“I NEVER THOUGHT I’D BE THAT STRONG”

The effect on the professional helper when working with assessment and treatment of child sexual abuse in South Africa.

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Abstract
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Keywords
The effect of work, Secondary traumatization, Child sexual abuse, Professional helper, Treatment of abuse, Assessment of abuse, Qualitative method
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Introduction

Professional helpers from all around the world agree that the hardest aspect concerning their work is children’s death and working with traumatised children (Dyregrov, 1997; Figley, 1995). Helpers usually find different ways to manage the difficult situations they are dealing with but when children are involved it seems to be more difficult for the helper to maintain an emotional distance (Dyregrov, 1997).

Figley (1995) argues that there is consensus about the statement that therapists are more likely to experience stress as a part of their job, yet few studies have found a more detailed description of what kind of experiences cause stress. Clinicians’ interest for the effect on helpers, who work with clients that have been exposed to trauma, arose in the late 1980’s (Cunningham, 2003). Since the years of the late 1980’s many theories about the phenomenon have been created (Pearlman & McIan, 1995; Pearlman & Saakvitne, 1995; Stamm, 2002; Figley, 1995). There has not been the same amount of empirical studies carried out (Hafkenscheid, 2005). In 2003 Zimering, Munroe and Bird Gulliver wrote that “Secondary trauma is an understudied and controversial clinical phenomenon” (p.1) and that “The current state of empirical literature on secondary traumatization among health care professionals is in its infancy” (p.2).

Most of the previous knowledge in this area has its origin in western society, predominantly in the USA. The research is focused on how the professional helper is influenced when treating clients who have been exposed to trauma (Bride, Robinson, Yegidis & Figley, 2004; Brady, Guy, Poelstra & Brokaw, 1999; Cunningham, 2003; Beaton & Murphy, 1995 in Collins & Long, 2003a; Collins & Long, 2003b; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995; Steed & Downing, 1998; Woodward Meyers & Cornille, 2002; Way, VanDeusen, Martin, Applegate & Jandle, 2004; Zimering, Munroe & Bird Gulliver, 2003). The majority of earlier empirical studies concern work with traumatised adults and not children (exception being Brady, Guy, Poelstra & Brokaw, 1999; Stevens & Higgins, 2002; Woodward Meyers & Cornille, 2002; Way, VanDeusen, Martin, Applegate & Jandle, 2004). Since most studies focus on trauma we do not know for sure if and how professional helpers are affected when treating clients who are not labelled as traumatised.

South Africa is a country where currently the statistics show a high number of child abuse cases per year (Child abuse in the RSA, n.d.). The government has become aware of the problem and there are several clinics working with these children. As in the rest of the world there is little research conducted regarding the treatment of children who have been sexually abused or regarding the effect.
this work might have on the professional helpers (Pierce & Bozalek, 2004). When looking for South African research about the effect on professional helpers we only found a few articles (Ortlepp & Friedman, 2001; Stamm, 2002). None concerned the issue of how the professional helpers are influenced by their work with sexually abused children. This study was carried out in South Africa due to the combination of the country’s high numbers of child abuse, the experience of handling these cases and the overall lack of research regarding the professional helpers who work with sexually abused children.

The aim of this study was to increase the knowledge about how professional helpers are affected when working with assessment and treatment of children where there is a suspicion of sexual abuse.

**South Africa**

The Republic of South Africa is a country with approximately 46.9 million inhabitants, of which 32 percent are under the age of 14 (Statistics South Africa, 2005). The official statistics still divide the inhabitants into four race groups where Africans comprise 79 percent of the population and Europeans, Coloureds and Asians make up 21 percent. There are eleven official languages (Landguiden, Sydafrika, 2003).

The number of HIV-positive people in 2005 was estimated to be 4.5 million, which is approximately 10 percent of inhabitants (Statistics South Africa, 2005). It is feared that six million South Africans will die from AIDS before 2010 (Forsberg Langa, 2004a). Today it is estimated that the number of orphaned children are 2.5 million, of these 1.1 million children are orphaned due to AIDS (UNICEF, 2006). Of the inhabitants 50 percent are living below the minimum breadline (equivalent to 500 Swedish kronor/ month) and the gap between rich and poor is the second largest in the world (Forsberg Langa, 2004a). The official unemployment rate is 29 percent.

The first democratic election in South Africa, where ANC (African National Congress) was elected as the ruling party and Nelson Mandela became the new president, took place in 1994 (Forsberg Langa, 2004a). In 1997 the new constitutional law was entrenched, a law that has been viewed as one of the world’s most progressive constitutions.

South Africa is a country that in itself contains a wide range of different cultures, from the different rural African villages to the cities influenced by European ways of living.
Mwamwenda (2004) explains that an African defines her/himself in relation to other people and that the emphasis is not on the individual but on being connected and related to others. There is an expression in the Zulu language, *Ubuntu*, which means: I am because we are (Stamm & Friedman, 2000). The interdependent and collective way of viewing the self is believed to be principal in most African cultures, especially in the more rural areas (Mwamwenda, 2004).

Hamber and Lewis (1997) talk about South Africa as a culture of violence. They describe how South Africa, since colonisation, has a history of violence. The violence has been political, domestic and structural. South Africa has a high rate of homicides, robberies, hi-jackings and rapes (Landguiden, Sydafrika, 2003). The number of rapes is among the highest in the world (Robertson, 1998; With Bush in Africa, 2003). According to Barbarin, Richter and deWet (2001) the number of interpersonal violence crimes, sexual and property crimes are still as high as during the era of apartheid, if not higher. Hamber and Lewis (1997) claim that the violence in the country is leading to lack of trust between individuals, the inhabitants having symptoms from trauma (PTSD) or feeling anxiety and anger. They even say that many South Africans will live their daily life with fear, suspicion and aggression as a consequence of this.

Barbarin et al (2001) investigated how children are affected by violence in society. One of their findings was that children are just as distressed by a traumatic event experienced by someone close to them, as if the children themselves had been the victims. This occurs with no regard to gender or socioeconomic status of the child. At the same time they also point out that many children in South Africa grow and develop in spite of violence.

*Abuse in South Africa.* UNICEF (2006) describes that the situation for children in South Africa seems to have become harder during the last five years. Part of this is the increasing abuse and violence towards children. Forsberg Langa (2004b) writes that abuse against children in South Africa seems to have become grosser. Glynis Clacherty, educational consultant in Johannesburg, took part in a research project sponsored by Save the Children organisation (Forsberg Langa, 2004b). She found that if one were to ask politicians about the greatest problem concerning children they would answer child maltreatment whereas if one asked the children they would say it is fear.

According to The Social Board in Sweden (2000) reports to the police concerning suspected sexual abuse imply that the numbers of victims are 1-2 per 1000 children under the age of 15. A report published from the Humans Rights Watch (2004) indicates that a third of all children under eighteen in South Africa have been victim to sexual abuse and in 2002 the number of rapes and attempted
Rapes reported to the SAPS (South African Police Service) reached above 52 000. Of these reported cases about 40 percent involved victims under the age of eighteen. The number of child victims to sexual abuse is increasing and the age of the victims is decreasing (Arkley, 2004). Childline SA found that 50% of children presented for therapy for sexual abuse were below seven years of age.

Humans Rights Watch (2004) claim that the number of cases reported to the SAPS is lower than the actual number that occur every year. There are several possible explanations for this. One could be that trust for the police and the legal system is broken and will take some time to restore (Meier, 2002). Another could be that abuse happens within the family and is therefore kept as a secret (Humans Rights Watch, 2004). Yet another explanation could be fear of what the perpetrators could do if the case was to be reported. In 2002 only 7.7 percent of the reported cases of rape in South Africa resulted in conviction (Humans Rights Watch, 2004).

The statistics of child abuse in South Africa is questioned. In an article published by the Medical Research Council’s homepage, Dr Rachel Jewkes, director of Medical Research Council’s Gender and Health Research Group, says that there is no evidence for the increasing number of infant rapes in South Africa (The “virgin myth”, 2002). She suggests that the increased rates can be related to the media.

The high numbers of sexual abuse and rape in South Africa can have many possible explanations. One of them is the virgin myth implying that a cure for AIDS is to have sexual intercourse with a virgin (Arkley, 2004; Meier, 2002; The “virgin myth”, 2002). According to Meier (2002) a survey done by the University of South Africa shows that 18 percent of respondents believe in the myth. Arkley (2004) writes about a survey where 10 percent of the respondents between twelve and eighteen years of age believed in the myth. This is, however, questioned by some of the organisations working with counselling in this area. Luke Lamprecht, manager at the Teddy Bear Clinic, is quoted in an article published on the Medical Research Council’s homepage where he says that he has only come in contact with this problem in one case four years ago (The “virgin myth”, 2002).

Another possible explanation to the high rates of sexual abuse and rape is society’s view on sexuality and women, which according to Meier (2002) and Hamber and Lewis (1997) is harsh. Meier (2002) says further that cultural beliefs favour the boy’s wishes. Dr Jewkes says that sexual violence against women and girls comes from the violence and inequalities that South Africa as a country has experienced in the past (The “virgin myth”, 2002). The inequalities between people make life more difficult for women and girls. Guma and Henda
(2004) describe South Africa as having a “rape culture”, where violence towards women and children is implicitly accepted. They mean that the way boys and girls are socialised into their gender roles decides the direction of society. The boys are socialised into being superior and to control others.

There are several possible explanations for the high rates of child abuse. Townsend and Dawes (2004) describe a variety of explanations on a socio-cultural level, down to a personal level. They mean for example that poverty and its subsequent lifestyle is a potential danger. Parents may need to work long hours and leave children unattended, or unemployment can lead to adults staying at home. In some cases, they might use abuse as a way of maintaining their status. Poverty can also lead to families living close to each other in small rooms and sexual abuse might not be easy to discover.

Public awareness of how high the numbers of reported abuse cases in South Africa are is quite new, due to the fact that black children were often excluded from statistics (Pierce & Bozalek, 2004). As the awareness of the children’s situation has developed, the need to act has grown. There are clinics and programmes working with treatment and prevention, but due to financial constraints there are cutbacks in staff. According to Pierce and Bozalek (2004) the workload on these clinics can be so heavy that it is difficult to find time to carry out research and consequently develop their methods.

**Background**

In our study we will use the words therapist and counsellor, when referring to persons with a therapeutic education. The words professional and helper are used synonymously and are defined as persons employed at a clinic, working with the client but with varying education such as therapists, social workers and teachers. Sexual abuse towards children is, according to Kempe and Kempe, defined as: “The involvement of dependent, developmentally immature children and adolescents in sexual activities which they do not fully comprehend, are unable to give informed consent to and that violate social taboos or family roles.”(Townsend & Dawes, 2004, p.59) The word trauma is used exclusively with a psychological meaning and indicates the psychological effect on a person exposed to a painful and shocking experience, usually a catastrophic, violating or separational incident.

We searched for knowledge on Medline and PsychInfo among other databases. The empirical knowledge we have found being closest to the subject of our study, is the research about working with clients supposedly exposed to trauma. This previous research is based on meeting traumatised clients, and there is no
room for questioning whether a client is traumatised or not. Woodward Meyers and Cornille (2002) mean that an event in itself cannot be traumatic, but is valued so. Therefore culture and social context can play an important role when valuing if an event is traumatic or not. In this study the aim is to look at professional helpers working with children where sexual abuse is suspected, whether the children are labelled as traumatised or not. However we find it important to have the previous research as a point of reference since this research describes an area close and sometimes intertwined with ours.

Several theoretical concepts have been used to try to explain the effect the work with clients who have been exposed to trauma has on the helper (Cerney, 1995; Figley, 1995; Figley, 2002; Maslach, Jackson & Leiter, 1996; Pearlman & Mac Ian, 1995). The concepts are Secondary Traumatic Stress, Secondary Traumatization, Compassion Fatigue, Burnout, Traumatic Countertransference and Vicarious Traumatization.

Secondary Traumatic Stress, Compassion Fatigue, and Secondary Traumatization are terms linked to PTSD that aim to explain the reaction to the client’s experience, expressed in the helper through symptoms close to PTSD (Collins & Long, 2003a; Figley, 1995). Traumatic Countertransference derives from the concept of countertransference and explains how the situation in therapy with a traumatised client can be difficult, and how the trauma can influence the worker’s ability to help in therapy (Collins & Long, 2003a; Figley, 1995). Vicarious Traumatization is thought to explain the accumulation of memories of clients’ stories, and how these memories are thought to transform the way that the professional experiences the self, others and the world (Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995). Burnout is a concept that clinicians have used to differentiate their own concepts (Cerney, 1995; Figley, 1995; Pearlman & Saakvitne, 1995). Some of the clinicians claim that Burnout does not incorporate the specific situation and interaction between the individual and the situation (Cerney, 1995; Pearlman & Saakvitne, 1995). Others argue that Burnout is a process that appears over time, whereas, eg, Secondary Traumatic Stress can emerge suddenly (Figley, 1995). Like Compassion Fatigue, Burnout is thought to increase the difficulty for the professional to offer the client the help that he/she needs and to keep a good therapeutic relationship with the client (Collins & Long, 2003).

The concepts have been criticised, mostly by researchers. Sexton (1999) believes that most of the theory in this field is built on “anecdotal experiences of the therapists” (p396) and not on research. Zimering, Munroe and Bird Gulliver (2003) point out that the amount of data that support the findings of Secondary Traumatization are not enough on which to build all the existing theories. They refer to a review of Psychlit journal articles where only 17 peer-review articles
on Secondary Traumatization were found. Collins and Long (2003a) and Steed and Downing (1998) criticise aspects of *Vicarious Traumatization* and claim that it only refers to negative changes in therapists, such as the therapists losing trust in mankind and starting to isolate themselves. They indicate that *Vicarious Traumatization* does not consider possible positive outcomes from working with people exposed to trauma, such as achieving a deeper meaning of life. Hafkenscheid (2005) questions the validity of the concepts of *Traumatic Countertransference* and *Vicarious Traumatization*, which he suggests have not been sufficiently proved. There are also researchers who claim that the concepts are overlapping and confusing (Collins & Long 2003a; Hafkenscheid, 2005).

**Research**

**Possible effects of treating clients exposed to trauma.** Working as a therapist and caring for a client can sometimes have an impact on the therapist’s sense of self (Dyregrov 1997; Figley, 1995; Pearlman & Saakvitne, 1995). Figley (1995) describes it as a sense of losing the self to the client. He asserts that the therapist can start to feel similar feelings as the client or view the world in a similar way. This way of being affected is, according to Figley, more likely to appear when the emotional bond between client and therapist is strong. Therefore therapists who show more empathy can be more likely to be affected by the client’s story, he claims. Pearlman and Saakvitne (1995) talk about the importance of self capacities, and argue that these can help a person to maintain a positive sense of self. These include the ability to control strong emotions and the inner sense of connecting to others, they say. If these capacities are disrupted they claim that it can lead to intense self criticism, hypersensitivity or on the other hand isolation from others and a loss of capacity to love. To disguise this, the therapists can become over involved in work or become numb to their own feelings (Pearlman & Saakvitne, 1995).

Pearlman and Saakvitne (1995) also argue that the therapist’s frame of reference can be altered. They say that working with trauma clients can open up to a reality that many of us want to protect ourselves from. Hearing about the trauma in others can make the therapist aware of the potential for trauma in her/his own life and the world can be seen as a more negative place to be in, they say. They claim that listening to the client also can make the therapist ask questions about her- himself, her/his identity and her/his history. If a therapist gets held up with these questions and cannot move forward to find a solution, Pearlman and Saakvitne (1995) imply that the sense of self can be confused and the identity affected. They say that when beliefs about others are changed relationships can be influenced. They argue that this could lead to the potentially traumatised helper withdrawing from social life, feeling alienated from intimate friends and sexual partners or feeling an inability to enjoy common forms of entertainment such as TV or movies. Cunningham (1999) points out that the process which
might occur when the professional helper starts to question her/his beliefs about
the world has not been given adequate attention by researchers in the field.

Schauben and Frazier (1995) wanted to further investigate the effect on
counsellors working with sexually abused clients. Their data was both
qualitative and quantitative. They found that the most commonly reported
difficulty in working with trauma was aspects such as difficulty in maintaining
boundaries and establishing trust in therapy. Other reported difficulties were
dealing with clients’ emotions due to abuse and organisational factors, such as
lack of funding to be able to carry out the therapy. Enjoyable aspects mentioned
by a large amount of counsellors were seeing positive change in clients’ lives
and being a part of it. Another positive aspect was learning about the resilience
and strength in humans. The conclusion of the quantitative data was that the
more trauma survivors the counsellors had in their case load, the more
symptoms of PTSD and Vicarious Traumatization they showed. Symptoms of
Burnout did not covariate with the number of cases.

Cunningham (2003) refers to Munroe’s study in 1990. In this study the
clinicians who worked with a large number of combat veterans who had not
fallen under the diagnosis of PTSD did not report any PTSD-like symptoms
themselves. The clinicians who worked with a comparable amount of veterans
diagnosed with PTSD did on the contrary report symptoms themselves. In a
research by Cunningham (2003) she came to the conclusion that the clinicians
who worked with sexually abused clients reported more indications of being
effected by their clients than did clinicians who worked with clients suffering
from cancer.

Steed and Downing (1998) found that twelve female therapists working with
sexually abused clients in Australia were influenced in a number of ways. They
expressed that the clients’ stories evoked strong feelings, for instance anger
towards perpetrators and society and a heightened feeling of vulnerability. All of
the therapists reported having periods when they had felt severe helplessness
and many of them experienced a diminished self-confidence due to this. They
talked about effects of the work that intruded into their personal life and the
need to find boundaries between personal life and professional life. The
therapists mentioned the need to be aware of the effects of the work, to be able
to seek help when needed and monitor their reactions when talking to the client.
All of the interviewees (including one therapist who had only been working in
this field for one year) experienced negative effects due to their work with
traumatised clients. Steed’s and Downing’s conclusion however was that the
therapists could also see several positive aspects of the work and the researchers
asked for a more open approach when conducting further research. Another
conclusion was that the therapists, even if they talked about many negative side
effects of their work, did not say that negative effects increased over time. More longitudinal research is needed to understand these questions. This is a suggestion that is shared by Sabin-Farell and Turpin (2003) (in Hafkenscheid, 2005).

In their study, Brady, Guy, Poelstra and Brokaw (1999) compared a group of clinicians working with adult sexual abuse survivors and a group of clinicians working with children who had been sexually abused. They found no significant difference for the likeliness of developing Vicarious Traumatization between the groups.

A longitudinal research was done by Collins and Long (2003b) in Northern Ireland after the Omagh bomb in 1998. Thirteen professionals, working in the temporary trauma team created after the bomb, filled in the Compassion Satisfaction/Fatigue test by Stamm, and the Life Status Review by Stamm four times between 1998 and 2001. The professionals were also asked three open-ended questions, concerning positive and negative aspects about working in the team and how they experienced leaving the team, when filling in the questionnaires for the last time in February 2001. The results on the quantitative data showed that the team members were at greatest risk for Compassion Fatigue and Burnout in August 1999. The symptoms had increased at first but at that time they started to decrease.

Another important finding was that Compassion Satisfaction correlated negatively to both Compassion Fatigue and Burnout, thus indicating that Satisfaction can contribute in a protective way. In the qualitative part of the study the team members talked about the importance of the team, and how it contributed positively to their work. Also, the feeling of contributing to recovery in clients’ lives and in society was seen as positive. The support that they received, in the form of supervision, and the opportunity that they had to develop new skills were also positive aspects of their work. What contributed negatively was the fact that media showed interest in the team’s work and disturbed them. Another negative aspect was dealing with the clients’ stories and the bereaved clients’ anger. Yet another negative aspect was the fact that the professionals sometimes knew the clients on a personal level, because of living in a rural area. The team members listed some of their coping strategies, which included: supervision, humour, resting and exercising. The conclusions that the researchers made were that: the professionals were influenced by their work on a personal and professional level; Compassion Satisfaction can be a protective factor to Fatigue and Burnout; team spirit was the most positive aspect of work in this sample and handling media and stories of clients was the most negative aspect. The researchers also stressed the importance of supervision and formal support. When talking about further research they asked for more research on
specific coping strategies and personal traits combined with working with trauma. They also saw a need of research focused on the administrative staff, who in this team worked closely with the clients and were the first to hear the clients’ stories.

Research carried out by Stevens and Higgins (2002) showed no connection between trauma symptoms and coping strategies. Schauben and Frazier (1995) found the opposite in their research; positive coping strategies were related to a lower level of PTSD symptoms. Stevens and Higgins (2002) mentioned some methodological limitations connected to their research; the sample was small and self-selected which had implications on the generalisation and the level of statistical power. Way, VanDeusen, Martin, Applegate and Jandle (2004) ask for further research that investigates specific coping strategies that may prevent the effect of the clients’ traumas on the professional helper. They also make inquires about qualitative research that could help exploring what the most difficult and stressful aspects of trauma work can be for clinicians.

Beaton and Murphy (1995) (in Collins & Long, 2003a) found a positive correlation between Secondary Traumatic Stress reactions and being new at work, working long hours, having large caseloads and the client contact being increased. Way, VanDeusen, Martin, Applegate and Jandle (2004) compared clinicians who treated survivors of sexual abuse and clinicians who treated sexual offenders. The study revealed that professionals who had recently started to work with sexually abused clients showed more signs of being affected. The study showed no association between the use of organisational supports and lower effects of working with trauma. The researchers acknowledged the possibility that some critical variables, which they do not explain, were not taken into account when conducting the study. In contrast to Beaton’s and Murphy’s (1995) and Way’s, VanDeusen’s, Martin’s, Applegate’s and Jandle’s (2004) findings stands the research of Woodward Meyers and Cornille (2002). Their study included 205 professionals working in child protection service. The professionals filled in questionnaires and were interviewed to find the prevalence of Secondary Traumatic Stress. Woodward Meyers and Cornille (2002) found that professionals seemed more affected the longer they had worked in the field. Those working more than 40 hours a week also showed more symptoms, especially anxiety and depression. There was, however, no difference in the prevalence of symptoms in those who had many cases a month than those who had few. According to this research it seems like it is the time spent with the work that changes the professionals more than the actual number of cases.

Steed and Bicknell (2001) conducted research where they found that there was no statistically significant correlation between how long the therapist had
worked and symptoms of Secondary Traumatic Stress. They did however see a difference when just looking at the mean values, where new therapists were at most risk for showing symptoms of avoidance. Therapists working between two and four years were at least risk for showing any kind of symptoms. Collins and Long (2003a) refer to research carried out by Rudolph, Stamm and Stamm (1997) who claim that Secondary Traumatic Stress reactions may appear to anyone who works with traumatised clients regardless of gender, age or level of training.

Pearlman and MacIlan (1995) found that trauma therapists who had recently started their jobs and did not get any supervision experienced a high degree of bad feelings. Another research carried out in 1993 by Pearlman found that the most common way for 85% of trauma workers in their study to deal with the effects of working with traumatised clients was to talk to their co-workers about it (Trippany, White Kess & Wilcoxon, 2004). Cunningham (1999) claims that helpers sometimes tend to grab the first available colleague they meet and use her/him as a tool to release their own anxiety after having met a client. She views the scheduled support as a much better way for trauma workers to talk about their thoughts.

**Trauma history.** Stevens and Higgins (2002) argued that according to certain research (carried out by Follette et al., 1994; Kassam-Adams, 1995; Little & Hamby, 1996; Pearlman & MacIlan, 1995) the therapists who reported having a personal history of trauma were more likely to show trauma symptoms and experience distress in the future, while the likelihood for experiencing Burnout in the future did not increase. In their own research they found that childhood experiences of abuse among 44 professionals who work with maltreated children predicted trauma symptoms but did not correlate with Burnout.

According to Pearlman and Saakvitne (1995) research has shown that therapists with a reported personal history of trauma seem to have more difficulties with handling their clients’ history of trauma and seem to be at greater risk of developing Vicarious Traumatization. In their research carried out in 1995 Pearlman and MacIlan found that the trauma worker’s personal history of trauma was such a powerful variable that they separated the people with personal trauma history from those without into two subgroups. The therapists who had reported experiences of personal trauma expressed more schematic disorders and a higher level of general stress than the ones that had not reported a personal trauma history. Schauben and Frazier (1995), on the contrary, found no correlation between the counsellors’ personal trauma history and PTSD symptoms, Vicarious Traumatization or psychological distress.
Cunningham (2003) found a positive correlation between clinicians working with sexually abused clients and the occurrence of a history of sexual abuse of their own, while a history of sexual abuse correlated negatively with clinicians working with clients suffering from cancer. She argued that other studies have presented rates of a sexual abuse history among clinicians working with sexually abused clients ranging from 19 percent to 83 percent. Cunningham (2003) explained that her research had a number of limitations, such as that the clinicians self-reported the data that the study is built upon and the difficulty of capturing the character of exposure. Cunningham (2003) pointed out that clinicians’ history of trauma and the influence the work with traumatised clients has on them is a field for further investigations.

**Satisfaction for the professional helper.** Zimering, Munroe and Bird Gulliver (2003) argued that clinical work with trauma clients can be very rewarding and improve the helper’s compassion and ability to grow personally. Collins and Long (2003a) pointed out that there are many therapists who seem to maintain their well-being while working with trauma clients and they appear to have protective mechanisms. They said that some of the protective mechanisms can be feelings of control, commitment and good social support and that these mechanisms also can be associated with the professionals themselves having fewer psychological problems. Stamm (2002) questioned the negative focus in the field of working with trauma. He argued that there is an important part of Compassion Satisfaction where people are glad to help. He pointed out that there is an important consideration to make about trauma and that is that many people are exposed to traumatic experiences but few develop PTSD. Stamm (2002) asserted that there can be resilience in people which might be easily forgotten. He has developed a test to measure Compassion Satisfaction as well as Compassion Fatigue. This test is relatively new and more research is being done. Stamm argued that satisfaction is a help to endure more Fatigue or Burnout symptoms. If, however, a person is exhausted and does not have the capacity or power to influence the work, the satisfaction may not protect against the process of Burnout.

In research carried out in South Africa the focus was to investigate the relation between sense of coherence and Secondary Traumatic Stress in counsellors (Ortlepp & Friedman, 2001). The findings showed that there was a statistically significant inverse relationship between sense of coherence, measured on Antonovsky’s OLQ (Orientation to Life Questionnaire), and Secondary Traumatic Stress, measured on the Compassion Satisfaction/Fatigue scale. The researchers also found that twenty-six percent of the variance in the score of the Compassion Satisfaction subscale could be attributed to the subscales of meaningfulness and comprehensibility in the OLQ, thus indicating that if a counsellor finds the job meaningful, the feeling of satisfaction is greater. The
authors could not say whether sense of coherence played a specific role in developing Secondary Traumatic Stress or not. They rather stressed the point that sense of coherence was an overall tendency to how people reacted to life events. Therefore they saw their research as confirming the position that personality can play a vital role in the development of Secondary Traumatic Stress. Hafkenscheid (2005) also came to the conclusion that it was the personal attributes of the therapist working with trauma clients that to a high level decided how much the therapist was influenced by her/his client’s trauma.

Stamm (2002) told of his experience when spending time in South Africa doing research. There he found that people who professionally were helping others were more focused on celebrating hope than denying the hard parts of life.

**Methodology**

*The sample.* A theoretical sampling (Mason, 1996; Silverman, 2005; Warren, 2002) has been used in this research. Mason (2002, p.124) points out that a theoretical sampling, in its more general form, means: “selecting groups or categories to study on the basis of their relevance to your research questions, your theoretical position. Theoretical sampling is concerned with constructing a sample which is meaningful theoretically and empirically, because it builds in certain characteristics or criteria which help to develop and test your theory or your argument”. To be meaningful theoretically and to increase the empirical knowledge about working with sexually abused children, the sample had to contribute to the previous theories and research on the subject. Mostly the theories and research talk about professionals working specifically with trauma. Our interest lies in the possible change that the professional helpers might experience when assessing and treating sexually abused children. Through an open approach, the purpose was to learn more about the professionals’ experiences of their work with the children without restricting the question to trauma. Since most previous research is of western origin our wish was to contribute to the understanding of the possible effect on the professional helper by getting a sample from another culture. We searched for a clinic handling sexual abuse cases in South Africa, since the statistics in the country show a high occurrence of child abuse and there is a vast experience of handling these cases.

To be able to find professionals, four NGOs (Non Governmental Organisations) were contacted. The regional office in South Africa of Save the Children Sweden gave us information about a certain clinic. This clinic was initiated in the 1980’s. The clinic has a head office and satellite sites. Some of them are placed within other organisations, e.g., the court. The sites are all situated in
urban areas. The clinic provides both medical and short term counselling services to children where there is a suspicion of sexual abuse and the children’s families. The children have various ethnic backgrounds. There is also a court preparation programme where the child and family can get help to prepare themselves for a coming trial.

The manager of the clinic was contacted by mail. (S)he received a written document explaining the purpose and ethical considerations of the study. The ethical considerations assured that the researchers were from the University of Linköping, and followed the ethical guidelines described by the Swedish Research Council (HSFR, 2002). Before we arrived the manager had informed the professionals working at the clinic about our visit. There were 20 professionals plus volunteers working at the clinic. The sample consisted of twelve of these 20 professionals. The professional groups represented in the sample are; doctors, psychologists, auxiliary staff, administrators and social workers. They worked with the children in different ways and came from all of the sites. The sample is thought to be representative of the clinic in that the different kinds of professions working at the clinic are included in the sample, as are the different sites of the clinic. The interviewees have worked within the field of child abuse for between three and twenty years, the median being five years. The professionals come from different ethnic groups. All have university education within the areas of psychology, medicine, social work and education.

**Interviews.** This study has its focus on subjective experience and in trying to find the essence in that experience, following the example of Kvale (1996) and Marks and Yardley (2004). A qualitative methodology and the use of a semi-structured interview was chosen in order to achieve a deeper understanding of the circumstances under which these specific professionals work.

In order to construct an interview guide for the semi-structured interview, theories on the topic were read. This is according to the research process described by Kvale (1996) where the first step is to find previous theory and research. A pilot-interview was performed with one of the professionals working at a clinic for alleged abused children in Sweden. This interview, and the comments from the professional, gave further information on how to formulate the questions in the interview guide.

The interview guide consisted of four open-ended questions with specific follow-up questions (Appendix 1). The four open-ended questions represent four areas of interest; background information, the work place, the work with clients and the effect of the work. The specific follow-up questions contain “what”- “when” and “how”-questions. According to the ideas of Kruuse (1998), the interviewer has the freedom to change the sequence of questions, follow up
answers that need further exploration or improvise questions due to the specific informant’s previous telling. When the interviewer has worked out the structure beforehand it is possible to avoid collecting information that is not necessary for the specific study (Ryen, 2004). An interview guide also ensures that the informants are asked the same questions to start with, which in this study means that the four open-ended questions were always asked in the interviews. At the same time this kind of interview allows for openness in the interview situation (Kvale, 1996).

The interviewees were provided by the manager of the clinic. Even though they were asked to participate by her/him once, they were asked again by us when a time for the interview was booked with each one. The interviews were then conducted at the clinic under informed consent. The respondent was always asked to give her/his consent to tape-record the interview and all approved. The interviewees were asked to sign an agreement that allowed the information to be used in the research (Appendix 2). The paper also informed them about how the interviews would be used in the study, to ensure confidentiality and how the tapes would be kept at the University of Linköping according to the Swedish Research Council (HSFR, 2002). Before the interview began, the interviewee was verbally informed about the purpose of the study and the possibility to end the interview at any time.

Twelve interviews were carried out during July and August 2005. We conducted six interviews each. The total time per interview ranged from 30 minutes to 1 hour and 35 minutes, median being 49 minutes. The interviews were tape-recorded to maintain the opportunity to go back to data in its original form. At the same time tape-recording the interviews meant that the one who did not conduct the interview still had the opportunity to listen to the full interview. In a few cases there were discussions with the respondents after the tape-recorder was off. This information did however not concern the research and was therefore not considered in the analysis. The information that was lost in the audio recording and the transcripts, such as interpreted emotions or body language, was written down directly after the interview. This was done in order to prevent losing the information, which Poland (2002) says can easily happen, since that information is not recorded in audio. The purpose was to help in the analysis, since it helps to remind the researcher of the context (Trost, 1995). When the first two interviews were done at the clinic, we listened through these together with the intention to conduct the rest of the interviews as similarly as possible. The interviews were conducted in English, even though it is our second language and maybe a second language for some of the respondents too. However the use of an interpreter could have created other problems. An interpreter had to be completely fluent in both English and Swedish and this was hard to find in South Africa; besides, the researchers and the interviewees were
quite fluent in English. The respondents were also accustomed to using English in their everyday life.

Warren (2002) points out that the interviewer’s roots and background will influence the interview and are therefore important to acknowledge. She means that this is especially important when it comes to interviewing in a different culture. The interviews were carried out in South Africa, which means that there is a cultural difference to relate to. This cultural difference could possibly mean that some of the concepts and words used in the questions might contain a different meaning for us than for the interviewees. This was important to consider during the interview and we asked the interviewee as soon as we did not understand words or situations they told us about. The interviewees sometimes asked us to clarify concepts, which we did.

Transcription. The interviews were transcribed verbatim and the system used for transcribing focused on the content of the interviews and not how it was said. According to Poland (2002) the transcription process can alter the research since it is necessary to make decisions, for instance when setting sentences or when the quality of the recording makes it difficult to hear. At times when the recording was too blurry and there were difficulties hearing what was said on the tape, a specific symbol was used to mark the amount of words that we were unable to hear. When uncertain of hearing a specific word, a guess was still written down and marked as a guess. The purpose of this was to try to maintain the meaning in the interview and at the same time ensure that no conclusions were built on uncertain information. The few passages where an uncertain word had a crucial meaning were not included in the analysis.

Analysis. The analysis is based on the information on the tapes. The transcripts were used to be able to search for themes in the interviews. The method of analysis in this study is inspired by Kvale (1996). He explains that the aim is to search the data for common or unique themes that can capture the professional’s perspective. Joffe and Yardley (2004) define a theme as: “… a specific pattern found in the data in which one is interested.”(p.57). The themes can refer to contents of the data that is explicitly observed as well as to contents on a latent level. Joffe and Yardley (2004) write: “Thematic analysis often draw on both types of theme, and even when the manifest theme is the focus, the aim is to understand the latent meaning of the manifest themes observable within the data, which requires interpretation.” (p.57). Meaning that the coding of data is not only based on the exact word, but also on the meaning of the word.

Marks and Yardley (2004) imply that bracketing, when the researcher puts her/himself aside to get an objective view of the subject of research, is neither easy nor required. Instead the researcher should reflect on her/his own
perspective since this will influence the interpretation of the data. As Kvale (1996, p.35) puts it, “The interviewer and the subject act in relation to each other and reciprocally influence each other”. Our intention has been to become aware of our own background and reflect on the possible influence it may have had on the interview situation and thus the analysis. An inductive approach was held in the analysis and there was no deliberate intention of using previous theory to find themes. The intention was, as much as possible, to let the data speak for itself. Joffe and Yardley (2004) imply that an inductive approach still requires that the researcher is familiar with existing theories since these are often the starting point. They mean that there is no point in “reinventing the wheel”.

At first the data was sorted according to the interview-guide. The first interview was independently divided into the four areas by both of us and after that compared with the other’s work. The second interview was done in the same way. Some parts of the interviews did not fit into the four areas and therefore a fifth area, containing the remaining information, was created. The fifth area contains information about South Africa and the culture or answers given to the informants after opening up for their questions. Joffe and Yardley (2004) present the inter-rater reliability method as a primarily quantitative method, and mean that it is rarely used in the thematic analysis. It can be argued that it merely trains two persons to look at the text in the same way. There is, however, a value of using this method in thematic analysis since it can make the researcher’s interpretation of the data more explicit and precise. In this study the interviews were coded separately by the two researchers, and then compared with each other. There was a point in having to explain themes and discussing differences, and thus making the themes more explicit. The two interviews were to a high extent sorted in the same way by the two of us. When the dividing varied we had a discussion and a decision in consensus was made in how to view this text. After the two initial interviews the remaining ten were independently sorted by both of us and then compared at one time.

After dividing the contents of the interviews in five areas, each area was read through several times to find themes. The example of Joffe and Yardley (2004) was followed, where the initial step is to search for themes on a low level, close to the text. New themes that were very close to the data were noted. The next step was to link themes together and fuse themes together into new more overall themes. Themes that originated from one area of the interview-guide were connected to similar themes in other areas. The procedure of linking and fusing themes together was repeated five times. The first two times it was done independently and then compared, the same procedure as when sorting according to the interview-guide. The last three times it was done together.
In the process of analysis Joffe and Yardley (2004) and Widerberg (2002) talk about being close to the data to see the specific context and being distant to the data to see the greater pattern. They claim that there has to be a movement between these levels. When linking and fusing themes the aim was to find a greater pattern but still keep the specific. When themes had emerged we counted how many interviewees mentioned the same theme. Some themes were more frequent and comprehensive and some more specific and in some cases even deviant from the comprehensive ones. The differences were seen, as Kvale (1996) says, as an opportunity to learn more about different nuances and depths of the themes asked about. The differences were also seen as a way to strengthen the validity of the research. Silverman claims that to ensure validity it is important to present findings that “are genuinely based on critical investigation of all their data” (Silverman, 2005, p.211). One way to do this is by including deviant cases in the analysis (Marks & Yardley, 2004; Silverman, 2005). In this study deviant cases are included.

In the result excerpts are used to illustrate the specific themes and have been selected from all the interviews, ranging from five quotations to eleven quotations per interview. The median amount of excerpts taken from an interview is six. The excerpts are adjusted to written language. When an excerpt is shortened, in order to make it easier to read, ellipsis dots are used as a symbol. Words that are written in brackets are included by us to clarify the context of the excerpt. When Xs are used it is as a symbol of names. Since all of the interviewees work at the same clinic there is an ethical reason in trying to avoid recognition. Changes were made to ensure confidentiality such as using synonyms for words that were seen as obvious and thought to be easier to connect to a specific interviewee. In the result relatively short quotations are used to make it harder for anyone to connect one specific excerpt to a specific interviewee. For the same reason there is no number attached to a specific interviewee. If there were, it might be easier to get an idea of which interviewee says what just through connecting the different excerpts together. The words "she" and "he" are replaced with (s)he.

Results

The analysis of the interviews resulted in five overall categories. These are: The work with children; Pressures at work; Motivation for doing the job; Influences on a personal level and Coping strategies. These categories are based on several specific themes.
The work with children
The clinic is a NGO (Non Governmental Organisation) and is organised as a “spider”, with a centre and satellite branches. Staff at the clinic represent different professions, different backgrounds, different languages and different geographical areas. The interviewees’ work with the children differs from seeing the child only a couple of times examining if the child has been abused and if possible, to identify who the perpetrator is, to continuing to see the child for another three to five sessions and continuing to help the child cope with the abuse. Some of the interviewees meet the child a couple of times to prepare her/him for the coming trial.

Cooperation with other organisations. All of the interviewees talk about the clinic’s need to cooperate with other organisations. They mention that cooperation could be with court, the CPU (Child Protection Unit, part of the police), the Social Welfare, other NGOs, the schools or educational system. They give several reasons for the importance of cooperation. One is that the clients can come from other organisations. To a large extent they come from the CPU, but also from Social Welfare. Another reason is that the clinic cannot give all the support that the child needs and therefore they sometimes need to refer a child to another organisation.

“We see ourselves as a piece of a puzzle, to assist the child in healing”. (Ex.1)

Eleven of the interviewees talk about the importance of being able to refer the child to another organisation. The reasons mentioned for referrals are the convenience for the family or if the clinic cannot give the client what (s)he needs. For example if the family travels a long distance to the clinic or if there is a need for longer therapeutic contacts with children or parents, or statutory welfare work. Six of the interviewees talk about the cooperation with other organisations as something positive and say that there is strength in being able to work together regarding a child and to be able to support each other with understanding the child from different specialities. However five interviewees express difficulties when cooperating with other organisations. Three interviewees talk about feeling frustrated. This feeling originates when other organisations fail to do their part of the work or when the interviewee can see that people from another organisation behave in a bad manner.

“Someone (at the CPU) won’t return your call, you phone, and phone but they won't return it. They will come when they need a report. Because the case is going to court and they come today and want a report. The case is going to court next week, they come and say “I want my report, I referred a child.” That inspector did not keep track with you to know whether the family did come or not.” (Ex.2)
“And then in terms of the welfare it’s, it depends on them, maybe the person who’s responsible for the case. You know like, you might respond properly and do the investigation quicker at times they’ll say “No we’ve got high work load and maybe we’ll see your client after some weeks, maybe six weeks”. Then when you do the follow-up nothing has happened, and so those things really make you unmotivated. At the end of the day it’s like if you can go and do it yourself it will be much better.” (Ex.3)

One of the interviewees explains that it is important that (s)he does not cross the boundaries of what (s)he is supposed to help the child with. If (s)he obtains knowledge about certain things happening to one of her/his clients at home, (s)he can refer to the Child Protection Unit. It is not her/his job to visit the child’s home but to make sure that someone else does. (S)he comments on the guilt (s)he would feel if (s)he neglected a case and did not refer.

“How are you going to feel tomorrow if the child has told you something about what is happening at home but you ignored to take it further?” (Ex.4)

When asked how to deal with cooperation on a everyday level, three of the interviewees say that they use whoever is on call in that organisation on that specific day, whereas three say that they find specific persons in the organisation that they cooperate with. In the latter case they will seek that specific person to get a personal contact, and even see it as part of the cooperation to find good people inside organisations to use the next time. These interviewees mention that the personal relationship across organisation borders is important. Four of the interviewees say that the relationships with other organisations is fine and that the specific work focusing on how to cooperate is important and seems to have paid off in that the collaboration is becoming easier.

Another aspect of cooperation with other organisations is that many of the satellite clinics are placed within other organisations, such as the court. Five of the interviewees describe their work as varying since they sometimes work in different branches and have different roles. One interviewee, who works in court, describes the positive side of working in an environment where (s)he can develop new sides of her/his professional role besides the therapeutic.

**Team work.** When talking about the work done at the clinic, all of the interviewees mention the fact that the team is central to the work. There are team conferences where the case is discussed and a plan for action is decided on. Six of the interviewees talk about the necessity of being able to refer clients to each other in the team. They describe the importance of referring cases to other members of staff when special competence is needed or when there is a problem with language. Three of the interviewees stress the importance that the teamwork is functioning and describe how hard it can be when there are conflicts or glitches.
“Most of the time we do work as a team. Sometimes you get people who slack off and then what happens is that it makes you extremely angry because you feel you must be working as a team. But you need to remind yourself that people don’t always have to be performing superbly all the time.” (Ex.5)

All the interviewees talk about their colleagues as important to their work. Two interviewees say that there is immense respect between colleagues for the work that they do.

“I’ve got a great respect for my colleagues here. I sometimes look at people and think “You’re so smart, you could actually have been rich right now.”” (Ex.6)

Two of the interviewees talk about the necessity among colleagues of seeing each other as individuals and not only as working professionals. However this seems to be difficult and one interviewee says that there is no time to talk about anything other than work. Two interviewees talk about the positive aspect of having parties at work. They say that the parties help when it comes to seeing each other as people; at the parties there is an opportunity for different sides of the person to be seen, not only the professional side.

“When you are working as colleagues you mustn’t always see each other as professionals. Sometimes you must have a picnic. It’s not nice to always wear those serious faces. You need to dance together or push each other into the water sometimes. Get to know each other on a different level. Not only knowing each other as a psychologist or a social worker.” (Ex.7)

“This environment does not encourage easy talk around the coffee table or a fun discussion about last night’s episode on whatever programme. Whenever there is a conversation it’s always about the necessities of a case. I would say in 90 percent of conversations here there’s a sense of urgency. And of being “I need this” rather than “how are you doing?” (Ex.8)

**Rapport-building.** Ten of the interviewees explain that they have to establish a rapport with the child to be able to get the child to talk to them about what has happened and to help the child to cope with the abuse. They say that when the child comes to see them the first time the child is often nervous and tense. In order to build the relationship they use different methods such as playing, painting and asking the child questions that are non-threatening and interesting for the child to talk about. All of the interviewees describe that they have to be flexible and open in approaching the child. Half of the interviewees describe the importance of explaining to the children the reason why they are there and what the helper’s role is. They talk about comforting the child in order to enable her/him to tell her/his story. They all agree that one of the most important things is to make the child understand that what has happened is not her/his fault and that they are not judging the child.
“...through the various techniques that’s used one hopes to get a disclosure from a child or consistency in what they’re saying.” (Ex.9)

“...the focus is on relationship building to ease their anxieties, to ensure and to make them understand that they’re not here because they’ve done something wrong... Obviously the victims come here feeling stigmatised, feeling ashamed and are portioning a lot of blame unto themselves and we need to take that away from them.” (Ex.10)

“You tell them that this is not your fault, you didn’t ask for it. You let them know that at least somebody is not judging them. There is somebody who is willing to listen to them and support them.” (Ex.11)

One of the respondents talks about the importance of always being alert to what the child is saying and doing in the client contact. Missing one thing in the child’s story can mean that (s)he might send the wrong person to jail. One of them emphasises the reality of the situation. The fact that it does not matter whether a person is rich or poor, or what background a person may have when it comes to being abused. Everyone who has been sexually abused faces the risk of contracting HIV.

“My work really teaches you about real life situations. There are things that we do, those things are real. And when you are doing those kind of things you must always be attentive because there is no way in which you can say I am practising with a child. What we do is real life. There is nothing like here is experiment on xxx, there is nothing like that... You’ll see people from all walks of life, the rich and the poor. That some things affect both. Like HIV sometimes, because we are working with sexually abused children, it doesn’t matter that you come from a good family or bad, all children that are abused can get AIDS.” (Ex.12)

Ten respondents emphasise the ability to find the right approach for every child to make the child feel secure. One of them says that they need to consider what is in the best interest of the specific child and that seeing the child always has to be in focus. Two of them talk specifically about trust and the challenge of getting the child to actually trust them, when it is the child’s trust that has been abused.

“Trust is a huge issue because that’s the thing that’s been broken...Some children take longer than others, depending on the age and what’s happened to them. Each child is unique so you have to treat them as the individuals they are.” (Ex.13)

A man points out the positive aspects of being a male in an environment where most of the helpers are females.

“I think I’m in a unique position being a male, I mean this field has very few males that actually work within the sexual abuse field. That puts me in a unique position to give the child a different experience and a different model from what they have had.” (Ex.14)
Another man addresses the complex situation when a girl comes to see him for the first time. She does not know what to expect and he wants her to be able to feel secure. None of the interviewees has any experience of situations where the rapport-building has been impossible. Three of the respondents say that at times it can be more difficult but that they always have managed to create working alliances with the children.

“She comes and she sits here and I close the door. And what’s going on in her mind? How do you make her feel at home? To feel at ease so she is able to tell you what happened. You know, it’s quite difficult.” (Ex.15)

One of the interviewees express that the workers are free to do their job in the way that is suitable for them as individuals. This is experienced as positive.

“I think we are given a certain amount of freedom to work our way which is in the best interest of the children. We all have different styles and that is fine.” (Ex.16)

Three of the interviewees stress the importance of understanding the child holistically. They say that they must not let the abuse determine who the child is as a person. One of them mentions that one of the tasks is to help the child understand that (s)he is not just a child who has been abused, (s)he is a person with many capacities. Two of them talk about how they want to normalise the situation of being abused and explain to the child that (s)he is not alone in experiencing this and that it is okay to feel the way (s)he does. A positive view of the children’s abilities to handle the abuse is expressed by three of the interviewees. One of them says that a great deal of what determines a successful meeting between the child and the helper is just to give the children space to talk about whatever is on their mind and to show the child that (s)he is accepted the way (s)he is.

“... I look at how they subjectively experience the abuse rather than the content of the abuse, and then pick out the themes and the issues. But a whole lot of other issues get raised and then I look at those, you know. So to focus solely on the abuse is to make that person’s identity almost determined by the abuse. So I look at their whole life rather.” (Ex.17)

“You have to stand up for children and make things better for them. I wouldn’t do it if there wasn’t a potential positive outcome for children. We are part of the healing process. To help them to get over the hurt and carry on with life, that’s positive.” (Ex.18)

**Special cases touch you more.** Eleven of the interviewees say that some cases stay in their mind for a longer time than other cases do. The twelfth respondent explains that when (s)he started to work at the clinic it happened that (s)he became over-involved in cases but that does not happen any longer. Even though their overall feeling is that they manage to keep the involvement in the cases at a, for them, desirable level most of the time there are cases that they
regard as harder to deal with. Often the way they describe it is that they bring these cases with them home in their minds. One of the interviewees says that there are some cases that touch her/his heart in a special way.

“Sometimes I take the children home with me and then I know it’s affecting me.” (Ex.19)

One of the interviewees mentions that sometimes (s)he find her-/himself in a situation where (s)he is close to crossing the line between, what (s)he considers, an appropriate level of involvement and over involvement due to the emotional engagement in the specific case. According to two of the interviewees the severity of the case and their own emotional involvement is not necessarily related. It is rather how the relationship between them and the client evolves that determines the involvement. Another one says that it gets harder to keep the emotional involvement on, considered by her/him, an appropriate level when (s)he experiences that there has been a total lack of protection of the child. The feeling of wanting to protect the clients is voiced by two of the interviewees. Two of the interviewees mention that it is especially hard when they can actually see that the child has been physically abused. One of the interviewees mentions that (s)he struggles when it comes to cases where the child’s trust in a closely related adult has been abused.

“There are a few cases that do get under the skin.” (Ex.20)

“There will always be one or two cases that you will get emotionally involved with even though you try not to.” (Ex.21)

“I don't care anymore was it a rape, was it a sodom...sometimes when you just meet the people and almost become aware of this person as a conscious being. This little person was raped...” (Ex.22)

Relating to parents. The contact that the interviewees have with the client’s family is spoken of in different terms. One of the interviewees expresses that (s)he is encouraged in her/his work when (s)he sees how the child’s parents engage in helping their child. Five of the respondents mention the issue of parents who fail in their responsibility towards their child and the anger and frustration that this may create in the interviewees. Two interviewees experience that a negative side of work is connected to events and situations that obstruct the effort of helping the children who come to the clinic.

“I think things that are negative with our work are that people... will not come in for their appointments or they’ll phone in saying that “You know what, I'm not coming on the xxx”. Or people coming in on the wrong day. So it feels like you did not do your work.” (Ex.23)

Five of the respondents mention the role they play for the parents of the children who have been abused. There are two sides of this; one side is that it feels good
to be able to support the parents; the other side is the problem that can occur when the parents cling on to the interviewees even after the case is closed.

“It’s like we empower both parent and children. You know when something has happened to you, you tend to lose trust.” (Ex.24)

“Then obviously you’ve got to be careful, you know we’ve got to be very careful with our boundaries. We’ve got to, because some parents get very dependant on us, so we’ve got to draw the line... Yes we provide support but to an extent. Then they know that once the case is finished, then they need to move on. They need to leave us and move on.” (Ex.25)

One of the respondents expresses that in the beginning (s)he had a wish of wanting to protect the clients’ parents:

“And sometimes you just need to be alone and think of that parent that you saw. How are they coping? You feel like you want to go and be with them, protect them you know.” (Ex.26)

**Pressures at work**
The interviewees describe their work as containing some negative aspects. The most commonly mentioned are connected to workload or systemic issues, such as economy and organisation. They also mention that there is a limit to how much pressure they can take and how this can affect their work.

**Workload.** Four of the respondents mention that a negative aspect of their work is that it never seems to end; there are new cases of children where sexual abuse is suspected coming in every day.

“Negative about my work? That there is so much of it! ... what people do to children.... you just think what’s it all about?... what are people about? It just seems to accelerate.” (Ex.27)

Two of the interviewees mention the difficulty in taking leave. One of them says that it is hard because no one will come in and continue work while (s)he is gone. The work will not proceed, and coming back to work after a vacation, will only mean that the workload is even heavier. Three of the interviewees say that the work is hard to plan, since they work with crisis. It is therefore difficult to predict the workload in advance because it can change very quickly. Two of the interviewees talk about taking work home to be able to manage the workload that they have. Two other interviewees say that they rather come in early and leave late from the office. Four of them talk about the workload being so heavy that the hours at work are not enough. Other consequences of this workload are that the time for a break during the working day can be difficult to fit in to the schedule. One interviewee mentions that lunch is often skipped, or taken in a rush.
"I’m going to have that lunch hour but then somebody phones and there’s a crisis you have to deal with, or the police phone and they need a report urgently the next day or whatever it might be. So you always have to prioritize the urgent stuff. ... It’s actually an exception to have a lunch hour." (Ex.28)

Two of the interviewees mention the fact that they have many cases open at the same time. Even though they do not work actively with all of them they still cannot close them because they are waiting for answers from other professionals in other organisations or in their own organisation.

Organisational factors. Four of the interviewees say that it is a reality for them to work under the pressure of fund raising. They describe the frustration over lack of money and having to fight for money. Other NGOs are described as good companions but one interviewee also talks about the fights that can emerge when competing over the same funds.

“The impression I have is we do a good job, just leave us the money so that we can do our job. I don’t want to constantly be fighting for money to prove our worth.” (Ex.29)

One interviewee says that the negative part of the job lies in the system. The government is an important source of funds, but then the clinic is obligated to fulfil special priorities. One of the interviewees says that as long as the government considers the work with children and sexual abuse as important, which (s)he claims that they do at the present time, it will be easier for the organisation to raise funds. (S)he expresses a worry about a change in the government’s priorities that can come suddenly.

“I think that it’s really a great field to work in but a lot of the stress has come from the system and fighting the system, rather than the actual abuse. I think what’s important to remember is that there is a big system, a political system where child abuse is very high in the country’s priority lists. But there’s a constant shift in priorities and funds.” (Ex.30)

One of the interviewees explains that at the branch where (s)he works she finds the communication between the working people and the management to be unsatisfactory. (S)he says that this is affecting the work with their clients because the professionals are not always getting the equipment they need for helping the children.

“Well, they (the management) don’t follow through on certain things, you know. Ah, if you are trying to have a play therapy room and there is not enough equipment and all of the paint brushes are gone, or you know, basic. There are simple things like that. Then you can’t do your work properly. If you ask for X, Y and Z and you don’t get it, you just get frustrated. If things are supposed to be in place… and then they’re not and then the burden falls on us.” (Ex.31)
Pressures exceeding capacity. Four of the interviewees say that there is a limit to how much they can handle when it comes to pressures at work. To name what can happen they use words such as Burnout, Compassion Fatigue, Secondary Traumatization or break-down. They explain that this can happen when a person has reached her/his limits of capacities and exceeds them. They say that breaking down is negative not only for your health but also for your career.

“Because when you are working there, sometimes you can end up having a lot of stress, burnout, and then you can end up not coming to work. If I have a lot of stress, having lot of medical certificates, then they can say you are not fit for the job. And if you have done such a lot and you cannot handle the situation it means that the whole carrier is done.” (Ex.32)

Four of the interviewees say that they have been close to the limit themselves and that they have taken a leave to be able to come back again. For three of the respondents a break down happened just before a leave and the interviewees used that leave to gather strength to return.

“I think if it doesn’t affect you then there’s something wrong, but, it’s inevitable that it’s going to affect you. And then you get to a point where you break down, it’s enough is enough, and you can only take so much. You know, it could be one case that will trigger it off, where you actually can’t cope anymore. That’s when our supervisor sends us on leave or tells us to get away from the situation for a while.” (Ex.33)

For one of the interviewees this experience was very recent. It was only a couple of weeks since (s)he felt (s)he had reached the limit.

“..like if you had interviewed me two weeks ago you would have seen a totally different person. Because I’ve just had a week off. I took a weeks leave because I was really there, almost just feeling at the end, no energy left”. (Ex.34)

Motivation for doing the job
The interviewees talk about how they came to work at the clinic and what has helped them to stay. One interviewee talks about the negative fact of not being able to receive a good salary. (S)he connects this to the low level of all salaries within this specific profession in South Africa. Three other interviewees say that the staff working at the clinic can see values of their work that are not connected to salary. All of the interviewees mention why they work at the clinic, and this is connected to affection for children, making a difference or personal growth.

Practical experience. Five of the interviewees started out as volunteers at the clinic. Volunteers do a lot of the in-take work, meaning that they are the first who meet the child and the care givers, taking information that can be the basis for the decision on how to proceed with the investigation. The main reason for four of the interviewees who started as volunteers is that they wanted to get
practical experience related to their University studies. Their motivation for
taking the voluntary job is not only described as a wish for practical experience
but also as a longing to do something that feels worthwhile and contributes to
society.

“I had an interest in working for the community” (Ex.35).

**Affection for children.** Seven of the interviewees talk about how
affectionately they feel about children. They are prepared to do their very utmost
to help every child who comes through their doors.

“You can work very hard to make the clinic a nice place for children to come to.” (Ex.36)

For half of the interviewees the love of children, or the interest in children, is
expressed as a major reason for taking the job. Five of the interviewees use the
specific word *passion* when they talk about the work that they are doing at the
clinic.

“I work here because I love children and I’ve got that passion for children” (Ex.37)

**Making a difference.** Nine of the interviewees reveal that they want to make
a difference. Some talk about wanting to change the way society deals with the
question of abused children and some talk about making a difference for the
specific children they meet. Two of the interviewees use the picture of a fighter
when talking about themselves as workers.

“The fact that we are able to help the children. Not necessarily the fact that we get verdicts,
which would be very nice if we did. Obviously it’s nice when we do get our verdicts, but you
know what if we don’t it’s really, it’s not the end of the world for us. The biggest challenge is
making children able to testify in court... if you can get your four year old to get in there and
testify it’s a huge accomplishment. That’s definitely one of the positives with my work. And
obviously just knowing that you helped the child in some way.” (Ex.38)

“The work almost turns you into a fighter for the rights of children.” (Ex.39)

Two of the respondents give voice to the connection between experienced anger
and frustration, due to the work they are doing, and the ability to transform this
into energy to make a difference in society. One of them says that instead of just
becoming angry about the things (s)he experiences at work (s)he uses that anger
to promote changes in society.

“We heal ourselves by actually going out and doing something positive about negative
things.” (Ex.40)
Five of the interviewees express that they feel responsible for the outcome of their work with the children. Half of the interviewees talk about valuing their work in the light of the fact that the problem with children being sexually abused in South Africa is such a huge problem. One of the respondents give voice to the frustration that the little they can do is not enough. Another one addresses the helplessness that (s)he may experience due to the strong wish to be able to help a child, but knowing that it is beyond the interviewees control to do anything about the specific matter. Another interviewee expresses how her/his way of dealing with this has changed over the years towards a more accepting understanding of her/his own capability. Five of the interviewees point out that even the small changes in the direction towards making a difference is encouraging and that every child that has been helped counts.

“You almost feel that the little you can do is not enough. Because there are so many people, so many children that are being hurt.” (Ex.41)

“I’ve stopped trying to save the world.” (Ex.42)

“Even if you can’t save the whole world, if you out of 100 save one it makes a difference.” (Ex.43)

Half of the interviewees talk about receiving feedback on the work that they have done with the children. They say that sometimes it is the children themselves who verbally or nonverbally express that they have received help and other times it is the parents of the children who communicate how the child's situation proceeds. The interviewees say that they do not always get this feedback, three say that they do not get it often at all while one says it is quite often (s)he gets feedback on the work that (s)he is doing. When they get it they all say it means a lot to them.

“The things that you get, maybe from one child or from one family, makes it so much more worthwhile. A parent coming back to say the things have improved, it’s like a miracle.” (Ex.44)

For one of the respondents the feedback does not only create positive feelings but also a feeling of concern.

“Sometimes you get feedback, people phone and say thank you, that really made a huge difference in our lives. I think: I hope it stays like that.” (Ex.45)

Another motivational factor is the feeling of meaning that three of the interviewees talk about. They explain that the work they are doing is meaningful, both directly by making the situation for the abused child better and indirectly by giving themselves a meaning of life.
“I’m hoping it’s making a difference in their life and in return it makes me feel better about my life, making my life meaningful.” (Ex.46)

**Personal growth.** Two of the interviewees say that the work is helping them to grow as people. They explain that the job is not only about helping but that another aspect of the job is that it can be developing for them as individuals.

“... more about you develop your skills you know, and you also develop as a person because you have to interact with other persons. You’re not only focusing on the children. The other thing that it is important is to see children smiling, you know, being happy. That makes a positive impact too, like there is a difference. At least these children now they can smile in spite of whatever has happened to them. So that, you know, keeps me going.” (Ex.47)

One of the interviewees explains that even though the job carries a lot of stressful events the positive aspects will be more predominant at the end of the day.

“I think if I made a list of the positive things and a list of the negative things I think the negative things would be a longer list, but I think the positive things would have to be more weight.” (Ex.48)

Four of the interviewees raise the question about how long they think they will continue to work with sexually abused children. One of them says that (s)he is glad to be working within this organisation but if it got to the stage where (s)he would suffer from working there (s)he would leave. Another one says (s)he does not think (s)he will continue to do this work for a long time. (S)he explains that (s)he has done her share of this work.

“... to actually leave this field, I think I could do it, but whether I’d be very happy in life I don’t know. I really, really don’t. But I also don’t know at this moment whether a person is meant to stay within this field for their whole life.” (Ex.49)

**Influences on a personal level**

All of the interviewees talk about changes concerning their own person that they have experienced when working at the clinic. Some of them mention these as ways of how they know they are being affected and need help. Others just state that it is a part of the job to feel like this.

**Physical well-being.** When talking about changes connected to work five of the interviewees mention physical symptoms that they have felt themselves and view to be a result of their job. Two of the interviewees say that they think physical illness can be a possible outcome of their job and that some of them actually have become physically sick at some time.

“I think sometimes it makes you physically sick, I really do.” (Ex.50)
Some of the symptoms mentioned are tiredness, having headaches and tension and having trouble sleeping; both with falling asleep but also being disturbed by nightmares.

**Emotional changes.** Eleven of the interviewees describe how their emotions change due to work. Seven of them talk about feeling anger. They feel anger towards the system, society, the perpetrator and the parents’ lack of caretaking.

“If it’s clearly a mother that’s allowing her boyfriend to do this to her child, I get very angry. You know, it is a real anger. Sometimes against society that has just such a neglect of children. So you certainly get anger against people occasionally. And not always anger against the offender, the offender is a criminal. But with other people who should actually have stopped it from happening, I get more angry with. Because if the child hadn’t been left it wouldn’t have happened.” (Ex.51)

One interviewee describes anger as a help in coping with the difficult aspects in the job.

“You know I get absolutely furious. I think that’s my way of dealing with it really, so that I don’t sit and cry every time. I just get annoyed, I get angry. It’s a better way of dealing with it, if you ask me.” (Ex.52)

One interviewee mentions feeling guilt when living in the kind of society that cannot prevent child abuse.

“I feel guilty on behalf of the society I live in that we’ve got homes with children who are not being protected and that we allow this.” (Ex.53)

One interviewee describes that (s)he, during a specific period of time, was afraid that (s)he would not be able to manage work and all the people that (s)he was going to meet.

Five of the interviewees talk about a changed emotional level, and that they can see how they are much more serious now than before. When asked how the attitudes to life have changed one interviewee says that:

“I think one becomes more intense, more serious about life. It takes the fun element out of life.” (Ex.54)

One of the respondents explains that the work with abused children has also made her/him aware of the struggles that poor people in the country deal with.
“…what they are going through also frustrates me. That people have to live in those conditions and then you’ve got other people living, in each condition. And I think this work definitely has a big effect in a number of areas.” (Ex.55)

Four other interviewees describe how they have become lower in spirit and feel sadder. They say that they have started to view life as much more difficult and troublesome. Two of them even talk about feeling depressed.

“You know, my friend said to me; “You know you’re so serious and you don’t laugh as you used to.”... But I feel like the rest of the world seems to think the world is a nice place. And I don’t. And I think that might be from working here. Just there is sort of deep down a sense of sadness and then you think “Oh why am I feeling sad?” There’s nothing with my life that is actually wrong.” (Ex.56)

**Influences on the family.** Six of the interviewees talk about how work can have an effect on their family. Sometimes, they say, they think about specific cases at home but sometimes it is just the feeling of being tired or having a bad day. Six of the interviewees say that after having a hard day the consequence can be that they take it out on their family when they get home. They explain that they can become grumpy or angry, that they might have a short temper or that they are tired. One interviewee describes it as the work poisoning the family.

“I get home very exhausted emotionally and don’t always have the high level of energy to interact with them (the family) the way I would like to or should be interacting with them. Because I usually after a hard day, after having seen rape victims and having heard those horrendous experiences and exposed to vicarious trauma, I sometimes I don’t want to talk I don’t want to hear. I’ve heard too much that I have little to say or just want to hear... I just want to sit... and just not want to actually say one word to anybody.” (Ex.57)

“If you don’t deal with something that really affects, you might see that overflow into your own home. When you are arriving home you are so cheeky towards your family members because you’re cross because of this and that.” (Ex.58)

“I think that those things are very plain, that people put things on you and you don’t always know what to do with that. If you take that, and you take it home and you take it wherever you go, you’re going to poison other people and then give it to other people. So I think that you need to be aware of those things. You need to be aware of your own reactions to those things. Otherwise they really have the power to poison.” (Ex.59)

One interviewee mentions that when (s)he started to work at the clinic (s)he had a problem with intimacy towards her/his spouse and that (s)he viewed this as related to taking over her/his client’s problem.

"Everything is fine now because I can separate the client’s case and myself. “This is not my problem; it’s the problem of the client”. Which is very important.” (Ex.60)
**Social life.** Six of the interviewees talk about the influence that work has on their social life as mostly negative. Four of the interviewees say that they are too tired to engage in any form of social life, and that they rather spend time at home. One interviewee indicates that not wanting to go out has more to do with having long days at work than the actual effect of work.

Four of the interviewees talk about social interaction with others outside work as something that could be negative, or at least not restful. They describe how people they met at parties have reacted in different ways when the interviewees introduced themselves and what field they work in. Some people became interested and asked questions, others did not want to hear of their work and yet some wanted help with private situations. One of the interviewees described a social gathering where this happened and (s)he was not happy to find her/himself back in a work role, as this was on private time.

“The minute someone else knows what you do, then everybody’s got a problem. So you keep getting pushed back into a work role, and nobody sees the other sides of your personality.” (Ex.61)

The four interviewees who talk about this phenomenon mention some ways to deal with it. One way is not to mention what they do for a living. Another way to deal with it is to stay home instead of going out to meet new people. In either situation they talk about work as a problem in interaction with new people and that it can lead to a feeling of isolation.

Two of the interviewees describe the problem of talking about work at social gatherings. They say that this influenced their social life, both in that people did not want to talk to them, but also in that they acted out on people, shouting and screaming. They explain that a more constructive way to handle this is to tell these stories in debriefing or supervision.

**Worldview.** Six of the interviewees talk about how their view of the world has changed in that they no longer see the world as a good place to live. They have too much information about what is happening. One interviewee says that when (s)he thinks about all that (s)he hears during one day her/his reaction is:

“Is that possible, what I’ve just heard today?! Is that possible in this world?” (Ex.62)

When answering the question of how their job has affected their trust in other people eight of the interviewees say that their trust in others has changed. One interviewee says that (s)he wants to keep the faith in humankind, but to trust another person is hard. Four of the interviewees do not mention a change in trust. Instead they talk about it as becoming more protective of children in
general. They also describe an increased awareness of abuse happening everywhere and to everyone and that there is no safe place and no one whom you can trust totally. Three of the interviewees talk about how abuse happens within a trusting relationship and how this alters their view of trust.

“Because the way the abuse has happened. At times even people that they trust, they still do it.” (Ex.63)

When talking about their change in trust three of the interviewees say that they are not willing to give up on trust and stop trusting. They talk about how they actively have to try to trust people to be able to handle life.

“Every person is capable of anything. You cannot trust a person completely. But at the same time you must learn to trust other people. You cannot live alone.” (Ex.64)

Four of the interviewees mention that you must be active in creating meaning and a good life. They say that life is not only work and that there has to be an awareness that life goes on irrespective of the horrible things that happen in society.

“So at the end of the day life has to go and continue.” (Ex.65)

One interviewee expresses concern about the issue of trust when thinking about her/his own family.

“And you wonder if ever you are going to live a normal life with your family. Are they going to trust me.” (Ex.66)

All of the interviewees talk about how the relationship to children they know personally has changed. It can be their children, grand children or someone else’s children close to them. They describe that they worry about the children and that they have a great need to protect them. They connect this worry to work. They explain that they want to know where their children are, what they are doing and who they spend time with. They also talk about teaching them more about the dangers in life, to be careful when talking to strangers and about healthy touching. One interviewee explains how (s)he talks about it with close friends saying:

“Don’t do this, don’t watch that, don’t go there” and I talk about good touching, bad touching, good secrets, bad subjects, all those kind of things you know.” (Ex.67)

Eight of the interviewees mention that one reason to why they become protective is that they have more knowledge about what can happen to children. They also talk about being protective as something positive. It helps children
close to them and also makes adults more aware of hazards in society. One of the interviewees claims that the awareness of potential dangers in society has slowly increased and that people nowadays are more protective of children. Three of the interviewees point out that it is important not to become overprotective. They say that being overprotective is not good, as that can harm the child more than help it. Two of the interviewees claim that an overprotected child may be limited and not get the chance to learn how to deal with problems on its own.

“Being overprotective is not a good thing. Once you’re overprotective you won’t even allow your child to go and play with others. There will be some limitations in terms of interactions and so on. So you don’t have to be overprotective but you have to be protective.” (Ex.68)

Another aspect that three of the interviewees point out when talking about children is a concern regarding having children on their own. They talk about not wanting to have children on their own or about wanting to have children although they are concerned about how they will react as parents.

Coping strategies
Three of the interviewees say that when they started to work at the clinic they did not know if they would be able to continue. They struggled with the stories of abuse that they constantly heard from their clients and were not sure if they would be able to manage this in the long run. One of them says that it took some time to get used to hearing the stories of the clients. Despite the struggle they stayed on working at the clinic. They mention that they have learnt to cope with the work.

“The first year I was emotionally exhausted. I was thinking I can’t do this.” (Ex.69)

“I’ve learnt to be stronger. I saw another side of me. I never thought I’d be that strong.” (Ex.70)

Two of the interviewees talk about being the right person for the job. They talk in terms of either you are a person who can cope with this job or you are not. They mean that there is an opportunity for learning how to deal with the job but that some people might not be able to learn this. The people who cannot learn how to cope with the job are the kind of people who will never know how to do it. One of the respondents points out that, because of the draining work this is, a person should not be too young when starting to work within the field of sexually abused children. Another one of them speaks about the voluntary period as a testing time where the person finds out if they can do the job or not.

"I think this is a good opportunity especially for volunteers to come in and to see whether this is what they can do or what they can’t do. But I mean 90 % of the volunteers are all studying
this field anyway, so. But I mean it’s all very well studying it in theory, but putting it into practice is completely different. So, I think it’s just a good thing to, to test to see whether you can or you can’t cope with it.” (Ex.71)

All of the interviewees mention a variety of support given to them at the clinic. Supervision can be given by the management and take place on a regular basis. Debriefing can be given by management and colleagues and can be regularly or spontaneously arranged. There is also unstructured support between colleagues. It is possible to receive external debriefing or supervision. The interviewees also talk about support from family and friends. Some mention specific activities that they carry out on their spare-time and that help them endure work. All of the interviewees talk about the importance to separate their work from themselves as people, to be able to handle the work.

Support at work. When talking about the atmosphere at work six of the interviewees express it as supportive and positive. The support given by colleagues is something that six of the interviewees express as positive. Three of the interviewees working in satellite branches also talk about the positive atmosphere at the head office and that the people there are easy to get hold of and get support from. Three of the interviewees say that a part of the informal support can take place at the formal team conference where staff can talk about their reactions to a specific case. Two of the interviewees also describe the informal support between colleagues as being able to get hold of someone when questions arise or when there is a need to talk.

“We often would debrief with each other we use each other for support... If I see a client or if my colleague sees a client she would just come in to my office and do a quick debrief. Or we would exchange and ask for support or advice.” (Ex.72)

However one interviewee talks about a possible downside of the informal support between colleagues and that it could affect workers negatively.

“Sometimes you would prefer they didn’t tell you... Some of the stories are so terrible and I think, you know what, I don’t need that in my head.” (Ex.73)

Two of the interviewees say that it is the debriefing and supervision that helps them through hard times. One interviewee talks about supervision and debriefing as vital, especially when (s)he feels that (s)he gets emotionally involved in a case. There are six interviewees that talk about the spontaneous formal debriefing or supervision as helpful. One interviewee talks about the importance of being able to ask for formal debriefing whenever it is needed, because they never know when it will be needed. They say that something can happen suddenly that they need to talk about.
“We don’t have a specific time. It’s something irregular because you never know when that thing strikes. You’ll never know. Now I can be ok but when I arrive in the office I can call xxx. “There is something that is bothering me.” It’s not something that is time framed; it’s something that we just leave open.” (Ex.74)

Three interviewees working in management do not talk about support in the same way as the others do. Instead they talk about the difficulty with debriefing and also mention the complexity in having to take care of staffs’ reactions. Mostly they talk about this in a stressful manner according to time. There is no time for their own debriefing and they have to be willing to un-plan their day for unknown events. Three of the interviewees working with management describe that they experience difficulties in approaching staff members on a lower hierarchical level if they need support. One of them describes that it is difficult since staff members do not have the same information about the cases as (s)he has. Instead they contact someone above them in the hierarchy or outside the clinic.

Four of the interviewees explain that they do not have debriefing or supervision. One explanation to why, is that there is no time for it. These interviewees also talk about how the work affects them. Four of the interviewees talk about the clinic as helpful in arranging debriefing or supervision and say that it is possible to receive if needed. On the other hand if you do not ask for it, it will not happen.

Another form of organised support is the in-service training that occurs frequently and the workplace meetings every month. Five of the interviewees talk about the clinic as very open to education and learning and that they feel encouraged to join in-service training, seminars and conferences organised by the clinic. Six of the interviewees talk about education or research that they do outside the clinic. They explain that there is openness, at the clinic, for development of skills and education.

“There is always a room for development, even for yourself. If you say “you know I want to do this management course” or whatever, there’s no limit. They say, ”Ok, you want to do this course? Let’s see the budget. Ok, why do you want to do it? Give your reasons.” So there’s always a room for development.” (Ex.75)

Seven interviewees talk about the clinic’s openness to staff taking leave. There are organised breaks, for example when the clinic closes in December. But they also say that the clinic encourages staff to take regular leave and if needed shorter spontaneous leave. One interviewee points out that the clinic is more generous with leave than other organisations. Even between colleagues there is an understanding of taking leave and two of the interviewees talk about how
they encourage each other to take leave. Taking a leave is seen by eight of the interviewees as the best way of coping with the tough side of the job.

**Support outside work.** Four of the interviewees mention family as providing important support for them. One interviewee says that (s)he has a stabile family and that helps her/him handle the work. Two of the interviewees talk about their spouses as being especially supportive, since they have an understanding of the work they do. It can be that the spouses have the same kind of education or work in a similar field.

“I can say I’m lucky because my partner understands the kind of job that I’m doing... you need support from home. Because my partner is from this field also... So (s)he does understand some of the things.” (Ex.76)

Two of the interviewees talk about their close friends as helping them to manage work. They say that spending time with close friends and doing things together with them helps them to take their mind off work. It seems like these friends know what their job is and they see them as people and not only as professionals.

**Separating work from personal life.** All the interviewees talk about the relationship between professional and personal life as a central theme. When the boundary between work and life outside work is blurry and things from work intrude on personal things, that’s when the respondents say work affects them. Ten of the interviewees talk about the importance of separating work and personal life, yet they describe the difficulty in doing so. They talk about it as important at work, to see each other as people and not only professionals, but also to be able to separate work from the rest of the life.

“I think the biggest thing is if you are able to separate work from personal, then you will be fine. And the biggest thing is if you start overlapping them, then there is no way that you’re going to cope in this. So you can’t take this kind of stuff home.” (Ex.77)

“People take their jobs very personally here. Whereas out in other jobs you’re just doing the job, you are getting a salary, you are getting a cheque at the end of the month... Whereas here people love their jobs. Sometimes I think it’s hard for people to separate their own sense of value, just as people, and their sense of value as people who work, doing this work. It’s almost stuck together, it’s one and the same thing. So we may struggle with the job and struggle personally as well. It’s more mixed. It’s not you and your job, you are your job in a lot of ways.” (Ex.78)

“Negative is that it becomes difficult to separate from one’s personal life. You know, it’s not always easy to separate it and switch off.” (Ex.79)
Two of the interviewees talk especially about putting up conscious boundaries to leave work at work. Things that are mentioned are using the door to the office or using some mark along the road home where they leave work behind and concentrate on other things. Two of the interviewees mention the difficulty of working within an area that can appear in the media and that the newspaper at home can become a reminder of the job.

One interviewee does not talk about the importance of separating work and personal life. This separation is seen as impossible and not necessarily wanted. (S)he does not mention any strategies or ways to deal with it. Rather (s)he tells of incorporating the work in life; finding information about it in spare time or finding her-/himself in a professional role looking out for children on spare time. The interviewee talks about the importance of taking care of the carer but says that (s)he does not know how to do so for her-/himself.

The interviewees do not describe how personal and professional get caught up together or what makes it happen. But some do talk about how they become aware of it. Two of them mention that they become aware when they notice that they are short tempered at home, or have difficulty in close relationships.

**Individual Strategies.** Ten of the interviewees express that they have different strategies to deal with tension caused by work. Four main strategies can be found: occupying your mind, relaxing, exercising and rewarding yourself.

A strategy which half of the interviewees talk about is to engage in things during spare time that take their thoughts away from work. One interviewee talks about the family as helping her/him to think about something else besides work. Two of the interviewees describe the positive feeling of doing something which, as a contrast to the work at the clinic, is well defined with a given goal. To do things that give them an immediate feeling of accomplishment is also a strategy that gives them something they do not often get at work. This could involve renovating an old car or playing computer games. Another thing mentioned as taking the mind off work is studying.

“If I’m at work, I’m just at work. You know I’m doing this. When I leave my office I forget about work. I’m telling myself that I’m going home, it’s not about work there, and decide that I don’t have to say anything in terms of work. You know whether I was angry during the day. And especially in terms of the clients because anyway you have to keep confidentiality. So I have to think about those things. When I go back home I have to focus on my family. So you keep yourself busy with the other things and forget about work, so that’s the best.” (Ex.80)

“The work in this field is very abstract, you know. Look at the impact of trauma to children... A lot of that is in the concept. ... It’s not one plus one is two.” (Ex.81)
Relaxing is a strategy that is used by five of the interviewees. This area covers a range from smoking and having a beer or a glass of wine after work, to taking a bath, listening to music or watching TV.

Exercising is used by four of the interviewees as a strategy to handle work pressure, for example to go for walks.

Using some of their spare time to do something for themselves is something that three of the interviewees mention that they do. This is a contrast to their job where rewards are seldom experienced. Some mentioned rewards are: going to a restaurant, shopping, going to the cinema or going away for the weekend.

“To reward yourself for things if the environment does not.” (Ex.82)

Another strategy mentioned by one interviewee is to let the hard emotions out by shouting to her-/himself in the car as a reaction to the bad traffic seen all around.

A strategy that is more connected to the working place is using humour, or black humour, together with co-workers. This is mentioned, by two of the interviewees, as one way to release a little bit of the tension.

“Sometimes when I find it gets kind of a bit much I use black humour. I mean, you have to do it some way or the other, so you can turn it around in to a black humour situation. And it takes away the tension and you can actually share that with someone… because you need an avenue to express it. And sometimes if you do it in a kind of funny way, you know, there are situations, and you do have the people that, I mean, laugh. You let off the steam.” (Ex.83)

In many of the interviews humour is expressed through comments and an ability to see the tragic-comic in different situations.

Discussion

Discussion of method
The purpose of this study was to explore more about how working with children where sexual abuse is suspected can affect helpers. By using interviews the aim was to come closer to the experience of the individual. The open questions used in the interviews helped with this and at the same time ensured that the interviewees were asked the same questions to start with. An important criticism, however, can be that when we asked about doing the interviews, we informed that we aimed to look at the possible effects that work might have on them. Even though this was not said explicitly to the interviewees, some of them
knew this from the information given to our contact within the clinic. This could have directed the interviews to have a more negative focus on how they experience work. In the interviews, however, we asked for the positive outcomes of the work as well.

Our contact person at the clinic was one of the twelve persons being interviewed. This might have influenced her/his interview in that (s)he had more information about the purpose of our study than the rest of the interviewees probably had. We considered not to use this interview but came to the conclusion that it was comparable with the other ones and it is therefore included.

Another aspect that could have influenced the interviews is that our contact person was also the manager at the clinic. This could have made the other interviewees feel more or less forced to take part in the interview, which in turn could have made them reluctant to speak freely in the interview situation. It could also have created an uncertainty leading to a resistance in mentioning things in the interviews that could be seen as compromising the manager etc. However our understanding is that the interviewees were quite open when sharing their experiences with us.

Two of the interviewees did not have a lot of time to set aside for their interview. Even though they had planned to set aside an hour for the interview, things came up in the last second and the hour was reduced to maybe 45 minutes or less. Three others did their interview in between dealing with important issues at work which could have influenced their capability to stay focused on our questions. Our overall impression, however, is that the interviewees found the issue of the interview important and they were interested in answering the questions. Some of the interviewees explicitly expressed that they found the research important.

The first interviews were conducted only a week after we landed in South Africa and the last interview was conducted the seventh week of our stay. There was no time to get to know the clinic before the interviewing started. Thus the first interviews contain more questions about how the clinic is organised and how they work, while the last interviews could focus more on the experience of work. The last interviews were also easier to carry out in English than the first ones. Conducting interviews in a language that is not our native tongue may have influenced the interviews in several ways. In the interviewing moment specific meanings of words can have been misunderstood or missed completely and thus lead to a loss in gathering accurate information. The interview being recorded enabled us to listen to the information several times and go back to special meanings or phrases that we did not grasp.
When doing interviews in a different culture the motivational aspect of the interview can become more important (Ryen 2002). The interviewees’ motivation depends on the different ways of communicating and this can influence how much the respondents want to share their thoughts. It can have shaped the relationship with the interviewees and sometimes have made it a bit strained. However, we were aware of this and did our best in the situation to be as relaxed as possible. Conducting interviews in another culture can also have lead to us missing important non-verbal signals. Ryen (2002) argues that the researcher needs to spend time in the specific culture, and have people to ask about certain issues of concern, to be able to increase the understanding of the specific context and thus be able to motivate the interviewees. In our case one of the researcher’s family members, who live in South Africa, and the contact person at the clinic informed us about the culture. We also spent more time in South Africa than required for the interviews to get a broader picture of the different cultures in the country.

We did not have the opportunity to get to know the interviewees and often the interview was the only time we met the interviewee. This could have influenced the results in that the interviewees did not want to open up to strangers and therefore did not tell us what they actually thought of. It could also influence the results in that the interviewee did not get a second chance to tell us something they came to think of after the interview. However, not knowing the interviewees can perhaps help them to feel more at ease when speaking freely, since they will not see us again. There is also an important issue in that all the interviewees were treated in the same way; we did not get to know some of them more than others, which we might have if we had spent more time at the clinic.

Our preconceptions, since we are students of clinical psychology in Sweden, might have influenced the analysis and interview situation. The South African culture seemed more violent than ours. In South Africa child abuse might not be the most dangerous issue for a child (Forsberg Langa, 2004b), whereas child abuse in Sweden is clinically valued as something potentially traumatic to a child (Svedin & Banck, 2002). In South Africa children fight against, for instance, starvation, violence and HIV, besides abuse. This was something that we became aware of during the interviews, and that showed that the difference in culture is important to consider when evaluating the results.

After conducting the first two interviews (one each) these were listened through together with the intention of carrying out the rest of the interviews as similarly as possible. This was thought to compensate, in a way, for not having the same researcher conducting all of the interviews. We are two different people and we did carry out our interviewees in slightly different ways. Since we both were
careful with sticking to the interview guide we anyhow found the interviews to turn out in a similar way. The analysis of the interviews was done independently in some of the steps. This was thought to help us find out if we were seeing the same themes in the material or not. The themes discovered were often the same for both of us which led us to believe that these could be a possibly accurate analysis of the material.

One of the interviewees said that if we had conducted the interview a couple of weeks earlier (s)he would have answered differently (Ex.34). In one way this can be seen as contributing negatively to the study’s consistency, the interviewee’s feelings about work change and are not easy to grasp. In another way this statement can be seen as making the study more consistent, since this interviewee has an awareness of how feelings fluctuate, and thus gives us that information. The study is also thought to answer the question in that specific moment, in that specific context and under certain considerations. We are aware that the results cannot be generalised.

Discussion of results

Management. The organisation that the professionals work in is a NGO. This fact seems to have a deep impact on the individuals in leading positions whilst it is not mentioned so much by the others (Ex.30). The people who work within management in this research seem to be more affected by their work than the people who do not work within management. They have more responsibility besides working with the children coming to the clinic. They also need to consider issues around staff and organisation.

The people working within management express that it is a reality for them to work under the pressure of fund raising. Because they are the ones with responsibility for fund raising they are also the ones who make sure that the organisation can continue its work (Ex.29). This seems to be a job that drains a lot of energy from them. Everyone in the organisation is depending on them to ensure help for abused children. Schauben and Frazier (1995) pointed out that reported difficulties in working with sexually abused adults could be organisational factors, such as lack of funding to be able to carry out the work. The management in our study does not only have the responsibility of the employees’ daily bread but they are also aware of the huge need that exists in the area to provide help for abused children. They are amongst the ones in the country who have the highest awareness of what is happening to thousands of children in South Africa when it comes to sexual abuse and they all seem to be passionate about what they are trying to do to help children. To lead an organisation like this and to have responsibility for the help provided as well as for the helpers could be considered a high work load in itself. These people,
working within management, have on top of that, the constant struggle of fund raising. If they raise no funds no work will be carried out.

**Predicting the effect of working with sexually abused children.** The professionals in our study have been working within the field of sexual abuse for between three and twenty years, with the majority having worked five years in the field. The previous research concerning working years and the effect it has on the helper is contradictory (Rudolph, Stamm and Stamm, 1997, in Collins and Long, 2003a; Steed and Bicknell, 2001). Since our study did not include any measurement of Secondary Traumatic Stress reactions we cannot compare our results to Steed’s and Bicknell’s (2001). Our findings seem to show that the professionals’ working years has little to do with how affected they are by their treatment of sexually abused children. Some of the professionals in our study talk about being more influenced in the first few years (Ex. 69). Maybe this could be because after the first few years they have developed coping strategies (Ex. 60, 70). Another reason could maybe be that support at work has helped them to manage. The most important factors for predicting the effect of working with the children on the professionals in our study seem to be if they are working within management, what kind of personality they have, if they have effective coping strategies and if they view their job as satisfactory.

The concept of “satisfaction” might involve several different aspects of work, for example the feeling of making a difference and the experience of working well together with colleagues (Ex.5, 6). Satisfaction can also involve a feeling of contentment with work and not feeling stressed or worried about things at work. Stamm (2002) claims that satisfaction is a help to endure more Fatigue or Burnout symptoms. Our study reveals clearly that there are positive outcomes for professionals treating possible victims of abuse. Most of the professionals say that they want to make a difference for the children and that they, to different extents, consider that they do make this difference (Ex. 38, 46). A couple of them also say that the work is developing for them as individuals (Ex.47). Ortlepp and Friedman (2001) see their research as confirming the position that personality can play a vital role in the development of Secondary Traumatic Stress; if a counsellor finds the job meaningful the feeling of satisfaction is greater.

Some of the professionals in our study say that a number of people can handle this work and others cannot (Ex. 32, 71). They seem to view the personal traits as important in determining who is fit for the job. For them the period of time that they have been working is irrelevant, besides that the first few years determine if you are fit for the job or not. Hafkensheid (2005) says that in his research personal attributes of the therapists determined how much the therapist was influenced by the trauma of the client. Since the research, on how personal
traits of the professional helper might determine how (s)he is affected by working with treatment of possibly traumatised clients, is incomplete this is a hypothesis that needs further research. Collins and Long (2003b) ask for more research on personal traits combined with working with potential trauma.

The professionals in our study communicate that after a few years, they know who can cope with the job or not. Maybe this could depend on the high amount of cases. The professionals have to manage numerous accounts of abuse during their initial time at the clinic, and those who cannot cope will not endure. One interesting thought that is derived from this, is that professional helpers working with sexually abused children in very demanding situations might have their ability to cope tested in a severe way. Without previous experience this might become too much for some people and they leave work. Can it be that the same people who would leave in a very demanding situation could endure longer in a less demanding situation but in turn show more signs of being affected?

**The effect of work.** All of the professionals seem to be influenced by their work. Four of them talk about how they have become lower in spirit and have started to feel sadder (Ex.54). A few of them talk about feeling depressed. Almost half of the respondents say that they have become more serious since they started to work at the clinic. More than half of the professionals say that the work has a negative effect on their social life and some of them describe how they have started to spend more time at home (Ex.61).

Half of the professionals describe that their worldview has changed while working at the clinic and that they no longer see the world as a good place in which to live (Ex.56, 62). Almost all of the professionals talk about how they have changed to be more protective of children (Ex.67, 68). Eight of the professionals say that their trust in other people has changed for the worse (Ex.65). To see the world in a negative way can be seen as a major cognitive shift (Figley, 1995; Pearlman & Saakvitne, 1995). In spite of this it does not seem like the helpers have turned cynical but rather, according to what Stamm (2002) saw in his research, that they have hope for the future. Some of the professionals are cynical about the culture and things surrounding work but none of them talk cynically about the children or the future of the children. There are also two of the professionals who say that they will not give up on trusting others and that they actively work on this issue (Ex.64). This active decision of not wanting to stop trusting is something that we have not seen mentioned in other research. Maybe this decision can be understood if viewing the South African helper as a “fighter”, living in a society where it is difficult to isolate themselves from crime and violence. It might take a conscious decision not to surrender to hopelessness and fear but to instead fight for hope. The picture of a fighter is mentioned by two of the professionals when talking about fighting to
help the children they meet (Ex.39). In our material the professionals talk about giving the child hope and about teaching them how to trust again.

Helplessness is a feeling that only one of the professionals talks about. In contrast to this stands Steed’s and Downing’s (1998) report where all the therapists in their research reported having experienced periods when they had felt severe helplessness. The fact that the professionals in our study did not talk about feeling helpless cannot be taken as a confirmation that they never have experienced this specific feeling, but it may point in that direction. If this tendency is true this is an interesting finding. South Africa is viewed to be a violent society (Barbarin, Richter & deWet, 2001; Hamber & Lewis, 1997; Landguiden, Sydafrika, 2003; UNICEF, 2006) where the abuse of and violence towards children seem to be increasing (Forsberg Langa, 2004b). This situation might create a feeling of helplessness among people living in the country. Working with the many abused children in this society might also create this feeling. If this does not seem to be the case with the professionals working with child sexual abuse in our study this can be an interesting field for further research. Maybe one reason why the professionals seem to have been able to avoid feeling helpless might be their ability to stay focused on the good that they are actually doing instead of what they have not done (Ex.42, 43).

There is, however, one of the professionals who gives voice to the frustration over how little they can do and that what they do is still not enough (Ex.41). Nonetheless this person seems to be getting on with her/his work in a similar way as the others do. This raises the question of how deep the frustration can be without having an effect on the professional’s performance when treating the child. If the situation the professionals are dealing with, which contains working in a context where the abuse of children does not seem to diminish, does not intrude too deeply on their emotions this might not influence the person negatively. If the knowledge about the children’s situation becomes too emotional it might be more difficult to endure in work. This might be seen as related to what Pearlman and Saakvitne (1995) describe, the therapist becoming numb to her/his own feelings or starting to intellectualise them in order to disguise disrupted capacities. However, this aspect was not visible in our study.

More than half of the professionals say that they feel anger. The anger is felt towards the system, society, the perpetrator and the parents’ lack in taking care of their child (Ex.51, 52). In our study reactions to anger described by the professionals are similar to Cunningham’s findings (1999). The overall tendency seems to be that there are more professionals who manage to channel their anger and frustration into trying to make a difference for the children. Two of the professionals explicitly say that this is what they do (Ex.40).
**Difficult aspects of work.** Difficult aspects of the work mentioned are the difficulty in taking leave due to the high number of cases (Ex.27), lack of funding and systemic issues (Ex.31) and when the cooperation with other organisations falters (Ex.2, 3) or cooperation with the parents of a child is not working (Ex.23, 25). Two of the professionals mention the importance of achieving the child’s trust but only one talks about this issue as problematic (Ex.10, 11, 13, 15). Schauben and Frazier (1995) found in their research that the most commonly reported difficulty for counsellors working with sexually abused clients was concerning the therapy, such as difficulty in maintaining boundaries and establishing trust. As mentioned above, the professionals in our study do not seem to consider these to be the major problems.

The professionals in our study talk about their amount of work as high and say that they do not have the time needed to finish it within working hours. One professional mentions that lunch is skipped often because of the amount of work that needs to be done (Ex.28). There are different solutions to this. Someone comes to work before (s)he actually starts in the morning and another one works at home when it is urgent to finish a case before a certain date but most of the professionals talk about trying to leave work at work. They seem to be aware of the importance of free time. Some of them say that they have made a conscious decision not to work over-time or to take work home with them (Ex.80). A decision like this might be a solution to enduring in this work. Our study shows that work might have the ability of “swallowing” the professionals.

Most of the males in our study gave their thoughts on the situation of being a male in a field where most of the clients are girls who have been sexually abused. One of them mentions the difficult side of that, whereas two of them do not seem to consider this a major factor when doing their job. One of the males even says that being a male puts him “in a unique position to give the child a different experience and a different model from what they have had” (Ex.14). None of the males mention feeling guilty for being a man, something that Cerney (1995) says might happen through Countertransference. Of course there is a possibility that the males could have feelings of guilt without telling us about it.

**Separating professional life from personal life.** Many of the professionals talk about the importance and difficulty in separating work from personal life. They talk about the effects of work that intrude on their personal lives and the need to find boundaries between personal life and professional life (Ex.77, 78). Work seems to have a way of getting under the skin of the professional and thus affecting her/him (Ex.79). Almost all of the professionals say that there are some children who touch them more and make it harder to forget about work when coming home (Ex.19, 20, 21, 22). The professionals talk about their families
being affected by their work. They say that sometimes they do not have any energy left for the family, or that they even act out on their family if they have had a bad day. Most of them say that they are aware of this and try to keep the boundary between work and family (Ex.57, 58, 59).

The professionals express the need to separate work and personal life, but at the same time they talk about the need to be seen as individuals at work and acknowledged for who they are as people and not just their professional role even when they are at work (Ex.7, 8). Maybe this can be caused by the overall wish that humans hold; to be seen as a special person and not just the role that one carries. It can be argued whether the aspect of the treatment of children might be the main reason for the professionals’ difficulties in separating the professional life from the personal or if the answer is more likely to be found in the professionals’ wish to be acknowledged for who they are, not just their professional role. One professional does not mention the need to separate work and personal life but on the contrary seems to combine them. According to this professional work is always around in some way; on the news or when meeting people. (S)he does not seem to be bothered the same way as the others by this fact.

The context that the professionals are living in is very violent (Hamber & Lewis, 1997, Humans Rights Watch, 2004, Landguiden, Sydafrika 2003, Robertson, 1998). The question is whether the influence that the professionals describe derives from working with sexually abused children or from the possible struggles that the professionals might be faced with in their everyday lives, such as the risk of being hi-jacked or robbed. If some of the professionals have been exposed to crime themselves this might influence the way they experience their meetings with children exposed to crime. In our research we did not ask the professionals about their own history of traumatically experienced incidents and therefore we cannot give an answer to the question, if there is a possible connection between the professionals’ own history of exposure to crime and their experience of their work.

**Prevention and support.** The professionals seem to be aware of the possible influence that their work might have on them. Most of them can also name specific activities or strategies that they consider help them to cope with work (Ex. 82, 83). When it comes to support by family and friends, the professionals talk about their family as being supportive (Ex.76). Previous research shows a contradictory picture when it comes to the connection between symptoms of treating clients who are traumatised and coping strategies (Schauben & Frazier, 1995). Our study does not contain any measurement of the professionals’ level of PTSD symptoms but shows that the professionals who express that they have coping strategies for dealing with the pressures of work seem to feel better than
the ones who do not have any explicit strategies.

The way that the professionals talk about the clinic gives a picture of the clinic as caring and understanding. There is an awareness of the need of support to help the professionals endure in the long run. Some of the professionals talk about debriefing or supervision as a help to become aware of how work affects them and to do something about it. Some professionals talk about taking leave as a way of coping with the job (Ex.33, 34). They also discuss that the clinic encourages development of skills and education (Ex.75). The overall picture is that the support provided by the work place is good, at the same time as some of them say that they do not have the time to take part in it. There are also two sides to the issue of taking leave. It is encouraged by the work place to take leave when it is needed but at the same time taking leave means that work is piling up and nobody is doing it until they get back. It does not seem as easy to use the support provided as it might look at first. The dedication and compassion that the professionals seem to have for the children can be seen as the key for their success in their work at the same time as this could be a possible snare.

The instant debriefing, whenever it is needed, seems to be a way that many of the professionals use to get rid of anxiety after having had a difficult meeting with a client (Ex.72, 74). Most of them seem to consider this a good way of getting support. There is, however, one of the professionals who says that (s)he finds it hard to constantly have to take part in all the tragic stories that other professionals are dealing with (Ex.73). (S)he thinks it is enough to deal with her own clients’ stories. Maybe it is not as unproblematic with this unstructured support as the picture tends to show. Cunningham (1999) views scheduled support as a better way for the trauma worker to disclose her/his thoughts. Some of the professionals in leading position talk about how they have to be able to un-plan their day for unknown events. This can be difficult to combine with scheduled support. Those who need a spontaneous debriefing seem to find it very positive, while those who give the debriefing or listen to the stories do not give the same positive view. A question is whether this can depend on those who give a debriefing not having the same access to debriefing for themselves, or if it can depend on their having to listen to and internalise the reactions of colleagues in addition to their own.

**Traumatised clients.** Our study did not contain any measurement regarding the question of sexually abused children being traumatised or not. In a research carried out in 2004 in Cape Town the prevalence of PTSD in a population of adolescents ages 16-18 was between 19-38 % depending on which scale that was used (Suliman, Kaminer, Seedat & Stein, 2005). The prevalence of experiencing an event of violence in these teenagers’ lives was over 90 %, meaning that 90 % had experienced an event that could be labelled as traumatic.
In a review article the rates of PTSD in South African children exposed to trauma vary from 9.2-22% (Suliman, Kaminer & Seedat, 2005). The authors indicate that the differences between studies are huge and therefore hard to compare. The differences lie in sample, assessment and how PTSD is diagnosed. What can be said is that the exposure to trauma in South African children is high, from 40-100% and that the level of PTSD is high. This can be compared to North American figures which, according to Hamblen (2005), show that girls had a 15-43% prevalence and boys a 14-43% prevalence of having experienced at least one traumatic event. Of the children and adolescents who had traumatic experiences there were 3 to 15% of the girls and 1-6% of the boys who could be diagnosed suffering from PTSD.

An interesting finding was made by Seedat, Nyamai, Njenga, Vythilingum and Stein (2004) when they compared adolescents living in Cape Town with adolescents living in Nairobi. The adolescents in Nairobi rated more exposure to trauma, more of them had witnessed violence, been physically hurt by a family member or been sexually assaulted. However the adolescents in Cape Town showed more signs of PTSD, 22% of them filled the criteria, compared to 5% of the adolescents in Nairobi. The authors have difficulty in explaining why the Kenyan sample shows a lesser rate of PTSD than the South African sample. One explanation they say, could be that the trauma is more violent in nature in South Africa, another explanation is that the questionnaires used are not culturally validated. Those adolescents that fulfilled the criteria for PTSD also reported more trauma on the checklist. Three kinds of trauma were more likely to be connected to PTSD. These were physical assault, serious accident and the highest connection was with sexual assault. Thus sexual assault led to PTSD to a higher degree than other traumas.

The South African research shows that roughly over 50% of adolescents who are exposed to something violent or traumatic do not show symptoms of PTSD. Even though children are exposed to traumatic events they might not become traumatised.

According to Munroe’s study in 1990 (Cunningham, 2003) the clinicians who reported PTSD-like symptoms themselves were those who worked with combat veterans who were diagnosed with PTSD. We do not know the prevalence of PTSD among children who come to the clinic in our study and therefore we cannot say anything about the likeliness of the helpers of being affected by the children’s PTSD. If the figures described by Suliman, Kaminer, Seedat & Stein, (2005) and Suliman, Kaminer & Seedat (2005) show a realistic picture, it might be likely that some of the children coming to the clinic in our study might have been diagnosed with PTSD, if tested. One important question to consider is
whether the diagnosis of the child can affect the professional helpers more than hearing the child’s story of abuse.

In this study the sexual abuse of the child is the reason for the child to come to the clinic. Even so the focus is not only on the sexual abuse. There can also be other serious problems that the child has and that are considered in treatment, for example HIV or poverty (Ex.12). The child gets help to one extent, but there lies an importance in helping the children grow by themselves. To see the child as strong and competent is mentioned by the professionals (Ex.40). The professionals also mention how they try to take the focus away from the abuse and see the child holistically (Ex.17). This may be understood as a way to counteract the widespread view in society, where the sexually abused child seems to be considered as a helpless victim. While the media may label the child as a victim the professionals at the clinic work hard to give back the child her/his whole personality.

**Conclusions**

The professionals who, besides working with the children, also work within management seem to be more negatively influenced by their work than the other professionals. It is not only the contact with the sexually abused children that contributes to the professional helper being negatively affected by their work; rather it seems to be the whole working situation, for example the heavy workload, difficulty in planning the day and lack of funds. The negative effect that the assessment and treatment of sexually abused children might have on the professional helper seems to be prevented or relieved by support at the working place. One aspect of working with assessment and treatment of sexually abused children seems to be that professional life and personal life become hard to separate and that value as a person is connected to value as a professional. Other effects of work seem to be a changed worldview and changed social interaction, losing trust in others and becoming more protective when it comes to children near to the professionals. Most of the professional helpers have explicit personal strategies for dealing with negative consequences that their work might have on them. These strategies seem to help them endure in their work with treating sexually abused children. To see the job as meaningful seems to help the professionals endure at work. Most of the professionals do not seem to be negatively influenced by their work to the extent of not being able to enjoy life. It seems like the personality of the professionals can contribute to how much they are affected by their work. The professionals who cannot cope with work leave the clinic.

**Suggestions for further research**

To continue to broaden and deepen the knowledge about how the professional helper is influenced by her/his work with sexually abused children there are
many possible issues for research. A quantitative research regarding the effect on the helpers working with sexually abused children in South Africa would make it possible to compare the results with other clinics and countries. Using a self rating questionnaire could be interesting to find out more about what we did not ask, for example if professionals have trouble sleeping, are grumpy at home, or do not have the capacity to engage clients at work. Such a questionnaire would ensure that all received the same questions, and the result would be easier to compare with others.

An interesting further research could continue to explore how the professional helper’s personality may influence the effect that work with abused children might have on her/him. This could be done by using a personality questionnaire and combining that with an interview on how the professional talks about work and if (s)he feels affected. It could also be of interest to find the professionals who have left their work with sexually abused children and learn more about them. Why did they find it hard to cope with work?

Another one could be to study how many alleged sexually abused children coming to a clinic could be diagnosed suffering from PTSD; and in relation to that, how many professional helpers would be diagnosed with PTSD too. Besides measuring the effect on the helper by using the diagnosis of PTSD, the Compassion Satisfaction/Fatigue scale by Stamm (2002) could be used to further learn how professionals are affected. An inventory for Burnout could also be used in order to explore if this concept lies closer to how professionals are influenced.

The question of the possible accumulative effect of treating sexually abused children could be explored by a longitudinal research on helpers in South Africa. This could be interesting due to the heavy workload that the professionals work with. Can it be that they do not endure as long as professionals in other less demanding situations?

A study focusing on the helper’s possible previous experiences of trauma and how they are affected by their work could shed some light on the cultural aspect of being a professional helper in South Africa. Since the culture can be seen as violent and traumatic experiences can happen to the professional outside work, an important question to further look into is whether the professional is influenced by work or by other incidents that happen outside work.
References


Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatised (pp. 150–177). New York: Brunner/Mazel.


The “virgin myth” and child rape in South Africa. (2002). Downloaded 18th of April, 2006 from [http://www.mrc.ac.za/publications/virgin.htm](http://www.mrc.ac.za/publications/virgin.htm)


INTERVIEW GUIDE

• Tell me why you started to work at this clinic?
  - How long have you been working here?
  - How long have you been working within this field?
  - What professional training do you have?

• Tell me about your working place?
  - How would you describe the atmosphere?
  - In order to manage your work, what support do you receive from your working place?
  - What importance do other organisations have for the work you are doing here?

• Tell me how you work with clients?
  - What do you do when you meet a new client?
  - What do you do to create a rapport with the client?
  - How do you cooperate with your fellow-workers regarding a client?
  - What do you experience as positive about your work?
  - What do you experience as negative about your work?

• Tell me if your work affects you?
  (If it does)
  Tell me how…
  - How does it affect your professional life?
  - How does it affect your close relationships?
  - How does it affect your spare time?
  - How does it affect your trust in other people?

Is there anything else you would like to tell me?

Is there anything you would like to ask me about?
Informed Consent

The information I give in the interview will be treated with confidentiality and will not be passed on to anyone who is not involved in this projects’ interest. According to the Swedish ethical regulations, the audiotapes from the interview have to be kept at the University of Linköping, after the thesis is completed. The thesis will be sent to the xxx Clinic in its final form. The data will be decoded so that the informants cannot be identified in the final thesis.

_____________________ (date)

Signature_________________________________________________________