personality; therefore they could possibly be hardier than social workers in other states.

The fourth objective was to determine a mediation effect of psychological well-being, and eudaimonic well-being on the relationship between secondary traumatic stress and satisfaction with life. It has been found that psychological well-being and environmental mastery (a dimension of psychological well-being) do indeed mediate the relationship between secondary traumatic stress and satisfaction with life. It is not surprising that psychological well-being mediates the relationship between secondary traumatic stress and satisfaction with life. It has been made evident, and widely reported, that positive emotions do indeed serve as a large contributor to all kinds of difficult, traumatic and adverse events in life (Danner, Snowden, & Friesen, 2001; Diener & Ryan, 2009; Frederickson, 2004; Ryff & Singer, 1998; Seligman, 2008). It is noteworthy that particularly the dimension environmental mastery serves as a mediator. The assumption of satisfaction with life being predicted by certain dimensions have been investigated on a global scale by Uchida, Norasakkunkit and Kitayama (2004) and it has been found that in North American cultures satisfaction with life has been predicted particularly by the

personality trait self-esteem, while in East Asian cultures satisfaction with life is predicted by the psychological well-being dimension, social relationships. Yet, this study particularly points environmental mastery out as a mediator between severely stressful events and well-being. Environmental mastery, according to the theory, is defined by manipulating and controlling a complex environment and the ability to act upon and change the environment, when desired (Ryff, 1989; Ryff & Singer, 2008). This is also in agreement with the demand-control model which postulates that if psychological demands are high and control over the situation low, environmental mastery is hampered (Taris & Kompier, 2004). Low levels of environmental mastery are linked to well-being in that the individual may bear the consequence of an individual avoiding negative outcome, feeling helpless, resulting in depression (Howel, 2009; Ryff & Singer, 1998). Environmental mastery is in jeopardy when demands are high and control is poor (Taris & Kompier, 2004).

No study could be traced in which environmental mastery in actual fact served as a mediator between secondary traumatic stress and satisfaction with life. It could be that environmental mastery plays a much more significant role than it has been assumed to play up to now. Increased stress levels in professional caregivers have resulted in misdiagnosis, delivering poor judgments and ineffective treatment planning as well as displaying abusive behaviours towards their clients, impairing the functionalities of these caregivers (Bride et al., 2003). Accumulated stress coupled with observing others, clients, to be helpless, can result in learned helplessness (Peterson, Maier & Seligman, 1993). According to Peterson, Maier, and Seligman (1993), learned helplessness leads to

low levels or even absence of environmental mastery. Learned helplessness can also wear the mask of vicarious helplessness, and similar to STS, the witnessing of another person's uncontrollability over events, has a significant impact on the social worker's own ability to master his or her environment. This was further supported in the study on nurses dealing with abused women, having difficulty mastering their environment, as a result of which the boundaries between professional and private life became blurred (Goldblatt, 2009). Mastery is also associated with perseverance (Peterson & Seligman, 2004), which is reflected in the concept of posttraumatic growth as a communality amongst survivors, who underwent traumatic life events, having the capability to prevail (Tedeschi & Calhoun, 2004). In the aftermath of trauma, traumatic growth may only occur if the individual makes a continual cognitive effort to rebuild a more resilient schema. Hence the effort, or perseverance, and cognitive engagement lead to positive changes and finally an increase in life satisfaction (Tedeschi & Calhoun, 2004). It may be questioned whether Namibian social workers are sufficiently cognitively engaged and so remain with a fundamental sense of control over their lives.

5.2 LIMITATIONS

A limitation of this study was that no previous research could be traced on well-being within the Namibian population. The sample population was too diverse in terms of language, which was one of the demographic questions, to conclude any cultural parallels. The intensity of traumatised clients was determined by the social workers' subjective assessment of their clients and it could not be established with certainty

whether the clients indeed fit the diagnostic profile of posttraumatic stress disorder. This study was limited to only one caregiver profession. Little is known of the well-being of other caregiver professionals in Namibia; therefore an adequate comparison to other professionals under similar circumstances was not possible.

The study was cross-sectional in nature, and so fundamentally a major limitation to identify causal relationships with absolute certainty. The risk of biased findings is relative and depends on whether the predictor (*X*) is more stable than the mediator (*M*) which can only be assessed with certainty through longitudinal studies (Maxwell, 2007). Furthermore, cross sectional designs are primarily influenced by mean population trends causing to overlook other influencing variables. A more analytic approach may bring deeper insight into the particular environment of Namibia in conjunction with the social work profession.

The possibility of common method variance should not be ignored. Common method variance "refers to the amount of spurious covariance shared among variables because of the common method used in collecting data" (Malhotra, Kim & Patil, 2006, p. 1866). Aspects such as social desirability, ambiguous words and length of the assessment tools may lead to unauthentic responses by the participants. In this study questionnaires ranging between five and 42 items have been used – two of them, namely psychological well-being and eudaimonic well-being, with overlapping dimensions; hence the various questions assessed sub-constructs which are very similar in nature. In addition the vast range of different languages fundamental to Namibia due to the many different cultural

groups of the participating social workers of Namibia may question the ability to understand some of the words or phrases correctly, possibly leading to erroneously falsified answers.

The small sample size of this study relates to the environmental constraints. No definite figure of how many social workers not only registered, but also actively working, could be obtained. At the time of commencement of this study, the two ministries housing the largest number of social workers together had 161 social workers in their employ. Other ministries and NGOs housed mostly an average of two to five social workers and another challenge was that these social workers were often very difficult to reach for various reasons or alternatively displayed no interest in participating in this research project, which was based on voluntary participation; therefore rejection to participate was respected without argumentation.

Small sample sizes fundamentally challenge statistical analysis in terms of limited variability in the sample population. Yet, Kareev (2005) argues, that stronger correlations are more easily seen in smaller sample sizes, and in larger sample sizes weaker correlations are more easily noted. Furthermore, Kareev points out that particularly correlations are based on effect size and do not influence the interpretation based on sample size. Although some researchers recommend a minimum sample size of 200 when doing confirmatory factor analysis and structural equation modelling, being multivariate statistical analysis investigating patterns of covariance or causality, it is

concluded that sample size does indeed make factor analysis and multivariate statistical analysis not as dire as suggested (Dochtermann & Jenkins, 2010).

The relatively low Cronbach alpha levels of the eudaimonic well-being and psychological well-being scale may be explained by various possible causes; one being a relatively small sample size used in this research, or secondly due to reverse scored items not appropriately recorded – the latter being ruled out for this research. The higher the variability within the subjects, the higher the alpha levels will be (Garson, 2011; Gravetter & Wallnau, 2007; Tabachnick & Fidell, 2007). However, Schmitt (1996) insists that a true reflection of homogeneity can only be established through additionally assessing unidimensionality and is not necessarily attributed to small sample sizes, and low alpha coefficients are not said to not be useful.

5.3 RECOMMENDATIONS

5.3.1 Recommendations to solve the research problem

When approaching social workers it was noted that the concept ‘secondary traumatic stress’ was not well-known and there seemed to be little awareness of the risks associated with intense emotional involvement with trauma victims. No confirmation could be found on special training sessions particularly focusing on the risks of secondary traumatic stress, how to identify the signs and symptoms and how to manage them. This is not a criticism towards Namibian agencies housing social workers, rather

an identification of a contemporary global need for more awareness in this particular niche. Motivated by the observation as stated earlier in this paragraph, intervention in two phases is recommended at least once, but ideally twice per year.

- First, on a cognitive level, training sessions should be held by the respective agencies, particularly focusing on well-being, by raising awareness of the risks of STS and empowering social workers to recognise the signs and symptoms and to be able to prevent or minimize the effect.

- Second, on an emotional level, training sessions should be based on the well-being constructs and mediators. Particularly tailored training courses should be included in the agency-educational training curriculum, focusing on the practice of self-care, the power of disclosure, and the transforming of traumatic experiences to traumatic growth, by acting constructively on the traumatic experiences and so regaining mastery over the environmental strains or occupational risk factors.

5.3.2 Recommendations for future research

More research focusing on other caregiver professions, and so building a data base on well-being and ill-health conditions of caregiver professionals in Namibia, may provide an opportunity for more insight into these emotionally taxing professions, and secondly,

should serve as a basis to improve circumstances, since the population eventually is the recipient and dependent on the quality of service provided by caregiver professionals.

To overcome the small sample size limitations, it may be feasible to repeat this study on social workers in the South African environment and compare those findings with the current findings. The South African environment is very similar to that of Namibia in terms of the degree of cultural variety and general social problems, and although not classified as a post-war society, many soldiers originated from South Africa and returned to South Africa, since Namibia was at the time administrated by South Africa and not an independent state. Therefore these two countries have some fundamental contextual parallels.

In order to re-confirm the mediation hypothesis, a longitudinal study is recommended, based on the risk of bias of mediation in cross-sectional designs.

In particular, when comparing the satisfaction with life with international norms, the high percentage in scores one point below and one point above average should be further investigated. Taking Namibia's demographic environment into consideration, it could be argued that those participants scoring above average experience a degree of fulfilment while those scoring below average may have too high expectations. Furthermore, the scale used is for developed countries/societies, for which Namibia does not yet classify. Therefore it may be that the score of average in actual fact is above average taking the context into consideration.

Unfortunately figures will never replace the power of words. Therefore, especially relating to the harshness of the Namibian social world, additional in-depth studies would be helpful in order to be able to grasp the emotional turmoil and to assess the strength of character of the individuals in the helping professions of Namibia.

Lastly, in-depth studies on the clientele of social workers may bring some deeper insight into the true nature of the Namibian environment, which can be used constructively by understanding the need of empathy many clients are desperate for and to identify with precision, core themes of their turmoil. This may shed light on causal relationships pertaining to the hardship they go through, whether these are once-in-a-lifetime incidents or whether they are repetitive, resulting in a pattern of living, and possibly also resulting from learned helplessness.

5.4 CHAPTER SUMMARY

In this chapter the research objectives and research findings were discussed and concluded. The limitations of the study pertaining to the cross-sectional design, small sample size and consequential shortcomings were discussed. Recommendations were made regarding how to solve the research problem, as well as regarding further research.

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Appendix 1

9 0X001

REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198	**Ministerial Building**	**Tel : (061) 203 2562**
Windhoek	**Harvey Street**	**Fax: (061) 272286**
Namibia	**Windhoek**	**Email: hnangombe@mhss.gov.na**
Enquiries: Mr. H Nangombe	**Ref:** 17/3/3	**Date:** 30th August 2010

OFFICE OF THE PERMANENT SECRETARY

Ms. M. Perstling
P. O. Box 40077
Windhoek
Namibia

Dear Ms. Perstling,

Re: The well-being of social workers in 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 approval has been granded under the following conditions

3.1 A quarterly progress report to be submitted to the Ministry's Research Unit;
3.2 Preliminary findings are to be submitted to the Ministry before the final report;
3.3 Final report to be submitted upon completion of the study;
3.4 Separate permission to be sought from the Ministry for the publication of the findings.

Wishing you success with your project.

Yours sincerely

Mr. K. Kahuure
Permanent Secretary

"Health for All"

Appendix 1 (a)

Martina Perstling

P O Box 40077

Windhoek

Tel: 061-247773 / 206 3728

Cell: 081-1293809

To: Ministry of Health and Social Sciences

The Permanent Secretary

Mr. K. Kahuure

P/Bag 13198

Windhoek

30th November 2010

Your ref: 17/3/3

Dear Mr Kahuure

Re: Progress report for "The well-being of social workers in Namibia"

Please be informed that the data collection has been finalized and I am proceeding with analyzing the data and consequently writing the research report from now onwards.

I thank you for your support and especially also thank the social workers who so kindly and willingly participated in this project. I look forward to presenting the results to you.

With kind regards

Martina Perstling

Appendix 1 (b)

Martina Perstling

P O Box 40077

Windhoek

Tel: 061-247773 / 206 3728

Cell: 081-1293809

To: Ministry of Health and Social Sciences

The Permanent Secretary

Mr. K. Kahuure

P/Bag 13198

Windhoek

10th March 2011

Your ref: 17/3/3

Dear Mr Kahuure

Re: Progress report for "The well-being of social workers in Namibia"

Please be informed that the research report and analyzing of data is currently still in progress and should soon be finalized.

I once again, thank you for your support in this study and will keep you duly informed.

Kind regards

Martina Perstling

Appendix 1 (c)

Martina Perstling

P O Box 40077

Windhoek

Tel: 061-247773 / 206 3728

Cell: 081-1293809

To: Ministry of Health and Social Sciences

The Permanent Secretary

Mr. K. Kahuure

P/Bag 13198

Windhoek 30th June 2011

Your ref: 17/3/3

Dear Mr Kahuure

Re: Progress report for "The well-being of social workers in Namibia"

Please be informed that the data analysis has been completed. Findings indicated that Namibian social workers experienced an average level of satisfaction with life, together with psychological well-being; both constructs measured higher than eudaimonic well-being and secondary traumatic stress. The results showed that secondary traumatic stress was negatively related to the emotional, psychological and eudaimonic well-being of social workers.

I once again, thank you for your support in this study.

Kind regards

Martina Perstling

Appendix 2

REPUBLIC OF NAMIBIA

MINISTRY OF GENDER EQUALITY AND CHILD WELFARE

Tel: +264 61 283 3111
Fax: +264 61 23894/240 648
Email: genderequality@mgecw.gov.na

Private Bag 13359
Windhoek
Namibia

Our Ref: .....
Your Ref: .....
Enquiries: Ms. H. Andjamba

May 14, 2010

Prof. S. Rothmann
Head: Department of Human Resources
University of Namibia
Windhoek
Namibia

Dear Prof. Rothman

RESEARCH PROJECT: WELL-BEING OF SOCIAL WORKERS IN NAMIBIA

Your letter dated 29 April 2010 on the above-mentioned subject is hereby acknowledged.

The Ministry of Gender Equality and Child Welfare is hereby granting permission to undertake the research on the above-mentioned subject as your findings will be beneficial towards the well-being of Social Workers in Namibia. You will be working closely with the National and Regional Social Workers.

Your office is therefore requested to provide methodologies of the research e.g. types of information you will need to collect and methods needed to gather desired data before we inform the Social Workers.

Yours sincerely

Sirkka Ausiku (Ms)
PERMANENT SECRETARY

All official correspondence must be addressed to the Permanent Secretary.

Appendix 3

University of Namibia
340 Mandume Ndemufayo Avenue
P/Bag 13301
Windhoek
Tel: 061-2063111
Faculty of Humanities & Social Sciences

Dear Participant

RESEARCH PROJECT

The purpose of this study is to investigate the general psychological well-being as well as the frequency and level of secondary traumatic stress of social workers in Namibia.

All information we receive is **confidential**. The participant details will remain anonymous. The researcher is willing to provide feedback to interested persons if contacted.

Your contribution to this study is extremely important and its success depends on the number of participants who complete the questionnaires. Please assist in submitting a truthful reflection of your thoughts, experiences and feelings.

Please answer all questions as honestly and accurately as it is possible to do so. Details of how to complete the questionnaires are provided. It will take approximately 45-60 minutes to complete the questionnaires.

Please return the questionnaires at the end of completion to Martina Perstling. In the event of queries or questions, feel free to ask or contact us:

- Prof Sebastiaan Rothmann: ian@ianrothmann.com
- Martina Perstling: martinap@mtcmobile.com.na – 081-129 3809

Kind regards

PROF. SEBASTIAAN ROTHMANN **Project Leader**	MRS MARTINA PERSTLING **Researcher**

YOUR UNIQUE CODE

This questionnaire contains questions about your general psychological well-being and secondary traumatic stress level. Please answer the following random questions to generate your unique 4 item code.

What is the second letter of your surname?	
What is the first letter of your father's name?	
What is the third letter of your mother's name?	
What is the first letter of your favorite animal?	

BOIOGRAPHICAL QUESTIONNAIRE

Unless requested to answer in *one word*, *sentence* or *numbers*, please indicate the correct answer with an "X" in the appropriate box, for example:

1	**Preferred Breakfast**	Fried egg & Toast	
		Yoghurt	
		Cereal	X
		None	
		Other	

Please answer the questionnaires truthfully.

1	**Your age in years**	35

2.	**Your gender**	Male	
		Female	

3.	**Marital Status**	Single	
		Divorced	
		Separated	
		Widowed	
		Other	

4.	**Number of dependants in household**	Below 18 years:	
		Above 18 years:	

5.	**Nationality**	Namibian	
		Non-Namibian	

6.	**Ethnicity**	African	
		European	
		Asian	
		Colored	
		Other	

7.	**Home Language**	Afrikaans	
		English	
		Oshiwambo	
		Herero	
		Damara	
		Nama	
		Tswana	
		Portuguese	
		German	
		Other	

8.	**Region of residence**	Khomas	
		Hardap	
		Karas	
		Erongo	
		Omaheke	
		Otjizondjupa	
		Omusati	
		Oshana	
		Kunene	
		Oshikoto	
		Ohangwena	
		Okavango	
		Caprivi	
		Outside Naimiba	

9.	**Region of occupation**	Khomas	
		Hardap	
		Karas	
		Erongo	
		Omaheke	
		Otjizondjupa	
		Omusati	
		Oshana	
		Kunene	
		Oshikoto	
		Ohangwena	
		Okavango	

		Caprivi	

10.	**Level of education**	Social Work Internship	
		University Degree in Social Work	
		Postgraduate Degree in Social Work	

11.	**Years in service with current organization**	
	Years in service in social work	
	Your current position in the organization	

12.	**Approximate number of traumatized clients within the past 6 months**	
	How long ago did you see the client you experienced most traumatized compared to others clients	

13.	**How severely traumatized did you find this client**	Little	
		Moderate	
		Severe	

14.	**Please indicate how severely traumatized you experience your clients in general**	Little	
		Moderate	
		Severe	

15.	**Please describe the nature of traumatic experiences you are working mostly with**

SECTION A

Please rate the extent to which you agree/disagree with the following statements by making an "X' in the box of the appropriate number on the 1 to 7 point scale next to the statement.

1 = Strongly disagree	*2 = Disagree*	*3 = Slightly disagree*	*4 = Neither agree nor disagree*	*5 = Slightly agree*	*6 = Agree*	*7 = Strongly agree*

	STATEMENT	SCALE						
1	**In most ways my life is close to my ideal.**	1	2	3	4	5	6	7
2	**The conditions of my life are excellent.**	1	2	3	4	5	6	7
3	**I am satisfied with my life.**	1	2	3	4	5	6	7
4	**So far I have gotten the important things I want in life.**	1	2	3	4	5	6	7
5	**If I could live my life over, I would change almost nothing.**	1	2	3	4	5	6	7

SECTION B

Please rate the extent to which you agree/disagree with the following statements by making an
"X' in the box of the appropriate number on the 1 to 6 point scale next to the statement.

1 = Strongly disagree	*2 = Disagree*	*3 = Disagree sometimes*	*4 = Agree sometimes*	*5 = Agree*	*6 = Strongly Agree*

	STATEMENT	SCALE					
1	I am not afraid to voice my opinions even when they are in opposition to the opinions of most people.	1	2	3	4	5	6
2	My decisions are not usually influenced by what everyone else is doing.	1	2	3	4	5	6
3	I tend to worry what other people think of me.	1	2	3	4	5	6
4	I have confidence in my opinions even if they are contrary to the general consensus.	1	2	3	4	5	6
5	I often change my mind about decisions if my friends and family disagree.	1	2	3	4	5	6
6	Being happy with myself is more important than having others approve of me.	1	2	3	4	5	6
7	It is difficult for me to voice my own opinions on controversial matters.	1	2	3	4	5	6
8	I do not fit very well with the people and the community around me.	1	2	3	4	5	6
9	I am quite good at managing the many responsibilities of my daily life.	1	2	3	4	5	6
10	I often feel overwhelmed by my responsibilities.	1	2	3	4	5	6
11	I generally do a good job of taking care of my personal finances and affairs.	1	2	3	4	5	6
12	I am good at juggling my time so that I can fit everything in that needs to be done.	1	2	3	4	5	6
13	I have difficulty arranging my life in a way that is satisfying to me.	1	2	3	4	5	6
14	I have been able to build a home and a lifestyle for myself that is much to my liking.	1	2	3	4	5	6
15	I am not interested in activities that will expand my horizons.	1	2	3	4	5	6
16	I don't want to try new ways of doing things – my life is fine the way it is.	1	2	3	4	5	6

17	**I think it is important to have new experiences that challenge how you think about the world.**	1	2	3	4	5	6
18	**When I think about it, I haven't really improved much as a person over the years.**	1	2	3	4	5	6
19	**I have the sense that I have developed a lot as a person over time.**	1	2	3	4	5	6
20	**I do not enjoy being in new situations that require me to change my old familiar ways of doing things.**	1	2	3	4	5	6
21	**There is a truth in the saying that you can't teach an old dog new tricks.**	1	2	3	4	5	6
22	**Most people see me as loving and affectionate.**	1	2	3	4	5	6
23	**I often feel lonely because I have few close friends with whom to share my concerns.**	1	2	3	4	5	6
24	**I enjoy personal and mutual conversations with family members or friends.**	1	2	3	4	5	6
25	**I don't have many people who want to listen when I need to talk.**	1	2	3	4	5	6
26	**It seems to me that most other people have more friends than I do.**	1	2	3	4	5	6
27	**People would describe me as a giving person, willing to share my time with others.**	1	2	3	4	5	6
28	**I know that I can trust my friends and they know that they can trust me.**	1	2	3	4	5	6
29	**I tend to focus on the present, because the future nearly always brings me problems.**	1	2	3	4	5	6
30	**My daily activities often seem trivial and unimportant to me.**	1	2	3	4	5	6
31	**I don't have a good sense of what it is I am trying to accomplish in life.**	1	2	3	4	5	6
32	**I used to set goals for myself, but that now seems a waste of time.**	1	2	3	4	5	6
33	**I am an active person in carrying out the plans I set for myself**	1	2	3	4	5	6
34	**I sometime feel I have done all there is to do in life.**	1	2	3	4	5	6
35	**I enjoy making plans for the future and working to make them a reality.**	1	2	3	4	5	6
36	**I feel that many of the people I know have got more out of life than I have.**	1	2	3	4	5	6
37	**I have made some mistakes in the past, but feel that all in all everything has worked out for the best.**	1	2	3	4	5	6
38	**In many ways, I feel disappointed about my achievements in life.**	1	2	3	4	5	6
39	**My attitude about myself is probably not as positive as most people feel about themselves.**	1	2	3	4	5	6
40	**The past had its ups and downs, but in general I wouldn't want to change it.**	1	2	3	4	5	6
41	**When I compare myself with friends and acquaintances, it makes me feel good about who I am.**	1	2	3	4	5	6
42	**In general, I feel confident and positive about myself.**	1	2	3	4	5	6

SECTION C

This questionnaire contains a series of statements that refer to how you may feel things have been going in your life. Read each statement and decide the extent to which you agree or disagree with it. Indicate your agreement with each item by placing an "X" in the box with the appropriate corresponding number next to the statement. Try to respond to each statement according to your own feelings about how things are actually going, rather than how you might wish them to be. Please use the following scale when responding to each statement.

0 = Strongly disagree	*1 = Disagree*	*2 = Neither Agree nor Disagree*	*3 = Agree*	*4 = Strongly Agree*

	STATEMENT	SCALE				
1	**I find I get intensely involved in many of the things I do each day.**	0	1	2	3	4
2	**I believe I have discovered who I really am.**	0	1	2	3	4
3	**I think it would be ideal if things came easily to me in my life.**	0	1	2	3	4
4	**My life is centered around a set of core beliefs that give meaning to my life.**	0	1	2	3	4
5	**It is more important that I really enjoy what I do than that other people are impressed by it.**	0	1	2	3	4
6	**I believe I know what my best potentials are and I try to develop them whenever possible.**	0	1	2	3	4
7	**Other people usually know better what would be good for me to do than I know myself.**	0	1	2	3	4
8	**I feel best when I'm doing something worth investing a great deal of effort in.**	0	1	2	3	4
9	**I can say that I have found my purpose in life.**	0	1	2	3	4
10	**If I did not find what I was doing rewarding for me, I do not think I could continue doing it.**	0	1	2	3	4
11	**As yet, I've not figured out what to do with my life.**	0	1	2	3	4
12	**I can't understand why some people want to work so hard on the things that they do.**	0	1	2	3	4
13	**I believe it is important to know how what I'm doing fits with purposes worth pursuing.**	0	1	2	3	4

14	**I usually know what I should do because some actions just feel right to me.**	0	1	2	3	4
15	**When I engage in activities that involve my best potentials, I have this sense of really being alive.**	0	1	2	3	4
16	**I am confused about what my talents really are.**	0	1	2	3	4
17	**I find a lot of the things I do are personally expressive for me.**	0	1	2	3	4
18	**It is important to me that I feel fulfilled by the activities that I engage in.**	0	1	2	3	4
19	**If something is really difficult, it probably isn't worth doing.**	0	1	2	3	4
20	**I find it hard to get really invested in the things that I do.**	0	1	2	3	4
21	**I believe I know what I was meant to do in life.**	0	1	2	3	4

SECTION D

The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Read each statement then indicate how frequently the statement was true for you in the past *seven (7) days* with an "X" in the box with the appropriate corresponding number next to the statement.

1 = Never	2 = Rarely	3 = Occasionally	4 = Often	5 = Very Often

	STATEMENT	SCALE				
1	I felt emotionally numb (decreased ability to feel emotions).	1	2	3	4	5
2	My heart started pounding when I thought about my work with clients.	1	2	3	4	5
3	It seemed as if I was reliving the trauma(s) experienced by my client(s).	1	2	3	4	5
4	I had trouble sleeping.	1	2	3	4	5
5	I felt discouraged about the future	1	2	3	4	5
6	Reminders of my work with clients upset me.	1	2	3	4	5
7	I had little interest in being around others.	1	2	3	4	5
8	I felt jumpy.	1	2	3	4	5
9	I was less active than usual.	1	2	3	4	5
10	I thought about my work with clients when I didn't intend to.	1	2	3	4	5
11	I had trouble concentrating.	1	2	3	4	5
12	I avoided people, places, or things that reminded me of my work with clients.	1	2	3	4	5
13	I had disturbing dreams about my work with clients.	1	2	3	4	5
14	I wanted to avoid working with some clients.	1	2	3	4	5
15	I was easily annoyed.	1	2	3	4	5
16	I expected something bad to happen.	1	2	3	4	5
17	I noticed gaps in my memory about client sessions.	1	2	3	4	5