RELATIONSHIP BETWEEN VICARIOUS TRAUMA AND COPING STRATEGIES AMONG HUMANITARIAN AID WORKERS IN MAIDUGURI METROPOLIS, BORNO STATE, NIGERIA

By **SHARON JORO YABILSU**

Supervised by
Prof. Salvatore Fava Ph.D.

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DECLARATION

I do hereby attest that I am the sole author of this project/thesis and that its contents are only the result of the readings and research I have done. Permission has been obtained from persons and institutions mentioned to include their interviews and their case studies.

To the best of my knowledge and belief, it has not been presented in any previous application for state diploma or degree. All quotations are indicated, and sources of information specifically acknowledged by means of references.

YABILSU, SHARON JORO

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Thank you all and God bless you.

And to all Humanitarian Aid Workers, serving in regions of armed conflict and situations of violence, providing care on the frontlines:

Do not believe that he who seeks to comfort you

Lives untroubled among the simple and quiet words

That sometimes do you good.

His life has much difficulty and sorrow.

Were it otherwise, he never would have been

Able to find those words.

Ranier Marie Rilke

ABSTRACT

The state of mind of the Humanitarian Aid Worker serving on the frontline of the armed conflict in Maiduguri Metropolis, Nigeria is becoming threatened, hence their functioning is becoming disrupted and impaired. The recognition of vicarious trauma and available coping strategies is an essential step to self-protection and minimizing the negative effects of their exposure to second-hand trauma.

This study examined the relationship between vicarious trauma and coping strategies and comprised 288 humanitarian aid workers, 136 males and 152 females, with age range between 25 to 50 years (M = 1.8, SD =.69).

After utilizing the purposive sampling procedure to select the location and participants, a cross-sectional survey was carried out. 4 research questions and hypothesis were raised and tested at p=<0.05 level of significance.

The study, among other findings, indicates that there is a significant prevalence of vicarious trauma, with prevalent coping strategies utilized by the humanitarian aid workers in North East Nigeria being positive reframing, instrumental support, planning, humour and acceptance.

As part of the recommendations made, psychologists should engage more in interventions working with frontline help providers, especially those working in volatile situations such as armed conflict, natural disaster and situations of violence.

Keywords*: vicarious trauma, coping strategies, humanitarian aid workers, Maiduguri Nigeria.*

Word count*: 198*

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CHAPTER ONE
INTRODUCTION

1.1 Background to the Study

The concept of vicarious trauma, secondary traumatic stress and compassion fatigue is manifested by a variety of symptoms that take on a similar appearance to the symptoms in individuals who have experienced first-hand trauma.

Vicarious trauma (VT) and secondary traumatic stress are reactions to emotional demands on help providers from exposure to trauma survivors' traumatic experiences; strong, chaotic affect; and intrusive traumatic memories. These concepts are often used interchangeably, however, despite some overlap, there are some differences (see Jenkins & Baird, 2002).

Pearlman and Saakvitne (1995, as cited in Jenkins & Baird, 2002, p. 424) defined Vicarious Trauma as the permanent "transformation in the inner experience of the therapist that comes about because of empathic engagement with clients' traumatic material." The major symptoms of Vicarious Trauma are disturbances in helpers' cognitive frame of reference. Verbal exposure to traumatic material theoretically changes cognitive schemas, regarding both self and others in the areas of trust, safety, control, esteem, and intimacy. Intrusive imagery and other PTSD symptoms also appear as disruptions to helpers' imagery system and emotions associated with the client's traumatic memories. These effects may be profound and long-lasting (McCann & Pearlman, 1990a, as cited in Jenkins & Baird, 2002, p. 424).

Vicarious trauma occurs with humanitarian workers' enduring exposure to very traumatic events of survivors. The workers are affected both by listening to trauma stories and witnessing the direct impact of those experiences on the lives of the clients. Pearlman and Mclan (1995) use the terms cumulative, permanent and pervasive to refer to the nature of vicarious trauma. Groups cited as most potentially vulnerable to vicarious trauma are therapists, counselors, crisis workers, police officers, disaster relief workers, nurses, clergy, doctors, child protection workers and paramedics (Pearlman, 2008)

Since the year 2009, the North Eastern region of Nigeria has been under intense attack of insurgency crisis, arguably the most dynamic and enduring violent crisis in the whole of Africa, leaving hundreds of thousand people dead, socio-economic activities paralyzed and recorded the highest number of Internally Displaced Persons within a decade in the Country (UNOCHA, 2017). Humanitarian response in emergency has hugely begun in this area to dampen the destructive effect on the survivors. However, the humanitarian workers are saddled with the responsibilities of always listening to survivors' stories, conducting assessments (and interview in the case of Mental Health and Psycho-Social Support Intervention), drawing intervention plans and eventually proceeding with the intervention proper. These underlying activities could cause serious emotional tension to a humanitarian worker.

Steed and Downing (1998) provide a comprehensive outline of signs and symptoms of vicarious trauma as well as identifying several workplace and personal conditions that may contribute to this phenomenon. These symptoms may take the form of any or all of nightmares, intrusive imagery, feelings of helplessness and hopelessness, changes in sense

of personal identity and world view, difficulty connecting to the joy and meaning in life, increased cynicism, hyper vigilance, social withdrawal, easily emotionally overwhelmed, numbing of usual feelings towards people and events (Stamm, 1997).

These symptoms may manifest themselves gradually in the life of the humanitarian workers and become increasingly pervasive over time. Helpers may not experience all of these symptoms and if they do, might experience them in differing degrees depending on their own professional and personal circumstances.

Many of these symptoms are a result of the physiological changes that the human body undergoes when it is subjected to trauma stressors. While Pearlman and Saakvitne (1995) indicate that symptoms attributable to post traumatic stress disorder (PTSD) and vicarious traumatization such as disturbed sleep patterns, hyper anxiety, alterations in belief schemas, etc. overlap, they specifically isolate certain symptoms of intrusive imagery and disrupted dream states as specific to Vicarious Trauma. These are instances where the images are specific to the trauma experiences reported to the humanitarian aid workers by clients rather than connected to the help providers' own experiences. An example of this might be the Counsellor who has counseled refugees fleeing from a war-torn country. Internally Displaced Persons' repeated narrations of bombing, mutations, beheadings, raping, excessive torturing, and bereavement experiences can greatly contribute to humanitarian workers experiencing flashbacks or dreams of same incident.

According to surveys conducted for the purpose of this thesis, some factors that contribute to vicarious trauma include: nature of the client being seen by the humanitarian worker, degree of how traumatized the clients, forms of physical and emotional gesticulation of the

client, organizational structure of the safe place, past experiences of the humanitarian worker, intrinsic and extrinsic coping circumstances of the humanitarian worker, social and cultural context in which the work is performed, training and professional history of the humanitarian worker, whether the counselor feels he or she is well suited to this work and the amount of background training and knowledge regarding client issues, degree of current personal life stressors and available support, knowledge of vicarious traumatization, burnout and stress and ways to cope, maintenance of a balanced and satisfying life and relationships outside of workplace.

Saakvitne and Pearlman (1996) argued that vicarious trauma may also encourage opportunities for personal and spiritual growth, lowering the toxic effects of working with survivor clients and enhancing help-providers' psychological needs. Integrating coping strategies may positively transform the negative feelings associated with vicarious trauma creating balance, healthy life style choices, appropriate boundaries, and meaningful connection to self and others. Recognizing the cumulative effect of vicarious trauma may potentially challenge helpers who work with survivor clients, thereby, disrupting their efforts to incorporate healthy practices. Examining the balance of psychological needs and means to maintain a sense of well-being may further the personal and professional growth of therapists. Vicarious trauma can be described as helpers' natural and consequential emotions and behaviors that emerge in response to knowing about a client's traumatic event as well as the stress associated with helping or wanting to help a traumatized person (Figley, 1995, Figley, 2002). Exposure to traumatic events, either directly or indirectly, can contribute to symptoms identical to Post Traumatic Stress Disorder (PTSD) including characteristic indicators such

as intrusion, avoidance, and arousal. Therefore, Figley (1990) proposed that Vicarious trauma defined symptoms reflect this similarity though specific to individuals who care for traumatized clients.

Dutton and Rubinstein (1995) discussed categories of vicarious trauma reaction including symptoms of psychological distress or dysfunction, cognitive shifts, and relational disturbances to describe secondary exposure to clients' trauma material reflecting the features of PTSD. Vicarious trauma therefore, can be considered a symptom-based diagnosis (Figley, 2002).

Vicarious trauma may be experienced by helping professionals who empathically respond to and engage with survivor clients. Therapists' indirect exposure to traumatized clients can potentially result in both physical and emotional stress reactions that parallel those of their clients. The distinguishing features of vicarious trauma include secondary exposure to other's traumatic event while performing a job with a rapid onset of symptoms associated with a particular event (Stamm, 2005). The act of empathic connection to a survivor client's emotional reaction to a shocking and horrifying event relayed within the therapeutic relationship can therefore result in the therapist experiencing symptoms analogous to post trauma stress expressed by their clients.

Bride (2007) argued that human service professionals who provide direct services are highly likely to be vicariously exposed to trauma material and are also likely to experience some symptoms of secondary trauma stress. Meadors, Lamson, Swanson, White, & Sira (2010) noted that professionals who treat traumatized populations will likely struggle with vicarious trauma at various times in their career. Within the professional work context, service

provision to survivor clients can be especially challenging, placing the help provider at risk on a variety of fronts. Vicarious trauma experienced by human service professionals may adversely affect their ability to effectively provide services, sustain positive personal and professional relationships (Meadors et al., 2010) and is considered to be one of the many viable reasons for leaving the field prematurely (Beaton & Murphy, 1995; Bride, 2007; Figley, 1995). Ignoring the signs of vicarious trauma can result in "short-term and long-term emotional and physical disorders, strains on interpersonal relationships, substance abuse, burnout, and shortened careers" (Beaton & Murphy, 1995).

According to Figley (2002), personal, professional, and organizational interventions are necessary when addressing vicarious trauma. Coping skills and self-care practices may include identifying disrupted cognitive schema as an avenue toward change; maintaining a balance between work, play, and rest to encourage healthy functioning; seeking healing activities and connecting to spiritual needs (Figley, 2002). Restorative opportunities that enhance the value of trauma work and that focus on professional growth are essential for self-care practices as well as effective supervision and maintaining professional connections; thus, avoiding isolation (Figley, 2002; McCann & Pearlman, 1990).

People decide to become humanitarian workers for many different reasons. Some because of a personal commitment to social change – perhaps to follow a spiritual path or to fulfill a calling. Some want adventure; others want to leave home. People usually come to humanitarian work expecting exciting challenges, meaningful work, and the chance to make a difference in the world. Few people really understand that it is likely that their lives will be changed forever by their experiences. Humanitarian workers often assist people who have

been victimized. They work in and with communities that have been devastated by natural forces or conflict. They themselves are sometimes the targets of violence. Because of all these things, humanitarian workers are likely to experience lasting psychological and spiritual changes in the way that they see themselves and the world (Ehrenreich, 2005)

Some of these changes can be positive. Humanitarian workers often talk about how witnessing (and sometimes sharing in) the sufferings of people they are there to help has led to personal changes they appreciate – such as more compassion and gratitude, and a deeper understanding of what they value in their own lives and why. However, some of the changes that can come from witnessing and experiencing suffering can be more problematic, leaving potentially permanent scars. Humanitarian workers also talk of how their work can sometimes leave them feeling numb, disconnected, isolated, overwhelmed, and depressed. Many talk of how their deepest spiritual beliefs have been challenged by their work. While some feel their faith (however they personally choose to define that) has been strengthened by the work, some feel they lose their faith or spiritual grounding because of things they see as humanitarian workers (Blaque-Belair, 2002).

Most simply put, vicarious trauma can be thought of as the negative changes that happen to humanitarian workers over time as they witness and engage with other people's suffering and need.

For the purposes of this research, Humanitarian Aid Workers (HAWs) are clinician and/or non-clinician employees or volunteers who may ask details of or provide care to those exposed to severe physical or psychological trauma in situations of armed conflict, situations of violence, natural disasters or epidemics.

1.2 Statement of Problem

Vicarious trauma among humanitarian workers has become a major concern in the humanitarian workforce. However, this phenomenon is prominent in Northeast Nigeria, where insurgency has taken a dreadful shape (UNOCHA, 2017). The state of mind of the humanitarian actors is becoming severely threatened, hence, official and private functioning are disrupted. It can be argued however, that recognition of vicarious trauma is the essential first step to self-protection therefore, normalizing vicarious trauma may minimize its negative effects.

The cumulative and transforming effects of working with survivor clients may lead to cognitive shifts with pervasive effect on humanitarian workers' cognitive schemas including identity, world view, beliefs, and psychological needs (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995), thus, contributing to vicarious trauma. The examination of humanitarian workers' responses to treating survivor clients is relatively new, with ongoing efforts to address the deleterious effects of vicarious trauma and the value of coping strategies.

Literature has established that vicarious trauma can potentially have a disruptive and devastating impact on the psychological needs of humanitarian workers as they engage in therapeutic relationships. Therefore, finding avenues to thoroughly examine and empirically validate vicarious trauma can be useful to the profession of psychology in general, and specifically, humanitarian workers who work with traumatized populations. Positive social change includes an increased awareness of the risk of vicarious trauma and the development of potential coping strategies necessary to address this phenomenon.

Researchers have recommended self-care practices to manage the stress vicariously experienced by therapists working with traumatized populations, including maintenance of physical health, balanced diet, adequate sleep, regular exercise, or engaging in recreational activities (Harrison & Westwood, 2009).

Steed and Downing (1998) noted that although the phenomenon of vicarious trauma has received a great deal of theoretical and clinical attention, there is a dearth of empirical research investigating the impact of exposure to traumatic clinical materials on professionals working with trauma survivors. Workers like Humanitarian Aid Workers, who are not trained clinically but do this work in the course of duty and/or out of compassion, have not been studied adequately.

1.3 Research Questions

The following research questions were answered in this study:

1. What is the prevalence of vicarious trauma among Humanitarian Aid Workers in Maiduguri Metropolis, Borno state, Nigeria?
2. What is the relationship between vicarious trauma and coping strategies among humanitarian aid workers in Maiduguri Metropolis, Borno state, Nigeria?
3. What is the influence of primary position held by Humanitarian Aid Workers in Maiduguri Metropolis, Borno State, Nigeria (Direct Practitioner, Supervisor, Both Practitioner & Supervisor) on the manifestation of Vicarious Trauma?
4. What is the influence of gender on the utilization of coping strategies among Humanitarian Aid Workers in Maiduguri Metropolis, Borno State, Nigeria?

1.4 Objectives of the Study

The specific objectives of this research are to:

1. To determine the prevalence of vicarious trauma among Humanitarian Aid Workers in Maiduguri Metropolis, Borno state, Nigeria.
2. To examine the relationship between vicarious trauma and coping strategies among Humanitarian Aid Workers in Maiduguri Metropolis, Borno state, Nigeria
3. To examine the influence of primary position held by Humanitarian Aid Workers in Maiduguri Metropolis, Borno State, Nigeria (Direct Practitioner, Supervisor, Both Practitioner & Supervisor) on the manifestation of vicarious trauma.
4. To ascertain the influence of gender on the utilization of coping strategies among Humanitarian Aid Workers in Maiduguri Metropolis, Borno State, Nigeria.

1.5 Statement of the Hypotheses

The following hypotheses were tested:

1. There will be a significant prevalence of vicarious trauma among Humanitarian Aid Workers in Maiduguri Metropolis, Borno state, Nigeria.
2. There will be a significant relationship between vicarious trauma and coping strategies among Humanitarian Aid Workers in Maiduguri Metropolis, Borno state, Nigeria.
3. There will be a significant influence of primary position held by Humanitarian Aid Workers in Maiduguri Metropolis, Borno State, Nigeria (Direct Practitioner, Supervisor, Both Practitioner & Supervisor) on the manifestation of vicarious trauma

4. There will be a significant influence of gender on the utilization of coping strategies among Humanitarian Aid Workers in Maiduguri Metropolis, Borno state, Nigeria.

1.6 Significance of the Study

The result of this study will provide Humanitarian Aid Workers with the knowledge on vicarious trauma and coping skills and assist the participants to understand the nature in which vicarious trauma can affect them in their work delivering support to trauma survivors. This study will provide necessary information for coordinators and partners of humanitarian Organizations to assist them put in place strategies to help the help providers cope with vicarious trauma.

This study will provide the government with facts that point out the relationship between vicarious trauma and coping skills and help the government to establish protocols and to protect help providers working with traumatized populations within the country.

This study will add to the existing body of knowledge by adding to the literature already on ground, especially with regards to vicarious trauma, coping skills and humanitarian aid workers on the frontlines of care.

The scales that will be used for this study will undergo reliability and validity tests. These validated scales will assist researchers, educators, testers, and professional caregivers in the conduct of researches.

Furthermore, the instruments used will assist mental health professionals like psychiatrists, psychologists, psychotherapists, counsellors and other clinicians, by providing them with an accurate and clear psycho-diagnostic measure to enhance their assessment procedure about

understanding vicarious trauma and coping strategies of humanitarian aid workers on the frontlines. It is expected that when this study highlights the relationship between vicarious trauma and coping skills among Humanitarian Aid Workers in North East Nigeria, the result of this study will advocate and foster policy change if need be.

Humanitarian Aid Workers are at the heart of intervention and since caring for trauma survivors presents unique and serious challenges, recognizing and addressing the needs of Humanitarian Aid Workers is fundamental to effective service and would create a domino effect on the quality of care provided in humanitarian service.

1.7 Scope of Study

The scope of this study is limited to Humanitarian Aid Workers in Maiduguri Metropolis, Borno State in North East Nigeria. The major indicator for inclusion is being a humanitarian worker serving in Maiduguri Metropolis, Borno state. The study sample is restricted to Humanitarian Aid Workers as a result of the peculiarity of this group and their susceptibility in manifesting vicarious trauma and engaging in coping strategies.

CHAPTER TWO

LITERATURE REVIEW

2.1 Conceptual Framework

2.1.1 Vicarious Trauma

Vicarious trauma can be considered a disruption in a helper's life experience associated with their role as a secondary witness to their clients' trauma narrative. Specifically, individual self-identity, ideals, and strongly held beliefs may be compromised when remaining empathically available to survivor clients over time; thus, changing one's perceptions of the world, personal relationships, as well as potentially disturbing a therapist's emotional and spiritual well-being. McCann and Pearlman (1990) defined vicarious trauma as a negative transformation within a help provider's inner experience through the process of empathic engagement with a client's trauma material.

The American Counseling Association (ACA, 2011) defines vicarious trauma as "the emotional residue of exposure that counselors have from working with people as they are hearing their trauma stories and become witnesses to the pain, fear, and terror that trauma survivors have endured." While this definition refers specifically to the counseling professional, in recent years, the focus of vicarious trauma research has grown to include members of various professions including nurses, social workers, crisis counselors, humanitarian workers, the clergy, and interpreters (Bontempo & Malcolm, 2012).

Helpers have much strength and resources that are used to help traumatized clients. Thus, applying resources to these helpers as a means of preventing Vicarious Trauma, will facilitate

the wellness of these helpers (Trippany, White Kress & Wilcoxon, 2004). Although many Humanitarian Aid Workers find that working with survivors of trauma is meaningful and rewarding and count themselves truly privileged to witness the survivors' resilience in the healing process, the challenges associated with frequent exposure to human trauma is great. Steele (1991), in a touching essay about treating survivors of severe abuse, states that 'all the therapists I know who do this work have been blindsided at least once by the horror of it. Their own vulnerability, their helplessness in the face of such abuse is staggering.' (as cited by Kassam-Adams, 1995)

The process of vicarious traumatization and its impact is unique for each helper, contingent upon one's personality, defense style, and resources (Pearlman & Saavitne, 1995). Pearlman and Saakvitne (1995) noted that vicarious trauma "includes significant disruptions in one's sense of meaning, connection, identity, and world view, as well as in one's tolerance, psychological needs, beliefs about self and others, interpersonal relationships, and sensory memory, including imagery". Vicarious traumatization can, therefore, substantially harm the professional caregiver and adversely influence delivery of care to clients. Pearlman and Saakvitne (1995) posited that the impact of vicarious traumatization on a helping professional resemble those of traumatic experiences; hence, enhancing an awareness of the potential harm in one's personal life and adversely affecting the therapeutic relationship if not addressed. According McCann and Pearlman (1990), vicarious trauma emphasizes the changes in helpers' cognitive schema, belief systems, and personality because of their indirect exposure to a client's traumatic material with manifestations of disruptive symptoms including intrusive imagery and painful affect. Symptoms associated with vicarious trauma

as contended by Bober et al. (2006) include "intrusive imagery, nightmares, fears for safety of oneself and loved ones, avoidance of violent stimuli in the media and emotional numbing" (p. 72). Empathically engaging with survivor clients' experiences can significantly transform help providers' perception of self, perception of the world, psychological needs, beliefs, and memory systems that are pervasive, cumulative, and permanent (McCann & Pearlman, 1990). For instance, feelings of personal vulnerability when walking alone at night, anxiety when driving on a busy highway, or parental hyper vigilance and perceived loss of safety within your home and community may be ongoing themes experienced by helpers who work with survivor clients.

Therapists who work with victims of sexual abuse is an example of one's potential vulnerability to vicarious trauma as exposure to graphic accounts of abuse within the therapeutic relationship fosters the realities of intentional cruelty and interpersonal violence (Pearlman & Saakvitne, 1995). Baird and Bracen (2006) suggested that vicarious trauma may be viewed as a normal reaction to continuous challenges to a helper's values, convictions, and principles, however, it can also result in harming the professional self by interfering with the motivation, efficacy, and empathy necessary in trauma work. Therapists often work in isolation which furthers their risk of vicarious traumatization (Pearlman & Saakvitne, 1995). Disregarding the impact of vicarious trauma may result in significant disruptions in beliefs of self and others and distressing psychological and physical symptoms (Pearlman & Mac Ian, 1995), emotional and physical depletion, sense of hopelessness, shift in world view including suspicion and cynicism (Bober et al., 2006), as well as a helper leaving their professional work (Pearlman & Saavitne, 1995).

Boscarino, Adams & Figley (2010) suggested that the emergence of constructs to describe the impact of secondary exposure to client narratives within the practice of trauma work appeared when therapists discovered occupational hazards of experiencing the effects of their clients' trauma vicariously. Accordingly, attention to the residual impact of the therapeutic relationship on the helping professional began to surface through the early research of Figley, (1995); Figley,(2002); Joinson, (1992) ; Pearlman, (1998); Pearlman & Mac Ian, (1995); Pearlman & Saakvitne, (1995), Sexton (1999), which examined the adverse effects placed on the therapist as a consequence of empathic engagement with clients' trauma material. Trauma work, therefore, may result in cumulative, transformative, and deleterious effects as well as cognitive shifts and reactions (Pearlman & Saakvitne, 1995); states of tension and preoccupation with traumatized clients; persistent arousal associated with clients; and numbing and avoidance of clients (Figley, 1995; Figley, 2002). These researchers concluded that the potential for a therapeutic impasse as well as the detrimental risk of disconnection, failure, and harm to clients may be a likely outcome of therapists' secondary stress. According to Adams, Boscarino & Figley (2006), therapists often re-experience clients' traumatic event with subsequent effects of emotional exhaustion, desire to avoid clients and reminders of the expressed event, and persistent arousal due to the intimate knowledge about a traumatic experience.

Helpers may also experience physical, emotional, and cognitive symptoms similar to their traumatized clients as contended by Harrison and Westwood (2009). The establishment and cultivation of a framework to describe the effect of trauma work on helpers was introduced in the literature through the examination of countertransference and burnout (Maslach &

Jackson, 1984). These concepts provided a basis to explore vicarious trauma and related constructs including compassion fatigue (Joinson, 1992; Figley, 1995) and secondary traumatic stress (Figley, 1995). These secondary trauma-related constructs significantly encouraged further attention and research surrounding helpers' emotional well-being in recent years, even though the concept of burnout offers more sophisticated and healthy empirical validation (Devilly, Wright & Varker, 2009).

Although there is an apparent overlap among the theoretical constructs of empathic stress, countertransference, secondary traumatic stress, compassion fatigue, burnout, and vicarious trauma, Sexton (1999) suggested that there are notable similarities and differences. Jenkins and Baird (2002) attempted to compare and differentiate secondary trauma stress and vicarious trauma, reporting both constructs stem from work with trauma clients and include similar PTSD like symptoms; however, differ in regard to observed symptomatology and observable reactions associated with secondary traumatic stress verses the theoretical underpinnings and covert changes in thinking as reflected in vicarious trauma.

Newell and MacNeil (2010) suggested that the defining features of vicarious trauma, secondary stress, and compassion fatigue are similar; nevertheless, the distinction between each include cognitive change processes as conceptualized by vicarious trauma verses the outward behavioral symptoms emphasized by secondary traumatic stress and the all-embracing experience of emotional and physical fatigue associated with compassion fatigue. However, distinguishing between each concept remains a challenge in the current research. Baird and Bracen (2006) concluded that a lack of clarity remains in the literature on vicarious trauma and secondary stress indicating that further research is necessary to provide

clarification. Devilly et al. (2008) noted that the distinction between secondary traumatic stress and compassion fatigue is unclear although compassion fatigue has been more so considered a form of caregiver burnout. Boscarino et al. (2010) further argued that vicarious trauma, secondary traumatic stress, and compassion fatigue are all concepts variously used in the research resulting from the lack of conceptual clarity in defining the adverse consequences of treating traumatized clients.

Consequently, vicarious trauma, secondary traumatic stress, and compassion fatigue are all frameworks that have been utilized interchangeably to describe the impact on helpers who work specifically with traumatized populations. As noted by Craig and Sprang (2010), definitive data has not been established that proposes a conceptual distinction between these frameworks which suggests, the most suitable term to use in any given situation would be premature.

2.1.1.1 Secondary Traumatic Stress

Secondary Traumatic Stress (STS) is referred to as a set of symptoms similar to those of Post-Traumatic Stress Disorder (PTSD) or Acute Stress Disorder as defined in the Diagnostic and Statistical Manual of the American Psychiatric Association (APA, 2004). It occurs as a consequence of indirect exposure to trauma through a firsthand account or narrative of a traumatic event (Zimering, Munroe, & Gulliver, 2003). Some symptoms of Secondary Traumatic Stress among care providing professionals can include change in sleep, fear, disruptive and invasive thoughts of clients and their traumas, and avoiding anything that serves as a reminder of the secondary trauma (Stamm, 2010).

Figley (1983, as cited in Jenkins & Baird, 2002, p. 424) first defined Secondary Traumatic Stress as the emotional pressure experienced by persons having close interaction with a trauma survivor. The symptoms of secondary trauma are nearly identical to those of Posttraumatic Stress Disorder (PTSD). A burnout aspect was later added to the construct to capture the energy depletion characteristic of secondary trauma that represents the exhaustion of providing ongoing support to the primary victim (Figley & Kleber, 1995, as cited in Jenkins & Baird, p. 424).

Secondary traumatic stress (STS) reactions have been studies in health care providers, journalists, attorneys, first responders, supportive services, military personnel, volunteers, and media personnel by Figley (2002), and in judges by Jaffee, Crooks, Dunford-Jackson, and Town (2003).

A study of 81 disaster mental health workers that responded to the terrorist attacks of 11 September 2001 discovered that higher STS was associated with therapist variables of heavier prior trauma caseload, less professional experience, youth and therapist's discussion of his or her own trauma or trauma work in his or her own therapy (Creamer & Liddle, 2005).

A survey of frontline workers at a Child Welfare Agency reported significant evidence of STS was found for the workers in the study (Jia, 2014)

2.1.1.2 Professional Burnout

The psychological demands and workplace expectations placed on helpers may result in acute emotional disturbances and emotional exhaustion leading to a state of professional

burnout. Prolonged exposure to the stress coupled with professional work and challenging client populations can be exhausting both emotionally and physically.

Instances of sleeplessness, irritability, general anxiety, depression, guilt, and a sense of hopelessness can be attributed to emotional exhaustion (Kahill, 1988). The inability to cope with the challenges of job and organizational responsibilities while engaging in the practice of service delivery can potentially lead to feelings of discouragement and ineffectiveness.

Professional burnout within therapeutic practices has been widely examined in the literature. Burnout has been defined as a psychological syndrome complicated from extended response to stressors within the workplace; thus, resulting from the chronic strain associated from an incongruence between the worker and the organization (Maslach, 2003; Maslach, Schaufeli, & Leiter, 2001; Newell & MacNell, 2010). The interplay between a helper's response to stress within the context of their work responsibilities and the organizational culture of their employment may compromise their ability to effectively engage in their work with clients. According to Maslach (2003), the interpersonal framework of burnout focuses on worker's emotions including distancing oneself from aspects of the job which in turn may lead to a high level of cynicism and dysfunctional or negative consequences for clients and/or colleagues. The gradual evolution of negative feelings associated with burnout includes feelings of hopelessness, challenges in coping with work or completing a job effectively (Stamm, 2005).

Although parallels can also be drawn between vicarious trauma and burnout, the essential feature of burnout is the emotional exhaustion resulting from the stress of interpersonal contact and organizational demands experienced by professionals in the human services

industry (Maslach, 2003; Maslach et al., 2001; Newell & MacNell, 2010). The progression of burnout can be attributed to a number of factors that ultimately lead to a diminished ability to cope with work related stressors. The interrelationship between the individual, the population served, and the organization can contribute to the cumulative effect of burnout resulting in emotional exhaustion, depersonalization, and a lowered sense of personal accomplishment. (Maslach, 2003; Maslach & Jackson,1984).

Professional burnout therefore, develops over time and can be the result of difficult working conditions. The difference between vicarious trauma and burnout is evident as incidents of burnout are attributed to the circumstances encountered within the working environment; whereas, vicarious trauma results in cognitive shifts and reactions of trauma therapists (Brady, Guy, Poelstra, & Brokaw,1999; McCann & Pearlman, 1990). As with the occurrence of countertransference, helpers who experience symptoms of burnout may treat clients with a variety of clinical diagnostic categories while, vicarious traumatization is the direct result of trauma work. McCann and Pearlman (1990) posited that vicarious trauma sequel is specific to the ongoing exposure of disturbing images and suffering as described by traumatized clients.

2.1.1.3 Post-Traumatic Stress Disorder (PTSD)

Instances of individual exposure to catastrophic life events or personal involvement in stressful life circumstances that is beyond normal human experience is an indisputable fact. Green, Wilson, and Lindy (1985) suggested that throughout history, people have experienced wars, earthquakes, tornadoes, floods, and devastating accidents, along with other comparable

critical life incidents which profoundly impact the lives of the average person. Interest in individual reactions to traumatic experiences and the short, and long-term emotional consequences, following crisis events, emerged in response to the increased societal awareness to the effects of war, hostage taking, domestic violence, natural disasters, accidents, and loss through death (Figley, 1995). The Korean and later, the Vietnam Wars encouraged further attention of the American public and professionals to the problems presented by returning soldiers who appeared to be emotionally and behaviorally compromised (Figley, 1995; Trimble, 1985). Efforts to capture the emotional distress associated with individual traumatic life events and to designate specific behavioral features observed in survivors has produced a variety of constructs.

Trimble (1985) identified concepts such as posttraumatic neurosis, compensation neurosis, hysteria, shell shock, survivor syndrome, and nervous shock to describe survivor responses to number of historical traumatic events.

The conceptualization of trauma as a diagnostic category of post-traumatic stress disorder (PTSD) was first introduced in the American Psychiatric Association DSM-III of 1980 defining the symptoms commonly experienced following exposure to an event that was catastrophic; thus, encouraging an accurate assessment and identification of a psychiatric diagnosis of trauma survivors. According to Friedman, Resick & Keane (2007), the initial formulation of PTSD within the DSM-III characterized a traumatic event as a catastrophic stressor that was beyond the scope of usual human experience such as war, torture, rape, human made, and natural disasters. However, PTSD as documented in the DSM-III of 1980 was limited to direct exposure to a trauma without consideration to the secondary or indirect

effects of trauma (Figley, 1995; Harrison & Westwood, 2009). To address this limitation, the DSM –IV of 1994 expanded upon this initial description of PTSD to include traumatic events that were learned indirectly or secondarily (DSM-IV, 1994). The DSM-IV-TR (2000) included diagnostic features and criterion for PTSD that includes indirect or secondary exposure to a traumatic event.

The essential feature of Post-traumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate.

In 2013, the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) developed criteria that included repeated and extreme indirect exposure to aversive details of event(s) usually in the course of professional duties. The criterion for PTSD as indicated in the DSM-5 (2013) included the following conditions: direct exposure; witnessing an event; indirectly learning about an event; repeated exposure via professional duties; avoidance; negative alterations in cognitions and mood; alterations in arousal and reactivity; duration; and functional significance. Since the introduction of PTSD as a psychiatric disorder, the presentation of symptoms associated with direct, indirect, and repeated and extreme indirect exposure in the course of professional responsibilities were validated; thereby, fostering the conceptual framework for vicarious trauma, secondary trauma, and compassion fatigue.

2.1.1.4 Compassion Fatigue

Compassion fatigue was a model used by Joinson (1992) to describe the feelings of stress and fatigue as a contributing factor of burnout among individuals in the nursing profession. The practice of caring for patients with multiple medical issues, providing palliative care for individuals diagnosed with terminal conditions, or responding to those in medical emergencies may potentially result in a profound sense of exhaustion. Emotional manifestations of compassion fatigue may include anger, ineffectiveness, apathy, and depression which are unique among people in care giving professions with nurses being especially susceptible (Joinson, 1992). According to Rutledge, Stucky, Dollarhide, Shively, Jain, Wolfson, Weinger, and Dresselhaus (2009), nurses as well as physicians experience burnout, depression, job dissatisfaction, and workplace fatigue resulting from the long work days, high caseloads, time pressures, poor sleep habits, and high-performance expectations. Figley (1995) expanded upon the concept of compassion fatigue to include trauma therapists, suggesting that providing therapy to clients who experienced a traumatic event within the context of formal care giving can be emotionally challenging. Compassion fatigue as noted by Figley (2002) is considered a more user-friendly term for secondary traumatic stress disorder. Both Figley (1995, 2002) and Stamm (1995) considered compassion fatigue and secondary traumatic stress most similar in meaning and often used interchangeably. Vicarious trauma is also closely associated with compassion fatigue with both identifying changes in cognitive and emotional well-being as well as sense of meaning, safety, spiritual needs, and feelings of trust (Naturale, 2007; Pearlman, 1998; Pearlman & Mac Ian, 1995; McCann& Pearlman, 1990).

Figley (1995) argued that compassion fatigue encompasses a number of stress reactions including cognitive, emotional, physical, and spiritual disturbances as a byproduct of therapeutic engagement with traumatized clients. Similar to vicarious trauma and secondary traumatic stress, a client's vivid and detailed presentation of traumatic event and the necessary confidentiality within the therapeutic relationship may leave a helper feeling isolated, angry, and frustrated about how and why incidence of trauma and brutality occur; thus, contributing to compassion fatigue. The cumulative effect of compassion fatigue may result in helpers becoming emotionally hardened to clients' traumatic experiences, lessening its effect on them and resulting in losing the ability to balance objectivity and empathy (Figley, 2002). Figley (2002) further suggested that the best helpers may become the most likely victims of compassion fatigue.

2.1.2 Coping Strategies

Examination into the effect of stress on the human condition was initially introduced through the work of Cannon (1932) who defined the concept of homeostasis, suggesting that internal physiological and emotional processes work in a coordinated effort to maintain a balanced state when subjected to high degrees of stress. Therefore, emotional and physiological responses synchronously react to stress. Based on Cannon's early research, theorists furthered the concept of stress capturing the zeitgeist of post-World War I and II.

Medical research, specifically the harmful impact of excessive stress on physical functioning (Selye, 1954) encouraged further study into the adverse effects of extremely traumatic events concluding that trauma may be a leading cause of emotional distress. Emerging interest in

the psychological study of stress and how people cope with its impact responded to the political and social climate of the world conflicts in the 20th century. Lazarus (1991) argued that the question of stress and its impact on the well-being and performance of soldiers during and following the world wars; technological advances in warfare that terrorized civilian populations making everyone a potential victim to war; as well as an acute awareness that stress was evident both in war and peace time are the most likely impetus for the exploration and growth of stress as of major importance to scholars and professional workers.

According to Cooper and Dewe (2007), the concept of stress was legitimized and established within the discipline of psychology by the end of the 1950s and the early 1960s. The analysis of stress specifically, the physiological, cognitive, and behavioral impact as well as the way individuals engage in coping and adaptation became a growing interest in the field of psychology and health care to address stress related conditions. The human response to acute and chronic stress and its influence upon physical and emotional adaptations and the potential to be a compromising factor on health care also contributed to the ongoing examination of stress within the mental and medical health models. Miller, Cohen, and Ritchey (2002) argued that psychological stress has been linked with a considerable number of adverse health conditions. However, acute stress within a limited time frame may be beneficial as a natural physiological response to environmental conditions that enhance survival and adaptation to inherent risks such as a potential injury. On the other hand, chronic stress as a pervasive force in a person's life can result in significant instability especially if the individual is unable to determine if and when a stressor will decrease or cease to exist. Segerstrom and Miller (2004) posited that a feature of chronic stress is the uncertainty of knowing whether or when a life

challenge will end or ever end. Although acute stress within a narrow time frame may be beneficial, stressors in our modern world are considerably different resulting in chronic stress.

The recent literature on resilience and positive adaptation to stress has provided additional evidence into the variability of emotional responses to trauma (Benight, 2012; Bonanno, Papa, Lalande, Westphal, & Coifman, 2004; Bonanno & Mancini, 2012; Fredrickson, Tugade, Waugh, & Larkin, 2003; & Waugh, Thompson, & Gotlib, 2011) suggesting that extremely adverse experiences may not result in psychopathology.

Resilience and states of positive emotion refers to the ability to cope with traumatic and/or stressful events with the capacity to positively adapt (Fredrickson et al., 2003) promoting the expectation that the outcome of a given situation will yield consistent positive results that guide stressful encounters and tendencies toward resolution. Fredrickson et al. (2003) contended that positive emotions accompanies cognitive broadening which improves and expands the way people cope with adversity; thus, increasing the odds the people will be optimistic about the future. Bonanno and Mancini (2012) argued that individuals exposed to highly disruptive life experiences may be able to maintain emotional stability, healthy degree of psychological and physical functioning, as well as the potential for developing a positive response to the traumatic event.

Emotional flexibility, including the capacity to both express and suppress emotion has also been linked to successful adaptation to life changing circumstances (Bonanno et al., 2004). Fredrickson et al. (2003) and Waugh et al. (2011) concluded that psychological flexibility,

life satisfaction, positive affectivity, optimism, and the ability to find meaning in crisis are common traits in the resilience of individual adaptation to ever-changing life circumstances. Individual ability to cultivate a sense of hope and optimism may be influenced by a number of factors. One's perception of self and their relationship with their world can be attributed to their personality styles, learned behavior, and their social environment. The way people respond to life events may have a long-term impact on their emotional well-being and physical health. Peterson, Seligman, and Vaillant (1988) suggested that individuals who explain the circumstances of their life as related to stable, global, and internal causes in young adulthood are more likely to be at risk for poor health later in life. Resilience and optimism therefore, may be a benefit as one engages in the processes of their lives. A proposed benefit of optimism is a positive well-being and emotional stability, consistent and effective problem solving, successful academic and occupational achievements, and good health whereas pessimism potentially foreshadows depression, failure, positivity, social isolation, and poor health (Peterson, 2000).

Coping can be defined as the way a person will use their resources, intellectual and behavioral, to respond to a stressful situation (Dollard, Byrne, Byrne, & Dollard, 2003). The way in which the people appraise their experience of vicarious trauma and the way they cope with its consequences, plays a significant role in determining the presence of post-traumatic symptoms.

A negative coping response is defined as behavior, which is used to combat distress, which ultimately contributes to increasing the level of subsequent distress (Steed & Downing, 1998). Coping can play an important role in the perception of psychological well-being

(Parsons, Frydenberg, & Poole 1996). Through the use of coping, a person can deal with stress or can reduce, minimize or tolerate a stressful situation and can shape one's wellbeing. A stressful situation refers to an individual threatening or harmful experience, which alters one's psychological well-being (Vaughn & Roesch, 2003). Lazarus & Folkman (1984) mentioned two functions of coping: problem-focused coping which aims to solve the problem, whereas emotion-focused coping uses the individual's emotions in order to reduce emotional reaction or tension. The relationship between type of coping and psychological well-being is complex and not fully understood.

There is general recognition in the literature on vicarious trauma that supports the notion that the intensity of working with traumatized individuals negatively impacts the well-being of clinicians (Bober & Regehr, 2005). Although not all helpers who work with victims of trauma will experience vicarious trauma symptoms, all are potentially at risk. All help providers should have a professional awareness of preventive measures that can be used to address the symptoms of vicarious trauma (Newell & MacNeil 2010). Theorists within the area of vicarious trauma recommend a variety of coping strategies for reducing the levels of vicarious trauma signs and symptoms that helpers may experience. The commonly recommended coping strategies for reducing the signs and symptoms of vicarious trauma fall into four areas. These areas include leisure, self-care, supervision, and spirituality activities. These coping strategies should focus on helping the help provider escape, rest, and play (Bober & Regehr, 2005).

Epstein and Meier (1989) have identified the problem that "a particular mode of coping that is effective for a particular person in a particular setting may be ineffective when used by the

same person in another situation or by a different person in the same situation" (p. 348). Litt (1988) concludes: "Interestingly, the nature of the coping strategy per se does not appear to account for the generally beneficial effects of cognitive coping. That is, no single strategy appears to be superior for coping with stressful stimuli." (p. 242). Folkman (1984) clearly states that according to cognitive-relational theory, coping simply refers to efforts to transact with situational demands, regardless of the outcome of those efforts. In other words, coping effectiveness is not inherent in any given coping strategy (Folkman and Lazarus, 1985).

2.1.3 Humanitarian Aid Workers

For the purpose of this research, Humanitarian Aid Workers (HAWs) are clinician and/or non-clinician employees or volunteers who may ask details of or provide care to those exposed to severe physical or psychological trauma in situations of armed conflict and other situations of violence.

At its core, the point of humanitarian work is to serve and collaborate with people who need help. Humanitarian workers do that in many ways. Some work as advocates; some help provide food, shelter, sanitation, or medical services; some work in community or economic development, or peace-building. Whatever particular role, a humanitarian worker is in the business of helping people who may have experienced terrifying violence and profound losses. Many of these survivors are desperate and some have lost hope. Humanitarian workers assume a heavy responsibility by showing up and being there in their time of utmost need (Danielli, 2002)

Many humanitarian workers are very committed to their work and take this responsibility very deeply. Though, this is not necessarily negative, feeling deeply committed and responsible can contribute to the process of vicarious trauma. It can lead to very high and sometimes unrealistic expectations of oneself, as a humanitarian aid worker and others and for expectations of results from the work. For example, one may take it personally when his or her work or the work of the organization doesn't have the impact one wants. Ironically, a Humanitarian worker's sense of commitment and responsibility can eventually contribute to feeling burdened, overwhelmed, and hopeless in the face of great need and suffering. It can also lead to extending oneself beyond what is reasonable for one's wellbeing or the best long-term interests of beneficiaries (Blaque-Belair, 2002).

Individuals in different jobs experience different demands, constraints, and priorities. Each situation has its challenges. For instance, field staff often work in very difficult conditions, sometimes without basic sanitation or other resources. They may be quartered in locations where their physical safety depends on living in compounds, which can severely restrict socializing, exercise, and other opportunities for relaxation after hours. They may feel isolated from their friends and family and face frustrations with communications and inadequate resources for their work. They are frequently exposed to the aftermath of violence and disaster and overwhelming levels of direct need, with little time and few opportunities to process their responses. Staff based in coordination offices or headquarters may experience chronic stress related to balancing the competing demands of budgets, donors, staff, and dividing inadequate resources among desperate beneficiaries. They may also struggle to balance the demands of their work with those of their family and other commitments.

National staff may be directly impacted by the disaster or violence, and daily have to return to the work of rebuilding their own lives. They may also be supporting their extended family and friends in the face of limited job security. Those who work for international Non-Governmental Organizations (INGOs) may also face discrimination and other risks because of their association with the INGO. Expatriate staff are frequently working in cultures quite different from their own, and far from the comforts and routines of home as well as family and friends. Isolation, long working hours, frequent travel, and working in cultures and with teams that are unfamiliar to them can compromise their ability to function at their best (Ehrenreich, 2005)

All of these factors and more, can contribute to vicarious trauma, hence, the need to investigate on vicarious trauma and coping strategies.

2.2 Empirical Literature Review

2.2.1 Vicarious Trauma

Studies have shown that helpers working with those who have experienced highly stressful events are themselves susceptible to becoming traumatized and to developing similar stress-related symptoms. (Kluft, 1989; Talbot, 1990; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Figley, 1995 and Stamm, 1997) What strains these professionals is that hearing the "stories" and witnessing the physical, emotional, and social reactions of survivors to a variety of primary traumas is a regular part of their everyday work life. Way and Vandeusen (2004) compared vicarious trauma in a random sample of clinicians who treat

survivors and those who treat offenders. The study reported high levels of avoidance and intrusions among the sample.

It is evident that the literature has explored the adverse effects of working with traumatized populations; thus, defining and establishing constructs such as vicarious trauma, compassion fatigue, and secondary stress (Sommer, 2008; VanDeusen & Way, 2006). It is, however, essential to appreciate help providers' ability to develop effective coping styles that allow them to withstand the burdens often associated with their work. Harrison and Westwood (2009) argued that the challenge to effectively cope with the stress of work and to sufficiently balance professional and personal aspects of life may lead to therapists abandoning their field of practice; thereby, resulting in an immense loss of resources and potential.

Briere and Scott (2007) further contended that therapists are often exposed to the pain and suffering revealed in the therapeutic process as they observe the worst humans can do to each other; thus, making their work vicariously traumatic. Sommer (2008) suggested that educators in counselling have an ethical obligation to inform counsellors and supervisors of the effects of vicarious trauma as a means of detecting and preparing them for the potential negative effects on service delivery and their well-being. Research to explore and identify practices that foster work satisfaction and encourage the professional and personal well-being of established and new therapists, as well as students is beginning to emerge (Harrison & Westwood, 2009; Myers, Sweeney, Popick, Wesley, Bordfeld, & Fingerhut, 2012; Patsiopoulos & Buchanan, 2011). The integration of self-compassion as a means of self-care within the practice of psychotherapy as suggested by Patsiopoulos and Buchanan (2011) fostered skillful management of the effects of occupational stress and challenges as well as

encourages individual well-being and an increased ability to identify and approach signs of depletion and ethical dilemmas. The process of effectively managing work related stressors leading to vicarious stress reflects one's ability to individually cope and to integrate and manage self-care practices. Therefore, it is necessary to fundamentally understand the effects of stress and the ability to recognize and cope with the potential strain and disruption of stress.

Saakvitne, Tennen and Affleck (1998) sum up: "Research and clinical experience have taught us that ignoring the impact of trauma work on providers jeopardizes the well-being of clients and treaters alike." Help providers "experience their work with trauma survivors as distinctly different and, on the whole, more personally distressing than their work with non-traumatized individuals." (Saakvitne, et al, 1998). "The reality of loss and suffering, the knowledge that lives have been irrevocably altered, the awareness of our own limitations, that we can never undo what has been done, are painful." (Charney & Pearlman, 1998)

It is important to note that "Anyone who engages empathically with trauma survivors is vulnerable to vicarious traumatization." (Pearlman, 1995). This would include helpers such as humanitarian aid workers, researchers, religious and community leaders, mental health workers, doctors, emergency responders, attorneys, journalists, military and para-military, police, fire fighters, emergency medical technicians, dentists, nurses, family, friends, and all those connected to people who have endured trauma, one way or the other.

It is evident that one cannot engage in therapeutic relationships with victims of traumatic life events, as a help provider and remain unaffected. (Saakvitne, et al, 1998). A survey of 355 professional caregivers in Maine reported that 79% of respondents reported some experience

of Vicarious Trauma and 91% indicated they had been affected by burnout (Gould, For the Office of Trauma Services, Office of Program Development, Maine Department of Behavioral and Developmental Services). A study on 105 judges, with majority representing criminal, domestic/civil and juvenile courts, self-reported one or more symptoms of Vicarious Trauma (Jaffee & et al, 2003). The study indicated that female judges reported more symptoms than male judges and those with 7 or more years of experience reported more symptoms. Jaffee et al (2003) concluded that although judges reported different types of coping and prevention strategies, there is a need for greater awareness of these issues and more support.

Harvey (2001) explained several ways in which sign language interpreters may experience vicarious trauma, one of which is bearing witness to ordinary acts of oppression. It is generally accepted that one witnessing or undergoing situations characteristic of trauma, such as abuse, murder, or natural disasters, will later experience stress to some degree because of this encounter. However, witnessing inappropriate, subtle acts of oppression and discrimination towards members of the Deaf Community could be considered equally as traumatic and may result in emotional distress (Harvey, 2001). A pilot study of sign language interpreters indicated that interpreters are likely to be impacted by traumatic information as a result of experiencing traumatic stories or events second hand, facilitating the delivery of highly emotional information and bearing witness to oppressive behaviors (Andert & Trites, 2014)

In addition, feelings of horror, fear and helplessness are related to the level of distress experienced. For example, working with child victims has been documented as increasing

vicarious distress in both therapists and police officers, due to feelings of helplessness and horror at atrocities inflicted against children (Brady et al., 1999; Carleir, Lamberts & Gersons, 2000). Herlofsen (1994, cited in Johnsen, Lovstad & Michelsen, 1997, p. 133) described intense feelings of helplessness as being an instigator for vicarious traumatization among witnesses of natural disasters. Pearlman (1995, cited in Lugris, 2000, p. 12) found being a helpless witness to other people's trauma stories was a contributing factor of vicarious traumatization. A study of child welfare workers reported that work-family conflict was positively correlated with vicarious trauma, secondary traumatic stress and burnout. (Donna, 2007). A study found supervision to be strongly correlated with lower levels of vicarious trauma in practicing counsellors (Taylor, 2018)

Recurring memories and intrusive imagery have been reported by people who had witnessed violence in the workplace (Fitzpatrick & Wilson, 1999). Having to intervene in severe crises or bearing witness to human tragedy, can take its toll on the individual (Erickson, Vande Kemp, Gorsuch, Hoke & Foy, 2001; Lind, 2000; Lugris, 2000). These effects can include severe, debilitating anxiety that persists for months and sometimes even years following the event. Because these people are not directly involved in the event, their distress often goes undetected (Brady et al., 1999; Motta, Joseph, Rose, Suozzi & Leiderman, 1997). A study reported findings of vicarious trauma existing among correctional health nurses (Munger, Savage and Panosky, 2015). Schauben & Frazier (1995), conducted a study on 148 female therapists working with victims of sexual violence and revealed that higher caseloads of sexual violence correlated with more disruptive beliefs, more symptoms of post-traumatic stress disorder and more self-reported vicarious trauma.

The concept of vicarious trauma clearly appears to resonate with professionals in the field of traumatology. Increasingly, it is being generalized to apply to groups of professionals working outside the context of trauma therapy (Clark & Gioro, 1998; Goldenberg, 2002; Lowe, 2002; Pearlman & Saakvitne, 1995; Robinson, Clements, & Land, 2003; Wasco & Campbell, 2002). Studies investigating vicarious trauma among professionals have focused almost exclusively on professionals working with populations who have experienced a traumatic stressor associated with interpersonal violence (Brady et al., 1999; Genest, Levine, Ramsden, & Swanson, 1990; KassamAdams, 1995; McCann & Pearlman, 1990; Munroe, 1991; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995; Schauben & Frazier 1995). According to Pearlman and Saakvitne (1995) such practices contributed to a widespread countertransference fantasy that the helper knows more than the client about the experience of the client. According to these authors, such arrogance on behalf of the psychoanalytic community has resulted in a lack of the sort of empathic connection between client and helper now deemed by many practicing helpers as vital in the successful treatment of trauma.

In addition, Culver, McKinney & Paradise (2011) concluded, in their study of incidents of vicarious trauma among mental health professionals in the aftermath of Hurricane Katrina, that repeated exposure to client's trauma material may have adverse effects including increased anxiety, suspiciousness, and vulnerability; thus, affecting their ability to provide effective services for clients. Voss Horrell, Holohan, Didion & Vance (2011) suggested that clinicians who treat veterans of the Iraq war and service members of the Afghanistan war must develop an awareness of their personal responses to their clients and the potential problematic symptoms similar to PTSD that lead to vicarious trauma and burnout. Ben-Porat

and Itzhaky (2009) reported both positive and negative changes in therapists specializing in the field of family violence including disruptions in their beliefs and schemata regarding spousal relations, the world, and humanity as well as increased awareness of spousal and parenting needs. It is therefore evident that trauma helpers are indirectly exposed to a variety of trauma experiences as relayed by clients.

The potential challenge for trauma helpers is empathically engaging in the therapeutic process, thereby encouraging the course of healing for a client while minimizing the impact of vicarious trauma. Examining the effect of vicarious trauma on the psychological needs of helpers who treat traumatized populations as well as exploring potential coping strategies that address the risk of vicarious traumatization is an issue to consider. Optimal service delivery to effectively treat, advocate, and coach can be further enhanced through professional and personal awareness of the risk of vicarious trauma inherent in trauma work thus, contributing to positive social change.

2.2.2 Coping Strategies

Findings on stress and coping have offered greater understanding of the commonality and uniqueness of human responses to adversity. Although, there is substantial literature promoting nomothetic perspectives that dictate causal factors of stress and adaptation that can be generalized to the greater population, there is also an abundance of research that lends itself to the individuation of human nature with each person retaining characteristics that may enhance or discourage coping strategies. From a clinical point of view, helpers strive to understand their clients' responses to trauma with the goal of encouraging diverse coping

strategies that meet the stressful demands of the event. In turn, this will lead to adaptive functioning within the social and cultural context of their clients' environment.

To foster successful progression, helpers must also consider relational issues that encourage support and empathic connection. Briere and Scott (2006) suggested that when a client is feeling respect, caring, and empathy from a help provider during a traumatic disclosure, they are better able to re-engage in positive relational feelings integral to the resolution of major traumas. While clients may demonstrate similarities in their reaction to trauma, they may also have a personal frame of reference, creating individual meaning of their experience. As clients' response to trauma may be unique, we must consider the individualization of the helper in response to a client's narrative of adversity.

There is an emerging interest in literature in identifying a need for enhancing professional and personal resources for practicing help providers and incorporating effective coping strategies (Bober & Regehr, 2006; Harrison & Westwood, 2009; Williams, Helm & Clemens, 2012). Recognizing the risk of vicarious trauma and individual means of coping may foster an integration of self-care practices that encourage professional and personal growth; thus, improving services for survivor clients. As each survivor clients' response to a traumatic event is individualized, so will the response of the helper to a client's account of their personal trauma experience (Saakvitne et al. 1998).

The effectiveness of the treatment process depends to a large extent on how the helper can engage in their own process of integrating and transforming the traumatic experiences relayed by the client (Harrison & Westwood, 2009). Developing a sense of awareness and incorporating effective coping strategies to manage the diverse impact of vicarious trauma is

therefore, essential. Williams et al. (2012) suggested that helpers should develop a plan to engage in regular wellness activities; thereby, diminishing cognitive distortions associated with vicarious trauma and decreasing individual vulnerability.

Williams et al. (2012) argued that a strong supervisory working alliance may potentially decrease helpers' risk of vicarious trauma as well as provide a safe environment in which help providers can explore their personal reactions to clients' trauma material. Organizational strategies to address vicarious trauma may include attention to one's physical setting that encourages a comfortable and relaxed work atmosphere that promotes self-care. Continuing educational opportunities and regular in-service training can provide an increased understanding of the impact of vicarious trauma, thereby, encouraging a sense of self-awareness and attention to potential risk factors (Harrison & Westwood, 2009). Integrating learned strategies may, therefore, diminish potential risks and symptoms of vicarious trauma and enhance therapeutic services to survivor clients.

Encouraging healthy behaviors and choices through exercise and nutritional counseling within the organizational structure offers employees greater access to effective coping strategies. Introducing the hazards of vicarious trauma for students pursuing a career in psychology as well as therapists specifically interested in trauma work by including the potential risks in the academic curriculum or in training opportunities may assist in the development of effective self-care practices and coping skills (Sommers, 2008; Williams et al., 2012). Providing strategies that promote self-care and awareness of the effects of vicarious trauma are also useful preventative measures (Adams & Riggs, 2008). Bober and Regehr (2006) concluded that potential solutions to developing effective self-care and coping

strategies may be more structural than individual in that, organizations should also consider case load and work conditions in addition to individual strategies.

Negative coping responses have been documented as increasing the risk of experiencing and maintaining post-traumatic distress. (Beaton, Murphy, Johnson, Pike & Corneil, 1999; Gidron, Gal, & Zahavi, 1999; Lugris, 2000; Marmar, Weiss, Metzler & Delucci, 1996; Resick, 2000). A negative coping response is defined as behaviour, which is used to combat distress, which ultimately contributes to increasing the level of subsequent distress (Steed & Downing, 1998). For example, Pearlman (1990 cited in Lugris, 2000, p. 5) suggested that people who suffer from vicarious traumatization become increasingly concerned with their safety, experience fearfulness and distrust others. This way of coping with trauma-related material increases anxiety symptoms (Lugris, 2000). Negative coping strategies used to combat vicarious traumatisation include, drinking too much coffee and abusing alcohol (Gidron et al., 1999; Marmar et al., 1996; Resick, 2000; Steed & Downing, 1998). This is often used to combat further negative coping responses such as beliefs of overwhelming helplessness, negative self-talk, self-blame, a crisis of confidence and a lack of self-esteem resulting from the trauma (Steed & Downing, 1998).

Gidron et al. (1999) examined the coping strategies of Israeli bus commuters, most of whom have been witnesses or have known victims of terrorist attacks. Their most common coping strategy was problem-focused coping. This includes checking behaviour, constantly reminding oneself that they are in a potentially dangerous situation and preoccupation with one's safety. Gidron et al. (1999) found that problem-focused coping was significantly related to anxiety resulting from the potential threat of a terrorist attack. The more the person focused

on their safety, engaged in checking behaviour and feelings of distrust, the greater their anxiety. This coping style makes the person focus more on the stressor and associated beliefs emphasize the uncontrollability of the potential for danger (Gidron et al., 1999; Van der Kolk, McFarlane & Weisaeth, 1996). The way in which people cope with trauma can be complex. Even so, the way traumatic material is appraised and dealt with, will invariably determine subsequent traumatization.

Lazarus and Folkman (1984) defined coping as behavioral and cognitive strategies used to manage stressful situations. Health professionals have reported utilizing a range of coping strategies in the work place, including religion and spirituality, debriefing with colleagues, humor, accepting their professional limits, separating their professional and personal lives, and engaging in pleasurable events in their spare time (e.g., Clemans, 2004; Markwell & Wainer, 2009).

It is possible that coping strategies work in a two-fold manner following vicarious traumatic exposure. First, they may protect against symptoms of Secondary Traumatic Stress; that is, it is possible that the more health professionals engage in coping strategies in the workplace and in their personal lives, the less likely they are to experience symptoms of Secondary Traumatic Stress. Second, coping strategies may facilitate Vicarious Post-Traumatic Growth (VPTG). It may be that, the more health professionals use coping strategies, the more likely they are to experience positive psychological growth because of their challenging occupational experiences (Manning-Jones, de Terte & Stephens, 2016). In a study on health professionals, Manning-Jones, de Terte and Stephens (2016) reported that psychologists and counsellors reported the highest use of coping strategies, while doctors and nurses reported

the lowest utilization of coping strategies; however, nurses reported significantly higher levels of peer support than psychologists.

Researchers have found that when help providers are able to identify strategies to prevent vicarious trauma from becoming severe and problematic, they are less likely to experience vicarious trauma symptoms (Cunningham, 2003). Researchers also have discovered that, "addressing vicarious trauma would not only alleviate the negative impact on the clinician, but also would help ensure quality services for clients who seek their assistance" (Cunningham, 2003, p. 457). Researchers have identified the significance of keeping a balance between work and personal life in helping to reduce the symptoms of vicarious trauma (Figley, 1995; & Hesse, 2002). Lastly, researchers have found that when appropriate coping strategies are in place, the negative cognitive changes associated with vicarious trauma occur less frequently (Canfield, 2008). The commonly recommended coping strategies for reducing the symptoms of vicarious trauma only work when an adequate amount of time is devoted to engaging in these activities (Bober and Regehr, 2005).

Leisure activities are important for reducing the effects of vicarious trauma (Trippany et, al., 2004). Leisure activities include spending time with family, vacation, hobbies, and exercise (Jordan, 2010). Researchers have found that leisure activities are effective at reducing symptoms of vicarious trauma because of their restorative nature (Trippany et al., 2004).

Helpers who work with trauma victims should make adequate time for self-care activities. Professional self-care is "the utilization of skills and strategies by workers to maintain their own personal, familial, emotional, and spiritual needs while attending to the needs and demands of their clients" (Newell & MacNeil, 2010). Researchers have found that self-care

activities reduce and minimize stress and therefore reduce vicarious trauma signs and symptoms (Jordan, 2010). Self-care activities include stress management, training, and self-care plans (Bell, Kulkarni & Dalton, 2003). Researchers state that self-care involves "appropriate management of vital functions and practicing a healthy lifestyle" (Jordan, 2010, p.231). These include adequate sleep, a well-balanced diet, and taking small breaks during the day.

Supervision is strongly encouraged as a coping mechanism for helpers who work with trauma victims. Many researchers have found that supervision that actively addresses vicarious trauma is essential to reducing the signs and symptoms of vicarious trauma (Bell et al., 2003). Rosenbloom, Pratt, and Pearlman (1995) state "supervision should foster an atmosphere of respect, safety, and control for the clinician who will be exploring the difficult issues evoked by trauma therapy" (p. 77). A helper should feel safe expressing fears, concerns, and inadequacies they are experiencing during supervision (Bell et al., 2003). Supervision should also address the effects of trauma in a non-judgmental manner (Cunningham, 2003). Studies have found that supervision is more effective at reducing symptoms of vicarious trauma if it is separate from evaluation (Bell et al., 2003). Supervision and evaluation should be kept separate because helpers may be more reluctant to bring up issues in their work that might be signals of vicarious trauma, out of fear of a poor evaluation. Bell et al., (2003) found that the "number of times a worker received non-evaluative supervision and the number of hours of non-evaluative supervision were positively related to low levels of vicarious trauma symptoms" (p.468). The literature on vicarious trauma also emphasizes the need for group supervision or group support within organizations. Researchers state that this should be an

informal time for staff to process traumatic material with supervisors and peers (Bell et, al., 2003). Researchers have found that peer support groups "may help because peers can often clarify colleagues' insights, listen for and correct cognitive distortions, offer perspective/reframing, and relate to the emotional state of the social worker" (Bell et, al., 2003).

Researchers have found that helpers with a larger sense of meaning and connections are less likely to experience vicarious trauma. Help providers who experience vicarious trauma often have distorted worldviews and cognitive schemas. Without a sense of meaning, researchers have found that helpers may become cynical, pessimistic, withdrawn, and emotionally numb, hopeless and outraged (Trippany et al., 2004). In a survey of trauma counselors, 44% reported that spirituality provided an effective coping mechanism in dealing with the effects of their work (Pearlman & Mac Ian, 1993). Finding meaning can help trauma help providers alleviate the impact of vicarious trauma. Humanitarian workers can find meaning in numerous ways. These can include organized religion, meditation, and volunteer work (Newell & MacNeil, 2010). These activities can facilitate a sense of spirituality. As a result, researchers have discovered that "counselors with a sense of spirituality are more likely to accept existential realities and their inability to change the occurrence of these realities" (Trippany et al., 2004). A quantitative survey of 450 social workers found that leisure, self-care and spirituality had a strong relationship for reducing the score on the quality-of-life scale (Gerding, 2012). However, in their 2006 study, Bober & Regehr did not find that engaging in any coping strategy recommended for reducing distress had an impact on immediate trauma symptoms and caution that focusing on the use of individual coping strategies might imply that those

who feel traumatized may not be balancing life and work adequately and may not be making effective use of leisure, self-care, or supervision, thus in effect, blaming the victim. They suggest that the solution to vicarious trauma seems to be more structural than individual and emphasize that organizations must determine ways of distributing workload to limit the traumatic exposure of any one worker.

Individual coping strategies identified in literature which might mitigate the impact of vicarious trauma include debriefing/peer support, physical activity and other types of self-care activities, monitoring the level of trauma in ones' caseload, identifying clients' resilience and strength, sociopolitical involvement (Iliffe & Steed, 2000) and continuing education in the area of trauma (Pearlman, 1999, as cited in Sommer, 2008, p. 65). Workers' perceptions that they had adequate training to effectively assist survivors has also been identified as influencing vicarious trauma symptoms (Ortlepp & Friedman, 2002, as cited in Bober & Regehr, 2006, p. 2). Bell (2003) identified strategies and resources that prevented symptoms of Secondary Traumatic Stress in the majority of counselors in the sample, including a sense of competence about their coping, maintaining an objective motivation for their work, resolving their own personal traumas, drawing on early positive role models of coping, and having buffering personal beliefs.

2.2.3 Humanitarian Aid Workers

In general, research suggests that humanitarian workers who have more exposure to trauma survivors are likely to experience more problematic vicarious trauma (Blaque-Belair, 2002). This means that some job-related factors such as working directly with more people in need

(beneficiaries), hearing more distressing stories and/or witnessing more distressing scenes and/or events, being in a position of responsibility and/or feeling responsible for more people while also feeling as if you do not have the control or resources you need to do your job well, working longer engagements or moving from one challenging assignment to the next without adequate rest and processing in between, are probably all significant risk factors for vicarious trauma (Danielli, 2002)

2.3 Theoretical Framework

2.3.1 Constructivist Self-Development Theory

As a comprehensive theory on how traumatic stressors affect individuals, the Constructivist Self-Development Theory (CSDT) provides a construct that defines the impact of traumatic life experiences either directly or indirectly on psychological needs within relational and sociocultural contexts (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). For this study, the researcher is specifically interested in examining the relationship between vicarious trauma that may alter the psychological needs of trauma helpers and coping strategies utilized by these helpers to moderate its effects. Therefore, the components of individual self-development most vulnerable to the effects of a trauma and those that encourage adaptation to a traumatic experience and its aftermath are rooted in the context of individual personality, history, society, environment, and culture.

To better appreciate the impact of traumatic life events on the survivor client and its secondary vicarious effect on the helper, McCann and Pearlman (1990) and Pearlman and

Saakvitne (1995) developed the CSDT. CSDT integrates personality theory and the clinical psychological complexity of psycho-analysis theory with the clarity and contextual emphasis of social learning, developmental, and cognitive theories (Pearlman & Saakvitne, 1995). The combination of stated theories fostered the idea that people individually interpret their trauma experience and all related circumstances associated with an event. As such, further understanding of the survivor client within their own developmental, social, and cultural context is established offering a psychological, interpersonal and transpersonal examination of traumatic life events on the adult survivor (Pearlman & Saakvitne, 1995).

The clinical implication of the constructivist model as presented by Pearlman and Saakvitne (1995) is that the survivor client constructs and interprets their individual trauma; thereby, defining the meaning of their experience. The secondary impact of a survivor client's narrative on the helper is also a consideration. Pearlman and Saakvitne (1995) proposed that the CSDT also provides a useful framework for understanding the impact of vicarious trauma on the professional caregivers. Helpers' individual responses to trauma disclosures offered within treatment can be as disruptive to helpers' cognitive schemas including personal beliefs, expectations, and assumptions as it is for client survivors. According to McCann and Pearlman (1990) disruptions in helpers' schema about self and their world may produce changes that are subtle or shocking depending upon the level of differences between client's trauma experiences and the therapist's existing schemas.

Constructivist Self-Development Theory is the framework McCann and Pearlman (1990) and Pearlman and Saakvitne (1995) use as a basis for understanding the impact of trauma work. According to these authors, CSDT emphasizes meaning, adaptation, and integration. It looks

at the meaning individuals make of the events they experience (first or second hand), and how these individuals are able to adapt to these life stressors and integrate them into their lived experience. According to CSDT, traumatic events impact the developing self. Symptoms are seen as adaptations to stressful 'events'. Some of these 'adaptations' serve the needs of the individual and others do not. Irrational or distorted beliefs that begin to form in response to trauma experiences are seen as attempts to protect the individual's meaning system. An example might be the female counselor or therapist who holds on to a belief that she is safe from sexual predators. With continual repeated exposure to stories of women who have been violated sexually, the counselor may begin to hold these women accountable for their victimization. She may begin to focus on the ways in which these women leave themselves vulnerable to potential sexual violation rather than focusing on their immediate needs. This distortion allows the female counselor to hold onto her belief that the world is still essentially a safe place in which she is not a potential victim due to her gender.

According to Saakvitne and Pearlman (1996) those components of the self that are impacted by first and second-hand trauma are:

Frame of reference: This includes our world view, our personal identity, and our spirituality, and constitutes the lens through which we see the world. We can know that we are being impacted by our work when we begin to lose our sense of a belief in something beyond us and when we are beginning to view the world as a sorry place and our part in it as somewhat inconsequential in the scheme of things.

Self-capacities: This consists of our ability to tolerate strong 'affect', to see ourselves as deserving of love, and able to love others. We know we are being impacted by our work

when we find ourselves emotionally overwhelmed by things that would not normally impact us so strongly. An example may be crying when we hear of something good that someone has done or getting overly angry and frustrated at a perceived 'slight' from one of our co-workers.

Ego resources: This consists of our sense of self-awareness along with our ability to activate self-protective and interpersonal skills. We know that we are being impacted by our work when we have lost our awareness of the empathic, humorous, and insightful parts of ourselves that we normally bring to the service of our clients. We may no longer be as clear on the concept of establishing and maintaining healthy boundaries between ourselves and others. This may be manifested in spending extra time out of the office with a client in need, partly due to feeling that we are not giving enough. It may manifest itself in the creation of increasingly rigid boundaries with family and friends.

Psychological needs and cognitive schemas: This consist of our conscious and unconscious beliefs and expectations about ourselves and others that are formed in ever increasing complexity over the course of our lives. In CSDT, these relate specifically to how we assimilate and accommodate experiences that impact our perceptions of safety, esteem, trust, control, and intimacy. According to the authors, these are the needs most likely to be impacted by repeated exposure to clients' trauma material. We know we are being impacted by our work when we no longer feel our usual sense of safety in the world. This may be manifested by being hyper-vigilant and in a constant heightened state of alertness. We may startle easily and feel the need to increase our home security. We may become more fearful of the possibility of car accidents and other misfortune happening to ourselves and our loved

ones. We may lose our normal sense of respect, caring, and intimacy for and with ourselves and others. This may be manifested in cynicism concerning our work and the professional ability of our co-workers. Counselors and other helpers who work with childhood sexual abuse trauma may report increasing suspicion that everyone is a potential child abuser and read into other's actions a meaning that is not present in reality. We may also present with increasing feelings of need for control over more aspects of our lives which may cause conflict between ourselves and our loved ones.

Memory and perception: The components of the self that consist of memory and perception are also extremely vulnerable to trauma exposure. As is well documented (Amen 1998; Carlson and Bailey, 1997 and Pert, 1999), stress and memory impairment go hand in hand as the body attempts to protect itself from disturbing material. Under extreme conditions, memories become fragmented, separating the cognitive, somatic, sensory, and interpersonal aspects of the experience. This in turn disrupts our ability to process complete memories, resulting in feelings of disconnection and dissociation. We know we are being impacted by our work when we find ourselves unusually forgetful and disorganized. We may find ourselves experiencing uncomfortable feelings of anxiety without a specific memory to go along with it, or we may discover a memory that is not actually ours. In addition, we may be triggered into a state of unease by external stimuli that resemble some aspect of the detail in our client's stories. An example of this might be a helper's feeling of anxiety when she smells a certain kind of cigar that featured in her client's stories of childhood sexual abuse by her cigar-smoking grandfather.

2.3.2 Countertransference

The concept of countertransference has its origins in psychoanalytic theory and is an inevitable component in all therapy. Countertransference consists of the unconscious activation of the helper's own personal issues in response to the individuals he or she is serving. According to literature, countertransference is not optional. Rather, it is an expected and unavoidable reality of life. We are all impacted by our experiences and all see the world through a lens that is somewhat distorted by them. The task for the helper is to be vigilant regarding personal awareness of these 'distortions', to work at making conscious that which is unconscious in us and to come to know when personal bias is negatively impacting the healing process of the persons served. The relevance of this for vicarious traumatization cannot be overly stressed. A common symptom of vicarious traumatization is a changed attitude towards clients and the issues they present.

A creeping cynicism is often reported by over-stressed helpers. This cynicism is seen in the manner in which clients are referred to and in the black humor that can be found in staff gatherings. If helpers are unaware of the subtle changes in their thinking and belief systems regarding those they work with, they are in danger of disconnecting from awareness of the painful reality of their clients; which, in turn, prevents helpers from proffering hope in the form of appropriate support and treatment.

The natural tendency to want to distance or disconnect from the painful realities of clients leaves helpers potentially less able to be aware of the times when personal life issues are getting in the way of treatment. This disconnection may also blind helpers to the existence

of the not-so-painful realities of their clientele. Helpers may not see windows of hope and exceptions to the problems because they have effectively stopped looking too closely.

When help providers are unaware of the existence of countertransference, they are in danger of harming both the therapeutic relationship and the healing process of the client. Psychic survival in the form of numbing and disconnection are especially hazardous in situations that require a strong degree of empathic engagement to create feelings of trust and safety in clients. Creating a space for the client to tell his or her story is an important part of the healing process. Being genuinely available to hear that story and others, time and again, is a difficult task. Sometimes, helpers may find themselves avoiding the client's story or moving too quickly to the celebration of an alternate, more hopeful story. While holding a new, preferred story is, in and of itself, a very appropriate and effective tool, the helper needs to able to ask himself or herself if this movement away from the trauma story is always in the client's best interest or if it is really serving the helper's avoidance needs. Acceptance of not needing to know the details is a strategy suggested by McCann and Pearlman (1990) for those workers who may become overly fixed on a need to hear all the details as part of their Vicarious Trauma response. While the authors heartily endorse practices that serve clients' needs to move on and put their trauma experiences behind them, it is important that the need be identified by the client rather than superimposed either one way or another onto the client by a helper who can no longer cope with hearing all the 'gory' details.

The likelihood of countertransference also plays a role in helpers' emotional responses to specific trauma experiences introduced by clients in the therapeutic relationship. Countertransference as an unconscious displacement of helpers' emotional reactions toward

their clients is typically triggered by a present clinical interaction within the therapeutic relationship. Although countertransference was originally thought to compromise the therapeutic process, the recent literature considers it to be potentially useful, in that help providers' self-awareness of their internal reactions encourages increased self-understanding, empathy toward clients, greater working alliance and trust, and attention to psychological health (Hayes, Gelso & Hummel, 2011; Fauth & Williams, 2005; Yeh & Hayes, 2011). Pearlman and Saakvine (1995) argued that helpers' powerful feelings and internal processes elicited through countertransference are critical components of the treatment.

Although countertransference and vicarious traumatization generate feelings and experiences on the part of the helper, they each offer distinct interpretations of the helper's experiences. According to McCann and Pearlman (1990), the phenomenon of vicarious trauma cannot be easily explained by the hindrance of countertransference or simply job demands leading to burnout. Hayes et al. (2011) posited that countertransference can be described as helpers' reactions to unresolved conflicts triggered by a client and manifested during a therapeutic session while occupational stress leading to burnout has been found to be organizationally related (Meadors et al., 2010). Countertransference identifies the helper's reaction to the client during the treatment process whereas; vicarious trauma is the result of a helper's ongoing trauma work with a variety of clients. Therefore, vicarious trauma is considered to be the cumulative effect of working with trauma populations and its pervasive impact on the self of the helper (Pearlman & Saakvitne, 1995) and not a short-term response within the context of a therapy session (Harrison & Westwood, 2009), or specific to one particular client or therapeutic relationship as indicated with countertransference.

2.3.3 Theories of Stress and Coping

Theories of stress and coping originated and presented by Selye and Lazarus attempted to conceptualize and define the impact of stress on the human condition. Selye (1954) approach examined the biological reaction to stress as described in the general adaptation syndrome including the alarm response and the stages of resistance and exhaustion. This stimulus response point of view defined external stressors as the catalyst that produces a physiological reaction therefore; the biological response to an environmental stressor is the critical factor in the interpretation of stress (Selye, 1954) and not a reciprocal relationship between perception and reaction. This theory did not, however, include the psychosocial and cognitive aspects of stress. Lazarus (1991) proposed that coping is essential to the emotional process and emotional life as it is a significant feature of stress and individual emotional reactions. The stress and coping theory established by Lazarus suggested that stress comprises three processes including cognitive appraisals (primary and secondary) identified as critical mediators by which an individual evaluates their interaction with their environment as being relevant to their well–being and coping (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986; Folkman, Lazarus, Gruen & DeLongis, 1986).

Lazarus (1991) opines that cognitive activity acts as a guide enabling individuals to grasp the significance of what is happening when adapting to encounters with the environment; thus, allowing us to choose among alternative values and courses of action. The way a person believes and understands the world around them in general and within a specific context is attributed to knowledge; whereas, appraisal is the evaluation of the significance of knowledge of what is happening within a given encounter that will impact one's personal well-being

(Lazarus, 1991). Therefore, individual stressors are relational and mutually interdependent between persons and their environments.

Selye and Lazarus's theories of stress differed in that Selye viewed stress as a reaction to a stimulus; whereas, Lazarus viewed cognition and coping as key elements in a reciprocal relationship. However, these theories of stress and the stress response incorporated internal and external factors in relation to a stress response and the strategies to adapt to cognitive, behavioral, and biological changes. Each describes the challenge of adapting to stressors especially when presented with an overabundance of stress thus, providing the groundwork to study the impact of stress and practices utilized in the coping process. Literature has suggested that ineffective coping results in increased stress; whereas, effective coping leads to decreased stress with individuals who effectively cope extending themselves more which in turn potentially creates additional stress.

2.3.4 Coping Theory

Lazarus and Folkman (1984) developed a widely-recognized model that described the role of coping with stress and the process in which coping evolves. This model identifies stress as a transaction between individuals and their environment, where the individuals' perception of the stressful situation is the mediating variable of how they are able to cope with it. Transactions that are perceived as stressful (i.e. harmful, threatening, or challenging) require coping that will manage their level of distress (emotion-focused coping) or manage the problem that is causing their distress (problem-focused coping) (Lazarus & Folkman, 1984). Regardless of the chosen coping mechanism, there is an event outcome that is either

favorable, unfavorable or there is no resolution. Event outcomes lead to positive or negative emotional responses. The Lazarus and Folkman (1984) model predicts that problem-focused coping will reduce the level of problems that could create stress, and that emotion-focused coping will reduce the level of internal emotional distress.

Coping strategies and how people use them to deal with life stressors are well documented (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986; Folkman, Lazarus, Gruen, & DeLongis, 1986, Frazier, Mortenson, and Steward, 2005; Ullman, 1996; Arata, 1999; Filipas and Ullman, 2006). Coping research tends to focus on an individual's perception of stressful situations and how the individual responds to these situations. Lazarus and Folkman (1984) defined the process of an individual's cognitive appraisal of an event as an evaluative process that reflects an individual's subjective interpretation. Stressful situations have been found to increase individual coping efforts, and coping strategies are expected to reduce stress (Moos & Schafer, 1993). Lazarus and Folkman (1984) describe coping as strategies used to deal with a threat. Coping consists of both cognitive and behavioral efforts aimed at mastering a stressful transaction. Coping efforts can be focused either toward dealing with the problem itself or managing the unpleasant emotions that are aroused because of the problem (Lazarus & Launier, 1978). How a person copes is an important factor mediating the relationship between a stressor and the individual's eventual adaptation (Panzarine, 1985). Kuiper & Nyamathi (1991), and Lazarus & Launier (1978) report that the perceptions, stressors and the strength of the individual's coping strategies influence their quality of life.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Research Design

The research design used in this study is a survey design. The design entails the collection and use of data systematically from a given population to describe certain characteristics of the population. There was no attempt to manipulate the variables since a survey design presumes that the data are collected after the events of interest have occurred. The survey design was adopted for this research as it is intended to collect data from a sample group with view to describing the entire population vis –a –vis determining the relationship between vicarious trauma and coping skill among humanitarian workers in North East.

This research is also cross-sectional in nature and a structured questionnaire was utilized. The questionnaires, which comprised close ended questions, were prepared and distributed to the sample participants to fill and return. This was accompanied with assurance to the participants that whatever information given will be treated with utmost confidentiality.

3.2 Population, Sample and Sampling Techniques

3.2.1 Population of Study

The population of this study was made up of employees currently within non-profit NGOs carrying out their humanitarian operations in Maiduguri Metropolis, Borno State, Nigeria.

Maiduguri Metropolis comprises of a number of Non-Governmental Organizations with inclusions of international NGOs such as United Nations Children's Fund (UNICEF), International Committee of the Red Cross (ICRC), and United States Agency for International Development (USAID). Based on information obtained from the State Emergency Management Agency (SEMA) by the researcher, SEMA has registered no less than 134 NGOs, both Civil Society Organizations (CSOs), Local Non-Governmental Organizations (Local NGOs) and International Non-Governmental Organizations (INGOs), operating within Borno State, each with no less than 50 humanitarian staff across various humanitarian intervention projects. This gives an estimated population size of 6,700 HAWs for this study.

3.2.2 Sample

For this study, the purposive sampling technique was applied. The purposive sampling technique was used to select the Local Government Area (LGA) for collection of data from Humanitarian Aid Workers (HAWs), which was the Maiduguri Metropolitan City (MMC) LGA. This technique was used due to the security situation in Borno state and difficulty in accessing other locations within the state. The purposive sampling technique was also used to determine the final respondents of the study. This sampling technique was selected based on the peculiar circumstances of the population and the judgment of the researcher. The participants of the study were gotten at the Humanitarian Hub in Maiduguri, as HAWs from every location in Borno state are found there. The final selection of respondents captured Humanitarian Aid Workers whose base and work are in Maiduguri Metropolis, Borno State.

To derive the sample size, the Yamane Sample size formula was utilized. The Yamane formula was developed by Taro Yamane (1967) and is suitable if a researcher is working with a finite population and the population size is known. The formula is:

$$\mathbf{n = \frac{N}{1+Ne^2}}$$

n = corrected sample size

N = Population size

e = Margin of error (=0.05, based on the research condition)

Therefore, for the purpose of this study, the sample size was calculated as thus:

$$n = \frac{6700}{1+6700(0.05)^2}$$

$$= \frac{6700}{1 + 16.75}$$

$$\mathbf{n = 377.46}$$

Therefore, the sample size for this study is 377 participants.

3.2.3 Participants

This study made use of Humanitarian Aid Workers who work with victims of armed conflict in Maiduguri Metropolis, Borno state in the North East region of Nigeria. To achieve this, keen attention was given to the socio-demographic characteristics of the participants.

The inclusion criterion used was that participants should be currently employed in a Non-Governmental Organization (NGO) that currently carry out services for and engages with

victims of armed conflict in Maiduguri Metropolis, Borno state, irrespective of their age or length of time in the organization. Individuals without this criterion were not taken into consideration.

3.2.4 Setting

The study was conducted in Borno State. It is a part of the North East geo-political zone of Nigeria with 5 other States namely, Adamawa, Bauchi, Gombe, Taraba and Yobe states. The focus of this study was on Maiduguri Metropolitan City (MMC) Local Government Area (LGA) in Borno State.

3.3 Methods of Data Collection

3.3.1 Instruments

Two standard instruments were employed. These instruments are:

3.3.1.1 Brief COPE

a. Description

The Brief Coping Orientation to Problems Experienced (approach) is a self-report questionnaire measuring coping styles developed by Carver (1997) and intended for use in health-related research. It consists of 28 items, divided into 14, two-item scales: Self distraction, Active coping, Denial, Substance Use, use of emotional support, Use of instrumental support, Behavioral disengagement, Venting, Positive reframing, Planning, Humor, Acceptance, Religion, and Self-blame.

a. Reliability and Validity

According to Carver (1997), Coefficient alpha was reported to be between .50 and .90 across the subscales. The Cronbach alpha of each subscale was reported as Self distraction (α =.71), Active coping (α =.68), Denial (α =.54), Substance Use (α =.90), use of emotional support (α =.71), Use of instrumental support (α =.64), Behavioral disengagement (α =.65), Venting (α =.50), Positive reframing (α =.64), Planning (α =.73), Humor (α =.73), Acceptance (α =.57), Religion (α =.82), and Self-blame (α =.69).

This scale was adapted to apply to the context of this study and a revalidation of the instrument was carried out for this study, indicating a coefficient alpha of .72

b. Administration

The questionnaire is likert-type with responses chosen on a 4-point scale, ranging from (1) I haven't been doing this at all to (4) I've been doing this a lot.

c. Scoring

Each subscale yields one score, the sum of the two corresponding items. The scoring indicates that higher scores on each sub scale imply higher use of the coping style.

3.3.1.2 Vicarious Trauma Scale (VTS)

a. Description

The Vicarious Trauma Scale (VTS) was developed by Vrklevski and Franklin (2008) to measure vicarious trauma and was developed during a study exploring vicarious trauma in the legal profession. It consists of 8 items that measure the subjective levels of distress associated with working with traumatized clients. The VTS was divided into 2 domains:

Affective domain and Cognitive domain during a study on a community sample of licensed social workers (Aparicio, Michalopoulos & Unick, 2013). Each domain consists of 3 items, with 2 items serving as quick assessment, to check for exposure to traumatized clients.

b. Reliability and Validity

The VTS Cronbach's alpha on a sample of members of the legal profession was .88 (Vrklevski & Franklin, 2008). According to Aparicio et al (2013), Coefficient alpha for the Vicarious Trauma Scale on licensed social workers was reported to be .77, which indicates good internal consistency reliability. The Cronbach alpha of the Affective domain, which measures the affective impact of working with traumatized clients was .72 and the Cronbach alpha of the Cognitive domain, which measures the cognitive impact of working with traumatized clients was .74.

This scale was adapted to apply to the context of this study and a revalidation of the instrument was carried out for this study, indicating a coefficient alpha of .85, with affective domain reporting a coefficient alpha of .74 and cognitive domain reporting a coefficient alpha of .74.

c. Administration

Each item on the Vicarious Trauma Scale is rated on a 7-point likert-type scale, ranging from 1 (strongly disagree) to 7 (strongly agree).

d. Scoring

A total VT score can be obtained by summing responses to items; higher scores indicate more VT. According to Vrklevski and Franklin (2008), a score in the range of 8 to 28 indicates

low level of Vicarious Trauma, a range of 29 to 42 indicates moderate level of Vicarious Trauma, and a range of 43 to 56 indicates high level of Vicarious Trauma.

3.4 Technique for Data Analysis and Model Specification

The research seeks to examine two dependent variables, vicarious trauma and coping skills on the independent variable, Humanitarian Aid Workers. Due to the hypotheses stated for this study, Frequency, Regression and Multivariate Analysis of Variance (MANOVA) were the most applicable in this context and therefore, are the statistical tools that were used to analyze the data of this research. The Frequency table was utilized for the first hypothesis, regression was used for the second hypothesis to determine if there is a predictive relationship between coping strategies and vicarious trauma and the Multivariate Analysis of Variance (MANOVA) was utilized for the third and fourth hypothesis. The data collected for this study was analyzed with the 20.00 version of the Statistical Package for Social Sciences (SPSS-20) and VassarStats.

3.5 Justification of Methods

Transcription and interpretation of data has been identified as the essential hurdles that qualitative researchers must satisfy in their quest to ascertain rich outcome in the data analysis process (Atkinson, 1998). This demands that, much attention and concentration should be vested in the work here.

The first hypothesis utilized the Frequency table to determine the prevalence of vicarious trauma among respondents. The second hypothesis made use of regression to determine if

there is a predictive relationship between coping strategies and vicarious trauma. The Multivariate Analysis of Variance (MANOVA) was utilized for the third and fourth hypothesis as this procedure allows for more than one dependent variable.

Before the main study, the reliability and validity of the instrument was established through a pilot study of 30 participants that were not part of the study but representative of the sample, to ascertain the standardization of the instrument. The participants were informed about the objective of the research. This enabled the researcher to obtain their consents and cooperation to participate willingly. Participants were not deceived or forced into participation. All the participants were treated with dignity as humans and the researcher assured them of anonymity and confidentiality of any information given.

A total number of 380 questionnaires were distributed and 288 were returned, indicating a return rate of 76%. It took an average of fifteen (15) minutes for the questionnaire to be filled and twenty-two (22) working days for the distribution and compilation of questionnaires.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.1 Data Presentation

The description of various characteristics of the respondents is as shown in the tables below. These characteristics include gender, age, civil status, religion, primary position, average hours spent with clients per week and length of time in humanitarian service.

Table 4.1.1 Gender Distribution of Respondents

Gender	Frequency	Percentage (%)
Male	136	47
Female	152	53
	288	100

Source: Researcher's Field Survey (2020)

Table 4.1.1 shows that 47% of our participants were Male and females made up 53% of the population.

Table 4.1.2 Age Distribution of Respondents

Age Range	Frequency	Percentage (%)
20 - 29 years	104	36
30 - 39 years	139	48
40 - 49 years	44	15
50 - 59 years	1	1
60 years +	0	0
	288	100

Source: Researcher's field survey (2020)

Table 4.1.2 above shows the age range of our participants. Participants between the ages of 30 and 39 made up 48(%) of the total participants, followed by participants between the ages of 20 and 29 who made up 30 to 39(%) of the participants. Participants between the ages of 40 to 49 made up 15 percent of the population while participants between 50 to 59 years made up the remaining 1(%) of the population.

Table 4.1.3 Civil Status Distribution of Respondents

Civil Status	Frequency	Percentage (%)
Single	121	42
Married/Living together	132	46
Divorced/Separated	35	12
Other	0	0
	288	100

Source: Researcher's Field Survey (2020)

Table 4.1.3 above shows the civil status of our participants. Forty-six (46%) of our total participants identified that they are married or living together with a partner, 42 percent identified that they are single while 12 percent noted that they are either divorced or separated.

Table 4.1.4 Religion Distribution of Respondents

Religion	Frequency	Percentage (%)
Christian	133	46
Muslim	155	54
Others	0	0
	288	100

Source: Researcher's Field Survey (2020)

Table 4.1.4 shows that 54% of the population identified themselves as Muslims, 46% identified themselves as Christians. None of the participant identified as any other religion.

Table 4.1.5 below shows the primary positions of the participants. Majority of our participants (43%) identified their roles as direct practitioners, (31%) identified themselves as supervisors and the remaining participants identified as both practitioner and supervisor (26%).

Table 4.1.5 Primary Position held by respondents

Primary Position	Frequency	Percentage (%)
Direct practitioner	124	43
Supervisor	88	31
Both Practitioner and supervisor	76	26
Other	0	0
	288	100

Source: Researcher's Field Survey (2020)

Table 4.1.6 below shows the level of education of participants. Majority of our participants identified themselves as higher education graduates (74%), followed my medium or secondary school graduates (21%), those with basic education qualification made up (6%) of the population while the remaining (1%) reported not having any formal education.

Table 4.1.6 Educational Level of respondents

Education	Frequency	Percentage (%)
Informal/No formal	3	1
Basic (Primary School)	13	6
Medium (Secondary School)	59	21
High (College, diploma or university)	213	74
	288	100

Source: Researcher's Field Survey (2020)

Table 4.1.7 below shows the working hours of the participants. Majority of our participants reported working hours to be between 31 to 35 hours per week (71%), followed by participants who work for 26 to 30 hours per week (14%), those who work between 16 to 20 hours were (8%), the remaining (3.5%) and (2.5%) were those who reported between 5-10 hours and 11 to 15 hours per week respectively.

Table 4.1.7 Average Hours Spent with Clients per Week by Respondents

Working Hours	Frequency	Percentage (%)
5-10	10	3.5
11-15	8	2.5
16-20	22	8
21-25	3	1
26-30	40	14
31-35	205	71
36-40	0	0
	288	100

Source: Researcher's Field Survey (2020)

The length of time spent in humanitarian service could play a vital role in the manifestation of vicarious trauma and the use of coping strategies.

From Table 4.1.8 below, more respondents have been within their respective NGOs between 2-5 years. This could be as a result of the difference in employment and recruitment structure of non-profit organizations compared to profit-oriented organizations.

Table 4.1.8 Length of Time in Humanitarian Service by Respondents

Length of Service	Frequency	Percentage (%)
0 - 12 months	82	29
2 - 5 years	189	65
6 - 9 years	14	5
10 - 19 years	3	1
	288	100

Source: Researcher's Field Survey (2020)

4.2 Data Analysis and Results

4.2.1 Hypothesis One

Objective- To determine the prevalence of vicarious trauma among Humanitarian Aid Workers in Maiduguri Metropolis, Borno state, Nigeria.

Research Question- What is the prevalence of vicarious trauma among Humanitarian Aid Workers in Maiduguri Metropolis, Borno state, Nigeria?

Hypothesis - There will be a significant prevalence of vicarious trauma among Humanitarian Aid Workers in Maiduguri Metropolis, Borno state, Nigeria.

Table 4.2.1 Prevalence of vicarious trauma among Humanitarian aid workers

Vicarious Trauma	Frequency	Percentage	Male - Frequency	Male - Percentage	Female - Frequency	Female - Percentage
High	136	47 (%)	60	44 (%)	76	56 (%)
low	21	7 (%)	10	48 (%)	11	52 (%)
moderate	131	46 (%)	67	51 (%)	64	49 (%)
	288	100%				

Source: Researcher's Field Survey (2020)

From the table above, there is a prevalence of vicarious trauma (VT), with 47% of respondents indicating high levels of vicarious trauma, 46% of respondents indicating moderate levels and 7% indicating low levels of VT. It is worthy to note that more female Humanitarian Aid Workers showed high levels of vicarious trauma while more males showed moderate levels.

Humanitarian aid workers reported a prevalence of vicarious trauma; therefore, the alternate hypothesis will be accepted.

4.2.2 Hypothesis Two

Objective - To examine the relationship between vicarious trauma and coping strategies among Humanitarian Aid Workers in Maiduguri Metropolis, Borno state, Nigeria

Research Question - What is the relationship between vicarious trauma and coping strategies among humanitarian aid workers in Maiduguri Metropolis, Borno state, Nigeria?

Hypothesis- There will be a significant relationship between vicarious trauma and coping strategies among Humanitarian Aid Workers in Maiduguri Metropolis, Borno state, Nigeria.

Table 4.2.2a Regression table for coping and vicarious trauma

Source	**SS**	**df**	**MS**	**F**	***P***
Regression	878.14	2	439.1	9.5117	0.0001*
Residual	13155.83	285	46.2		
Total	14033.97	287	48.9		

*P<0.05

Source: Researcher's Field Survey (2020)

Table 4.2.2b Regression table for coping and vicarious trauma

Predictor	**Coefficient**	**Estimate**	**St.Error**	**t-static**	**R-squared**	**Adjusted R-Squared**	***P***
Constant	β_0	27.42	3.16	8.67	0.0626	0.056	0
Avoidant Coping	β_1	0.1368	0.1102	1.2412			0.23
Approach Coping	β_2	0.3229	0.1099	2.9379			0.004*

*P<0.05

Source: Researcher's Field Survey (2020)

From the tables above, a multiple regression analysis was calculated to predict vicarious trauma based on avoidant coping (denial, substance use, venting, behavioural disengagement,

self-distraction and self-blame.) and approach coping (positive reframing, planning, acceptance, seeking emotional support, and seeking instrumental support) for humanitarian aid workers in the Maiduguri Metropolis, Nigeria. A significant regression was found with $R2 = 0.063$, $F (2, 878.14) = 9.512$, $P<0.05$. A further analysis of the multiple regression model with the two coefficient predictors showed a significant predictor relationship between Approach coping strategies (positive reframing, planning, acceptance, seeking emotional support, and seeking instrumental support) and vicarious trauma with $P = 0.004$. On the other hand, the predictor relationship between Avoidant coping strategies (denial, substance use, venting, behavioural disengagement, self-distraction and self-blame) and vicarious trauma showed a non-significant relationship with $P = 0.23$.

Therefore, the null hypothesis will be rejected and the research hypothesis accepted, which states that there will be significant relationship between vicarious trauma and humanitarian workers' coping strategies; With the result indicating that those who used approach coping strategies had a significant relationship with vicarious trauma.

4.2.3 Hypothesis Three

Objective- To examine the influence of primary position held by Humanitarian Aid Workers in Maiduguri Metropolis, Borno State, Nigeria (Direct Practitioner, Supervisor, Both Practitioner & Supervisor) on the manifestation of vicarious trauma.

Research Question - What is the influence of primary position held by Humanitarian Aid Workers in Maiduguri Metropolis, Borno State, Nigeria (Direct Practitioner, Supervisor, Both Practitioner & Supervisor) on the manifestation of Vicarious Trauma?

Hypothesis- There will be a significant influence of primary position held by Humanitarian Aid Workers in Maiduguri Metropolis, Borno State, Nigeria (Direct Practitioner, Supervisor, Both Practitioner & Supervisor) on the manifestation of vicarious trauma

Table 4.2.3a Box Test of Equality of Variance

Box M	F	Df1	Df2	Sig
21.41	3.53	6	982967	.002

*P>0.001
Source: Researcher's Field Survey (2020)

The table above indicates that Boxes M (21.41) was not significant, P (.002) >α (.001). This means that there is no significant difference between the covariance metrices. Therefore, the assumption of homogeneity of covariance across the group assumption is not violated and Wilks Lamda is the appropriate test for our groups.

Table 4.2.3b Wilks Lamda Multivariate Test

Test	Value	F	df	Error df	P.E.Squared	Sig
Wilks Lamda	0.91	7.03	4	568	0.47	.000*

*P>0.001
Source: Researcher's Field Survey (2020)

The table above shows that there was a statistically significant difference in primary position held by Humanitarian Aid Workers on the manifestation of vicarious trauma, F (4, 568) =

7.03, $p < .001$; Wilk's $\Lambda = 0.91$, partial $\eta 2 = .47$. however, to understand the differences between the groups hence Table 4.2.3b below.

Table 4.2.3c below is a follow up of Univariate ANOVA for the influence of humanitarian aid workers present position and the manifestation of vicarious trauma (cognitive and affective domains of vicarious trauma).

The table shows that there is a significant difference between humanitarian aid workers position and the manifestation of cognitive component of vicarious trauma $F(2,288) = 27.40$, $P<0.05$, $\eta 2 = 0.69$.

Secondly, the table also showed that that there is no difference between humanitarian aid workers' position and the manifestation of affective component of vicarious trauma $F(2, 285) = 132.20$, $P> 0.05$, $\eta 2 = 0.16$.

Table 4.2.3c Subject Effects for Humanitarian Aid Workers Primary Position and Vicarious Trauma

IV	DV	df	Error	F	P.E Squared	Sig
Primary Position	Cognitive Vicarious Trauma	2	285	27.40	0.69	0.00*
	Affective Vicarious Trauma	2	285	132.20	0.16	0.96

*P<.05

Source: Researcher's Field Survey (2020)

Table 4.2.3d Estimated Marginal Means for Cognitive Domain of Vicarious Trauma

Variable	Mean	95% Confidence level Lower Bound	95% Confidence Level Upper Bound
Direct Practitioner	15.05	14.42	15.68
Supervisor	12.93	12.19	13.68
Both Supervisor and Direct Practitioner	14.95	14.15	15.75

Source: Researcher's Field Survey (2020)

Table 4.2.3d above shows the estimated marginal means and confidence level for the humanitarian aid position on the manifestation of cognitive component of vicarious trauma. The table shows that Direct practitioner (15.05) had higher mean than the supervisor and the Supervisor practitioner (12.93). The result also shows that supervisor/direct practitioners had higher mean (14.95) than the Supervisor (12.93).

Therefore, the research hypothesis will be accepted, which states that there is a significant difference between positions held and the manifestation of vicarious trauma among humanitarian aid workers in Nigeria $F(4, 568) = 7.03$, $p < .001$; Wilk's $\Lambda = 0.91$, partial $\eta 2 = .47$

A further analysis revealed that the difference was only significant for cognitive component of vicarious trauma $F(2, 288) = 27.40$, $P<0.05$, $\eta 2 = 0.69$. The result of the mean differences indicates that Direct practitioner position manifest more vicarious trauma than the Supervisor position; and Both direct practitioner/supervisor position manifest more vicarious trauma than Supervisor position but there is no difference between the Both direct practitioner/supervisor position and Direct practitioner position.

4.2.4 Hypothesis Four

Objective- To ascertain the influence of gender on the utilization of coping strategies among Humanitarian Aid Workers in Maiduguri Metropolis, Borno State, Nigeria.

Research question- What is the influence of gender on the utilization of coping strategies among Humanitarian Aid Workers in Maiduguri Metropolis, Borno State, Nigeria?

Hypothesis- There will be a significant influence of gender on the utilization of coping strategies among Humanitarian Aid Workers in Maiduguri Metropolis, Borno state, Nigeria.

Table 4.2.4a Box Test of Equality of Variance

Box M	F	Df1	Df2	Sig
291	2.6	105	248532	.000

*P>.001

Source: Researcher's Field Survey (2020)

Boxes Test was conducted to check for the homogeneity of covariance across the group. Our result indicates that Box M (291) was significant P (001) < α(.001). Meaning that the assumption was violated, therefore Pillars Test is the appropriate Test to use.

Table 4.2.4b Multivariate Test for Gender Influence

Test	Value	F	Df	Error df	P.E. Squared	Sig
Pillars Trace	0.18	4.26	14	273	0.18	.000

*P>0.001

Source: Researcher's Field Survey (2020)

The table above (Table 4.2.4b) shows a MANOVA table using Pillars Test Trace Test. Using (α of 0.001), we see that the test is significant. Pillars Trace = 0.18, F (14, 273) = 4.26, P<.001, Multivariate η2 = .18. This significant F indicates that there are differences between Males and Females on utilization of coping strategies and the differences lies somewhere between the groups. The Multivariate η2 =18 indicates that approximately 18% of multivariate of variance of the dependent variable is associated with the group factor.

Table 4.2.4c Test of Between Subject Effects for Gender on coping strategies

D.Variable	Df	Error	F	P.E.Squared	Sig
Active coping	1	286	0.61	.002	0.4
Self-Distraction	1	286	0.49	.002	0.5
Denial	1	286	1.60	.006	0.2
Substance use	1	286	0.34	.001	0.6
Emotional support	1	286	0.04	.00	0.8
Instrumental support	1	286	5.94	.020	0.02*
Behavioral engagement	1	286	0.01	.00	0.9
Positive reframing	1	286	8.05	.027	0.05*
Planning	1	286	6.58	.022	0.01*
Humor	1	286	5.44	.019	0.02*
Acceptance	1	286	8.73	.030	0.01*
Religion	1	286	0.002	.000	0.9
Self-blame	1	286	2.93	.010	0.09

*P<0.05

Source: Researcher's Field Survey (2020)

This table above is a follow up of Univariate ANOVA for the influence of gender on the utilization of coping strategies among humanitarian aid workers. The test result indicated that the influence of gender was significant for the following coping strategies. Positive reframing – $F(1, 286) = 8.05$, $P<0.05$, $\eta 2 = .027$; Instrumental support – $F(1, 286) = 5.94$, $P<0.02$. $\eta 2 = .020$; Planning – $F(1, 286) = 6.58$, $P<0.01$, $\eta 2 = .022$; Humor – $F(1, 286) = 5.44$, $P<0.02$, $\eta 2 = .019$; Acceptance – $F(1, 286) = 8.73$, $P<0.01$, $\eta 2 = .030$

Table 4.2.4d Estimated Marginal Means for Gender and coping strategies

D. Variable	Gender	Mean
Positive reframing	Male	1.43
	Female	1.59*
Instrumental Support	Male	1.63
	Female	1.76*
Planning	Male	1.60
	Female	1.74*
Humor	Male	1.55
	Female	1.68*
Acceptance	Male	1.57
	Female	1.74*

Source: Researcher's Field Survey (2020)

The table above for estimated marginal means shows that females humanitarian aid workers have higher means in the utilization of positive reframing, instrumental support, planning, humor and acceptance more than male humanitarian aid workers.

Therefore, the alternate hypothesis will be accepted, which states there will be a significant gender differences in the utilization of coping strategies among humanitarian aid workers in Nigeria. Pillars Trace = 0.18, F (14, 273) = 4.26, P<.001, Multivariate η2 = .18.

The result suggest that female humanitarian aid workers utilizes positive reframing, instrumental support, planning, humor and acceptance coping strategies (all positive) than males humanitarian aid workers - Positive reframing – F(1, 286) = 8.05, P<0.05, η2 =.027; Instrumental support – F(1, 286) = 5.94, P<0.02. η2 = .020; Planning – F(1, 286) = 6.58, P<0.01, η2 = .022; Humor – F(1, 286) = 5.44, P<0.02, η2 =.019; Acceptance – F(1, 286) = 8.73, P<0.01, η2 = .030. The differences between male and female is approximately 19% to 30% multivariate variances.

4.3 Discussion of Findings

The outcome of this study indicates that there is a prevalence of vicarious trauma among Humanitarian Aid Workers, ranging from low to high levels. This aligns with the study on 105 judges, in which majority representing criminal, domestic/civil and juvenile courts, self-reported one or more symptoms of Vicarious Trauma (Jaffee & et al, 2003). It is noteworthy to point out that in the present study, there was a higher prevalence of vicarious trauma among direct practitioners and humanitarian aid workers engaging in both direct practice and supervisory roles.

However, it is interesting to note that studies have shown that culture do mediate for the outcome of psychological variables (Gershoff 2002). For example, some of the constructs of avoidant coping strategies like substance use, venting and self-distraction, are well known

and accepted means of coping within the African society. Therefore, more studies are needed to conceptualize coping within the North East Nigerian culture.

The psychological tools of Brief Coping and Vicarious trauma had not been validated within the emergency context of North East Nigeria. There is need therefore, that future researches into this, should validate the psychometric properties of the tools within this context.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary

1. There is a prevalence of vicarious trauma (VT) among humanitarian aid workers in Maiduguri Metropolis, Nigeria, with female humanitarian aid workers showing high levels of vicarious trauma.
2. There is a significant relationship between vicarious trauma and humanitarian aid workers' coping strategies, with results indicating a significant relationship with those who engaged in approach coping strategies such as positive reframing, planning, acceptance, seeking emotional support, and seeking instrumental support.
3. There is a significant difference between positions held and the manifestation of vicarious trauma among humanitarian aid workers in Maiduguri Metropolis, Nigeria, with direct practitioner and combined direct practitioner/supervisor positions manifesting more vicarious trauma than supervisor positions.
4. There is a significant gender difference in the utilization of coping strategies, with female humanitarian aid workers having higher means in the utilization of positive reframing, instrumental support, planning, humor and acceptance coping strategies, more than male humanitarian aid workers.

5.2 Conclusions

From the findings of this study, humanitarian aid workers indicated a prevalence of vicarious trauma and reported utilizing positive reframing, instrumental support, planning, humour and acceptance coping strategies.

5.3 Recommendations

The prevalence of vicarious trauma observed among the humanitarian aid workers studied has brought to the fore the need for clinicians to engage in more interventions for frontline help providers. Clinicians should join forces with other mental health practitioners to engage in intervention drive in non-profit organizations especially for humanitarian aid workers and volunteers since it has been found in this study that the females manifested higher levels of vicarious trauma than their male counterparts.

Clinician should engage in immediate intervention to normalize and alleviate vicarious trauma in humanitarian settings as a result of enduring exposure to traumatic materials or narratives. The findings of this study suggest that help providers such as humanitarian aid workers be made aware of coping strategies available to them, to help them manage disturbing experiences. It is expected that this will go a long way in curbing the level of vicarious trauma among humanitarian aid workers and other frontline care responders.

Clinical Psychologists should launch methods that will encourage increasing the use of adaptive coping strategies and self-care practices. This could be done through novel research findings and ingenious treatment protocols. It could also be achieved through awareness campaigns and staff health talks in organizations that work on the frontlines of care.

Management should be educated on vicarious trauma and coping strategies so they can pass on the information to the staff and possibly encourage its prevention or provide support for cases.

5.4 Limitations of the Study

Some limitations encountered during the course of this work should be taken into cognizance in order to put the findings of this study in the right context. This implies that the results of this study should be interpreted cautiously, bearing in mind some of the limitations encountered in the course of it which are presented below:

Field work limitations (obstacles encountered):

1. Due to the security challenge in Borno state, the researcher was unable to go to some locations as a result of inaccessibility.
2. The time to meet with humanitarian aid workers was hard to be allocate, as they insisted that they would not want the researcher to use working hours or lunch break time.

Methodological limitations:

Although great care was taken to craft the research methodology, it was found that some information could not be included in this study and this poses a limitation to it. Some of these are as follows:

1. The samples were not separated based on any psychological, biological or environmental challenges and these could have been in existence in the sample.

2. The dearth of adequate literature from Nigeria in the area of the constructs used for this study, especially vicarious trauma, was a major methodological limitation because it hindered tapping previous indigenous findings so as to build on them in order to resolve through this study, their methodological flaws and come up with better outcomes.
3. Data analysis had to be reduced in order for the study not to have overly large tables to be interpreted. Hence, some information contained in the questionnaire were not analysed to avoid information overload.

5.5 Suggestions for Further Studies

From the outcome of the present study, the following are suggested for further studies:

1. This study was limited to one city in the North East geo-political zone in Nigeria. It is suggested that further studies be spread across more states and geo-political zones.
2. Further studies should compare volunteer humanitarian aid workers and fully employed humanitarian aid workers.
3. It is also important to investigate the psychological adjustments of humanitarian aid workers.
4. Further studies should integrate a specific intervention method in quasi experimental study.
5. Further studies should investigate other frontline helpers such as clinical psychologists, nurses, emergency first responders, dead body management personnel etc.

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INDEX

Dear Respondent,
I am a Masters student in the Faculty of Psychology in Selinus University of Science and Literature. My research work is on **Relationship Between Vicarious Trauma and Coping Strategies Among Humanitarian Aid Workers in Maiduguri Metropolis, Borno State, Nigeria.** Kindly, in your opinion, help complete this questionnaire which is strictly for research purposes. Your answers are highly valued and will be treated with utmost confidentiality. Thank you

Yabilsu Sharon Joro
(Researcher)

SECTION A: Personal Data

Gender:	Male		Female		**Age:**		
Civil status:							
1. Single		2. Married/Living Together		3. Divorced/Separated		4. Other (Specify)	
Religion:	1. Christianity		2. Islam		3. Other (Specify)		
Primary Position:	1. Direct practitioner		2. Supervisor				
	3. Both supervisor and Practitioner		4. Other (Specify)				
Education:							
1. Informal/no formal			2. Basic (primary school)				
3. Medium (secondary school)			4. High (vocational school, college, diploma or university)				
Average client hours /week:							
No of Months/Years in humanitarian service:							
Present Location in North East Nigeria:							

Section B: Vicarious Trauma Scale (VTS)

Please, read the following statements and indicate how much you agree or disagree with them. (**1=Strongly Disagree, 2=Disagree, 3=Slightly disagree, 4=Neither agree nor disagree, 5=Slightly Agree, 6=Agree, 7=Strongly Agree)** Please tick appropriately.

s/n	Items	1	2	3	4	5	6	7
1	My job involves exposure to distressing material and experiences.							
2	My job involves exposure to traumatized or distressed clients.							
3	I find myself distressed by listening to my clients' stories and situations.							
4	I find it difficult to deal with the content of my work.							
5	I find myself thinking about distressing material at home.							
6	Sometimes I feel helpless to assist my clients in the way I would like.							
7	Sometimes I feel overwhelmed by the workload involved in my job.							
8	It is hard to stay positive and optimistic given some of the things I encounter in my work.							

Section C: Brief COPE

Please, indicate for each of the statements to what extent you agree or disagree, as it applies to you. Don't answer based on whether it seems to be working or not—just whether or not you're doing it. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true **FOR YOU** as you can.

(**1=I haven't been doing this at all, 2=I've been doing this a little bit, 3=I've been doing this a medium amount, 4=I've been doing this a lot)** Please tick appropriately.

S/n	Items	1	2	3	4
1	I've been turning to work or other activities to take my mind off things.				
2	I've been concentrating my efforts on doing something about the situation I'm in				
3	I've been saying to myself "this isn't real."				
4	I've been using alcohol or other drugs to make myself feel better				
5	I've been getting emotional support from others.				
6	I've been giving up trying to deal with it.				
7	I've been taking action to try to make the situation better.				
8	I've been refusing to believe that it has happened.				
9	I've been saying things to let my unpleasant feelings escape.				
10	I've been getting help and advice from other people.				
11	I've been using alcohol or other drugs to help me get through it.				
12	I've been trying to see it in a different light, to make it seem more positive.				
13	I've been criticizing myself.				
14	I've been trying to come up with a strategy about what to do.				
15	I've been getting comfort and understanding from someone.				
16	I've been giving up the attempt to cope.				
17	I've been looking for something good in what is happening.				
18	I've been making jokes about it.				
19	I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.				
20	I've been accepting the reality of the fact that it has happened.				
21	I've been expressing my negative feelings.				
22	I've been trying to find comfort in my religion or spiritual beliefs.				
23	I've been trying to get advice or help from other people about what to do.				
24	I've been learning to live with it.				
25	I've been thinking hard about what steps to take.				
26	I've been blaming myself for things that happened.				
27	I've been praying or meditating.				
28	I've been making fun of the situation.				