MENTAL HEALTH WORKERS' COPING STRATEGIES IN DEALING WITH CONTINUOUS SECONDARY TRAUMA

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ABSTRACT

This study explored the coping strategies of mental health workers (MHWs) who are dealing continuously with traumatised children (younger than 18) and their families/caregivers. A convenience sample was used to recruit MHWs (female, n = 9; and male, n = 1; age range 26 to 57) at Childline Gauteng. Visual and textual data were obtained by using the Mmogo-Method®, a visual data collection method. Textual data were analysed thematically and visual data were analysed using a six-step visual method. Findings revealed that intrapersonal coping is facilitated by awareness of self, challenges and achievements, and by retrospective reflection, utilisation of resources, flexibility, positive virtues and protection of professional and personal boundaries. Relational coping is mediated by the reciprocal unconditional acceptance of and by family members and a supportive network of friends. The organisational norm of care facilitates coping through formal and informal discussions. Coping with continuous trauma requires facilitation on different levels.

Key words: continuous trauma, coping strategies, intrapersonal coping, mental health workers, Mmogo-method®, relational coping, subtle trauma

INTRODUCTION

Mental health workers (MHWs) – social workers, social auxiliary workers, trauma counsellors and lay counsellors – who provide face-to-face or telephone trauma counselling services to sexually abused children, their parents and caregivers, families and groups, are subjected unremittingly and continuously to stressors that can provoke secondary trauma (Fullerton, Ursano and Wang, 2004). According to Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (2013), a stressor may be experienced directly and personally or by witnessing another person in a traumatic situation, or indirectly by learning of an event through others or through repeated, extreme indirect exposure to it. The DSM-5 also makes provision for people who experience reactions other than fear, helplessness or horror, or who exhibit no pronounced emotional response (Jones and Cureton, 2014).

Many MHWs in South Africa are increasingly expected to deal with traumatised children. In the 2010 Crime Report compiled by the South African Police Service (SAPS), 24,417 sexual offences against children were reported during the period 2009 to 2010 (SAPS, 2010). In the following year an increase of 2.6% in sexual offences against children was reported (SAPS, 2011). Mostly MHWs deal with traumatised children and it is not uncommon for a MHW to be dealing with individual caseloads exceeding 120 at a given time (Naidoo and Kasiram, 2006). In the light of the prevailing shortage of MHWs to render services to children (Department of Social Development (DSD), 2011; Earle, 2008), this research is timely and important.

Literature review

MHWs, who respond on a daily basis to trauma survivors' sharing of disturbing images and intrusive memories, may experience Vicarious Traumatisation (VT) and burnout (Figley, 2002; Holden, 2002). VT arises from emphatic interactions during trauma counselling in the course of which MHWs experience their clients' traumatic events as their own (Figley, 2002). Burnout, a state of physical, emotional and mental exhaustion, occurs as a result of intervening in emotionally demanding situations (Mac Ritchie and Leibowitz, 2010; Collins, 2009; Figley, 2002). Burnout is also associated with emotional exhaustion, depersonalisation, and learned helplessness (Weber and Jaekel-Reinhard, 2000). Emotional exhaustion is usually the first sign of burnout, and has implications for MHWs' coping effectively, while depersonalisation and learned helplessness lead to an inability to cope with the psychological burden of trauma counselling (Mac Ritchie and Leibowitz, 2010; Peterson and Seligman, 2004; Figley, 2002).

In addition, many MHWs in South Africa have to make do with poor infrastructure and limited financial resources (Earle, 2008; Clarke-McLeod and Sela, 2005). In a resource-strapped milieu, dealing with trauma is described in terms of the conservation of resources (COR) theory (Hobfoll and Shirom, 2001). COR highlights the importance of building on resources that already form part of individuals' work experiences (Seligman and Csikszentmihalyi, 2000; Hobfoll, 1989). Protecting and improving available coping resources, for example, lead to positive reinforcement; on the other hand, perceptions of deficiency intensify stress (Hobfoll and Shirom, 2001).

Trauma and coping

Trauma is distinguished according to the type of stressor or trauma-activating events to which people are exposed (Steenkamp, Van der Walt, Schoeman-Steenkamp and Strydom, 2012). Acute trauma is associated with trauma-activating events which occur unexpectedly and are subjectively appraised as life-threatening (Heller and LaPierre, 2012; Scaer, 2005), while continuous or subtle trauma usually develops in the course of prolonged exposure to hidden and often intangible trauma-activating events (Steenkamp et al., 2012).

Coping with acute trauma-activating events is usually associated with problem-focused (or action-orientated) and emotion-focused coping strategies (Endler and Parker, 2000; Lazarus and Folkman, 1984). Problem-focused coping strategies attempt to find alternative ways to remove the self from the intense trauma-activating events or stimuli (Smith and Baum, 2003). Emotion-focused coping such as denial or ignoring problems is often used when problems become overwhelming (Folkman and Moskovitz, 2004). Trauma provokes psychological and physiological reactions and exposure to subtle trauma-activating stimuli on a continuous basis could leave MHWs with an overwhelming feeling of helplessness, eroding their coping in the long term (Steenkamp et al., 2012). What remains unclear is how MHWs cope with continuous trauma associated with their work as counsellors of traumatised clients. It is anticipated that the findings of this study will be used to reinforce the existing coping strategies employed by MHWs and inform organisational policy or to develop psycho-education programmes for expanding coping strategies.

RESEARCH DESIGN AND METHOD

An onto-epistemological (relativism-realism) stance was adopted in this study because it recognises that MHWs are actively creating their subjective coping strategies in relation to the social reality of trauma to which they are

exposed on a daily basis in their work context (Clark, MacIntyre and Cruickshank, 2007; Roos and Baart, in press; Sayer, 2000). A relativist perspective was adopted in researching subjective perspectives of MHWs individually and as a group. A realist perspective was adopted when subjective perspectives were treated as reflections of the social reality of coping with continuous/subtle trauma to produce knowledge that is transferable to other contexts. Qualitative research was applied by using a descriptive-interpretive design (Thorne, 2008; Sandelowski, 2000).

Research context and participants

The research was conducted at Childine Gauteng, an NGO in the Gauteng Province, South Africa, which employs social workers, social auxiliary workers, trauma- and lay counsellors, referred to collectively in this study as MHWs. Participants were selected from the NGO's satellite offices in Tembisa, Katorus, Soweto, Sebokeng, Orange Farm and inner-city Johannesburg (Childline Gauteng Province (GP), 2013). These MHWs intervene daily, face to face or by telephone, with children who have experienced violence and trauma, including sexual, physical and emotional abuse and neglect (Childline GP, 2013; Childline GP, 2012). Statistics compiled for Childline Gauteng from 1 April 2012 to 31 March 2013 show that lay counsellors and auxiliary social workers answered 498,432 telephone calls (Childline GP, 2013). Approximately 60% of these interactions were with girls, and 40% with boys, mostly aged between 10 and 18 years (Childline GP, 2013). Between April 2010 and February 2013, social workers and trauma counsellors conducted 12,786 face-to-face counselling sessions (Childline GP, 2013; Childline GP, 2012).

Sampling

Criteria for including MHWs as participants' in the study were their ability to speak English, intervention in at least one trauma-related case a week, and at least six months' working experience with an NGO dealing with traumatised children. A convenience sample of five social workers, two social auxiliary workers, one trauma counsellor and two telephone counsellors (female, n =9; and male, n = 1; age range 26 to 57) was recruited.

Data gathering and procedure

The management of Childline Gauteng approached the researchers and requested an exploration of the coping strategies used by their MHWs to implement strategies to support the MHWs and to prevent staff turnover.

Ethical permission to conduct the study was obtained from North-West University (ethical reference number NWU-0005-10-A1). Permission to access the research sample was also obtained from the Childline Gauteng board. The organisation's heads of department were informed about the proposed study and MHWs who met the research criteria were invited to take part. Before data gathering commenced, participants were asked to sign a consent form giving permission for their participation in the research and permitting the video- and audio-recording of data.

The Mmogo-method®, a visual data collection method which can be used to obtain the subjective perspectives of individual participants in a group setting, was applied in four phases (Roos, in press). In Phase 1, researchers created a context for optimal participation by introducing group norms of respect and care. For example, participants were assured that any information they shared would be treated with confidentiality. As a group they were requested not to divulge sensitive information outside the group. Participants were also warned that the eliciting nature of the method could trigger emotional discomfort, in which case they would be free to withdraw from the group and to seek support from a clinical psychologist made available. In Phase 2, participants were asked to sit together around a table. They were presented with malleable clay, beads in different colours and sizes, dried grass stalks and a circular piece of cloth, packed in a container. Following an open-ended prompt: "Make anything visual that will tell us about your experience of working within an environment characterised by a lot of trauma, and when you have coped at your best", participants used materials they had been given to represent their own perceptions or definition of the trauma experienced and to focus on what they regarded as their best coping strategies. On completion, their visual representations were photographed to serve as visual data. Participants took 40-45 minutes to complete their visual representations. In Phase 3, each participant explained her or his visual representation in response to the following questions by the researchers: what they had made, what the relationship between the objects was, and how this related to their coping strategies. When participants had completed the explanation of their visual representations, others added their views in a group discussion. In Phase 4, participants and researchers were debriefed. The verbal discussions of the researchers and participants were transcribed verbatim, treated as textual data and analysed with the visual data.

Data analysis

Two sets of data were analysed, namely visual and textual, thus contributing to trustworthiness.

Textual data

Data analysis was guided by the six steps noted by Clarke and Braun (2013): (1) familiarisation by transcribing and studying data, (2) coding systematically across the entire data set, (3) searching for themes, (4) generating a thematic map of coded data to be analysed, (5) defining and renaming themes to obtain a clear picture of data analysis, and last (6), producing a scholarly report on extracts that support themes.

Visual data

Visual data were analysed by applying the six-step method of analysis proposed by Roos and Redelinghuys (in press). First, the research production context is described (see research context and sample). Second, researchers assume an empathic position towards the data but do not read meanings into the visual data. They analyse visual data in combination with the textual data. Third, the observations of the visual images are described. Fourth, the symbolic meanings participants associate with the visual images are identified. Fifth, any other contexts participants introduced are indicated and related to their coping strategies. Sixth, informed by the previous steps, the transferability of knowledge is demonstrated in the discussion of findings.

Trustworthiness

Lincoln and Guba's (1985) trustworthiness criteria were applied. To ensure truthfulness of the data, participants were involved in the first stage of the analysis of the Mmogo-method® through a process of member checking (Roos, in press). The nature of the Mmogo-method® provided rich textual and visual data for a deeper understanding of the research topic (Ellingson, 2009). Researchers' bias was reduced by the use of reflexivity, introspection and reflective notes made during and after the data collection (Ellingson, 2009). A systematic analysis of the textual and visual data was carried out to crystallise the findings, thereby contributing to their trustworthiness (Ellingson, 2009).

FINDINGS

The findings are presented by using direct quotes (textual data) and photographs from representations (visual data) from the MHWs in the study, referred to as participants P1–P10. The table below presents the main themes and subthemes that emerged from the data.

Table 1: Themes and sub-themes on coping strategies

Main themes	Sub-themes
Intrapersonal coping strategies	Awareness of the self, challenges and achievements Retrospective reflection and utilisation of resources Flexibility Positive virtues Protection of professional and personal boundaries
Relational coping strategies	Reciprocal unconditional acceptance of and by family members Supportive network of friends
Organisational norm of care	

Intrapersonal coping strategies

Intrapersonal coping strategies refer to MHWs' ability to draw from their inner qualities, such as awareness of self, their challenges and achievements; retrospective reflection and utilisation of resources; flexibility; positive virtues; and protection of their professional and personal boundaries.

Awareness of the self, challenges and achievements

MHWs commented on their ability to be aware of themselves, which incorporates their challenges as well as their achievements. This is reflected in the comment: "*I think the most important thing for me is having this self-awareness. This is how I cope, having self-awareness about myself, about my challenges, about my achievements*" (P10).

Retrospective reflection and utilisation of resources

Coping involves a process that starts with retrospective reflection on the actual interventions employed during trauma counselling and by considering other options that could have been employed, before consulting other sources such as literature and peers. This is illustrated in the following comment: "*I did what I could do, and reflect on myself and maybe think of other things that I could do that could help the client and then maybe read more and then maybe talk to other people, like phone and share with them what the problem was that I had, or maybe share with a supervisor*" (P2).

Flexibility

MHWs cope when they are able to move between different perspectives. They are then able to see things from different angles, as expressed in the following statement: "*There are always different ways to see things from different angles and also make things work for me differently*" (P6).The model below illustrates the different perspectives (dark and beautiful) associated with counselling traumatised clients.

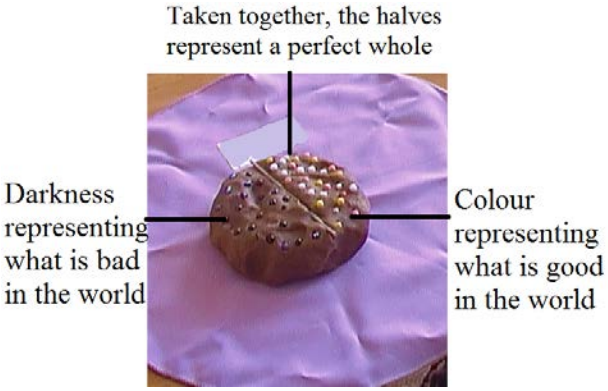

Figure 1*:* Awareness of the duality "good and bad"

Figure 1 illustrates "*a world that I've created as a way of coping with my work. These bits that are dark represent [show] that it can be difficult. It can be very dark sometimes, but there is beauty as well that I've always seen in the context of this darkness. And it is how I also see the world – that it's not perfect, it's bad, and sometimes it's good*" (P5).

Positive virtues

Positive virtues such as hope, being open to learning, being grateful and finding meaning through spirituality were linked to MHWs' positive thinking styles. Hope was expressed in the following quote: "*The internal motivation of positivity – that helps me to escape to the goodness is the hope. From this valley of darkness I'm going to learn something. I can only come from this much, much better, much, much strengthened*" (P5), and: "*I believe that out of any horrible or terrible experience there is always something to learn. What should I learn from this situation?*" (P2). This willingness to learn was linked with acquiring new knowledge: "*New knowledge to better help clients*

to better help support each other [colleagues] through supervision and to better help yourself. It keeps the environment exciting and make [sic] you kind of getting somewhere with new knowledge" (P1). MHWs were also able to learn from their work experiences: "*Badness is an inescapable part of the work at Childline. So, somehow we have to be able to learn to find meaning in it*" (P1), thus making sense of the situation.

The use of gratitude was reflected here: "*Thinking of my office...the little that I have, make use of it and use it positively. Appreciate the little that I have, because I cannot have everything*" (P5).

All participants reported they were able to deal with the challenges associated with their work through spirituality and that this also contributed to coping. Some of the quotes and Figure 2 are included as illustration: "*Spirituality applies in finding meaning in what I do. I find it helpful if I find meaning. I don't know how I would've coped if I didn't find meaning in it"* (P1).

"The fact *that I am a Christian and that I go to church, I get re-energised every time that I tap into that part of me and that also helps me cope with what I deal with on a daily basis" (P3).*

"*I believe that, for me, working at Childline is fulfilling a divine mandate*" (P7). This belief provided a sense of meaning. It is reflected graphically below in Figure 2:

Figure 2: The divine mandate

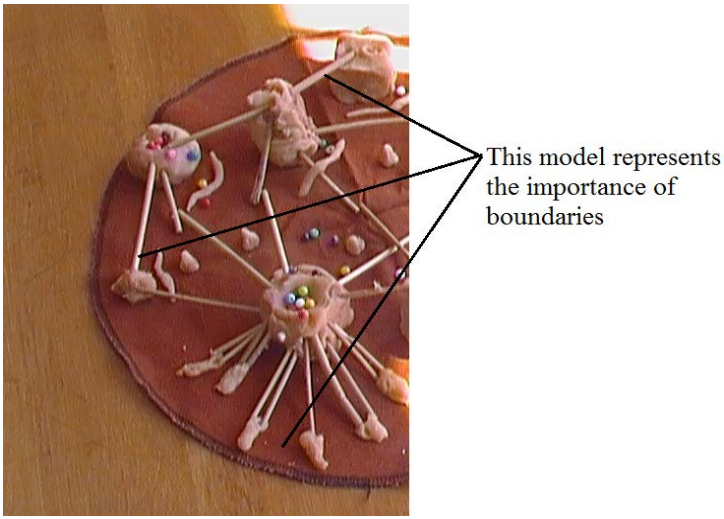

Figure 3: Boundaries between private and professional contexts

Protection of professional and personal boundaries

MHWs protected their professional boundaries by "*still [remaining] involved but not totally absorbed*" (P2) when clients shared highly emotive experiences. The protection of boundaries also applied after counselling sessions, when MHWs seek solitude: "*During lunch hour to remove myself from this environment. Maybe take a walk outside for a few minutes or to do window shopping*" (P8).

MHWs felt it was imperative to create boundaries between work and home: "*It's just like having your home and having your work and trying to have a boundary between those two areas*" (P4). One participant graphically represented these boundaries, shown above in Figure 3: "*These are boundaries. Respect each other's boundaries and personality and uniqueness. Boundaries help me to go home and not still be a Childline counsellor*" (P1).

Personal boundaries are protected when MHWs focus on themselves as the first priority and subsequently on other objects and people: "*I believe in starting with myself first and then other things and other people will come after*" (P10). "*I need to be alone and that's okay too. I'd like to teach myself that it's okay to say 'can you take my son [for a while] I need to be with myself' and it's okay*" (P5). Personal boundaries in the family context were

also reflected in creating private time. One participant said: "*I introduced a new term at home, that it's my 'me time' and now my children have adopted that. Now they say 'it's my, me time' also"* (P2).

Activities which also contribute to the preservation of personal boundaries are self-care, such as painting and reading, reflected in the following statements: "*My easel and paint are permanently set up. My painting is never packed away, so it's also ready whenever I feel like painting*" (P1), and "*The reading ritual, this is my special time"* (P1).

Relational coping strategies

Social contexts and relationships were experienced in terms of reciprocal unconditional acceptance by family members and a supportive network of colleagues and friends.

Reciprocal unconditional acceptance of and by family members

Participants described the importance of giving and receiving unconditional acceptance from their families: "*It's important for me to accept them [my family], and then in return they are able to do that for me*" (P2), and "*My family is always supporting. Being in regular contact with them has been a major supportive function*" (P1). However, MHWs noticed that because of their professional work role as counsellors they tend to assume the same role with their family. "*As counsellors we tend to always be the ones that are giving and give and give. And then find that we are wearing that hat at home with our parents as well and everybody is telling you all their problems and you never get a chance to share yours. So to tell them that you also want people to listen to you and not just having a support system that just uses you all the time*" (P4).

Supportive network of friends

MHWs used their friends as support systems: "*I also find my coping mechanism [in] friends*" (P10). These networks offered mutual encouragement, expressed in: "*I've got these networks of people that I also go to [and] who help me. Sort of direct me to say there is a positive*" (P4).

Although the participants realised the value of social support and expressed a need to expand their network, they were not very specific about the source of this support. "*I'm always looking out for extra support knowing that no one's perfect, looking out for extra support that I can draw from*" (P6), and "*I'd like to use people more as a support system*" (P5). "*Where I would like*

to improve is to draw on people as well as support systems and not only on myself, like to ask for help from other people and to ask for support from other people" (P5).

Organisational norm of care

The organisational norm of care refers to norms guiding interactions in which formal and informal care is demonstrated. The norm of care was expressed by MHWs as an open-door policy which gave them access to the support of their director and heads of departments (HOD), described as: "*A down-to-earth director, a down-to-earth team of HODs, people that you can chat with in the kitchen, in the corridors, about anything. It already constitutes something of a very good support mechanism*" (P7). "*This is a team here at Childline that if we're having a problem we talk about the problems that we're having and then they are here to support me*" (P9). Interaction with colleagues through reciprocal debriefing, after experiencing difficult cases, greatly contributed to coping. It was reflected thus: "*When I've got a hectic case, I can easily debrief [with peers], so we've got that open door policy. That really gives us quite a good support [when] you really need to work it through with somebody else*" (P3).

It seems that informal conversations in a physically nurturing space also fulfil an important support function. This was highlighted: "*It's crazy, this little kitchen, how many colleagues can fit into it*" (P1), with reference to employee interaction in the mornings. Participants said they found comfort in the thought that they shared similar experiences with colleagues and valued the camaraderie: "*We share the same experience. So for me it's helpful [to] know [that] I am not alone*" (P10), and "*experiencing friendly smiles and empathic interaction with colleagues*" (P4).

DISCUSSION

The coping strategies of MHWs exposed to continuous or subtle trauma presented on different levels: intrapersonal, relational and organisational. On the intrapersonal level coping is facilitated when people are aware of themselves – not only of the challenges they face but also their achievements. This holistic awareness enables retrospective introspection in the process of which MHWS are able to assess their counselling interventions and consider what the effect of possible alternative actions would have been. The processes involved in awareness and retrospective introspection contribute to ontological authenticity, referring to insight not previously realised (Lincoln, 2009). Awareness is a prerequisite for action (Botha, 2013). In coping with

continuous trauma, some MHWs were motivated to consult external resources, such as literature or interpersonal support, to complement their self-assessment with new insights. Another intrapersonal quality associated with coping is flexibility. This enables people to move from one perspective to another (the "darkness" and the "beauty"). Flexibility also encourages positive thinking styles (Zhang, and Sternberg, 2006; Sternberg and Zhang, 2001). Coping by drawing on hope, assuming a learner position, being grateful and by finding meaning through spirituality, are qualities that have been researched extensively and linked to psychological well-being (Linley and Joseph, 2004; Peterson and Seligman, 2004; Seligman and Csikszentmihalyi, 2000).

A coping strategy in exposure to continuous trauma-activating events that is often overlooked is the protection of boundaries. In the case of MHWs, they protected their professional boundaries during counselling and their personal boundaries afterwards. During the interaction with traumatised clients, MHWs kept a therapeutic-appropriate distance (Stiles, 2001) while remaining present – being there physically and therapeutically with the client (Baart, 2014). By using this coping strategy they were able to maintain their own psychological integrity without becoming absorbed in the impact of the trauma, while at the same time providing a healing space for their clients.

MHWs protected their personal boundaries after the impact of the trauma-activating event by physically removing themselves from the environment, by engaging in activities in which they have control, and by creating a space for solitude: actions that mitigated the effect of feeling entrapped and helpless (Mikulincer, 1994). The protection of their personal boundaries also manifested in self-care activities, such as reading, or painting. However, MHWs for the most part expressed the importance of taking time for self-care without indicating what they needed or how they would negotiate the satisfaction of their needs in other relationships.

Not surprisingly, findings of this study also confirmed literature which describes extensively the importance of social support in coping (Taylor, 2011; Heaney and Israel, 2008; Uchino, 2004; Cohen, Gottlieb and Underwoord, 2000). What was observed in the current research, however, was that MHWs often took on the role of continuous counsellor outside work as well, in their relationships with family members and friends.

On an organisational level, successful coping with continuous trauma is strongly related to resources within the supportive norm that underpins caring actions. The types of support drawn upon ranges from formal, offered by organised discussions with peers and supervisors, to informal, with people

who share the same experiences in spaces and places perceived as safe and physically nurturing. Interestingly, the value of these discussions is expressed as the sharing of similar experiences which break the isolation MHWs face when continuously being exposed to trauma. Organisations providing services to traumatised clients should note how care as the norm could support the intrapersonal and relational coping strategies of their staff. Formalised peer support, such as a buddy system, could encourage counsellors to reach out to one another and serve as added support. Finally, encouraging activities and providing amenities that provide MHWs with the opportunity to remove themselves from the organisation for short periods – such as yoga, gym or a chill room – could lead to self-care by creating opportunities for private time, which was one of the themes identified as enhancing their coping.

Even though the Mmogo-method® produces rich data, a limitation of the study includes the fact that only one method of data collection was used. It is, therefore, recommended that qualitative data collection be supported by including more than one collection method. Nevertheless, the findings offer wide application possibilities for MHWs or other health professionals dealing with traumatised clients. The findings can also be used to support the coping strategies of clients who are exposed to continuous or subtle trauma.

CONCLUSION

Coping with continuous or subtle trauma may not manifest the noticeable severity associated with acute trauma. Irrespective of the nature of the trauma, those affected apply coping strategies to deal with the impact and to restore their equilibrium. MHWs are particularly vulnerable due to the persistence of their exposure to extreme trauma; and given the composition of their clientele, traumatised children, coping with continuous trauma requires dealing with helplessness. The vulnerability of children is a reality in the face of their relationship with adult perpetrators or as a result of ineffective intersectoral collaboration between those who have to protect them or deal with the impact of the trauma. Moreover, given the increase in trauma caused to children, MHWs' coping strategies should be strengthened and psycho-education programmes developed as a matter of urgency to equip them to deal with the impact of continuous or subtle trauma. To this end, the study has contributed by indicating that coping is facilitated at intrapersonal, relational and organisational levels. Accordingly, it is recommended that interventions developed and implemented to support MHWs' coping strategies should adopt a holistic approach which includes all these levels if they are to make an effective contribution.

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