‘It hurts to help’: Vicarious trauma in sensitive research and community projects in South Africa.

Simóne Plüg  
*Durban University of Technology*  
Anthony Collins  
*La Trobe University*

*Vicarious trauma* is a recognised issue in psychotherapeutic practice. There is growing literature exploring the necessity of recognising and managing the negative effects of vicarious trauma for both practitioners and clients alike. Less research, however, has explored the parallel experiences of researchers working on community-based projects dealing with emotionally challenging issues. This work can entail engaging with the life experiences of vulnerable groups and individuals who live with the traumatic impacts of both direct and structural violence. This is especially true in developing contexts such as South Africa, where gross inequality, poverty, violence and physical vulnerability are major problems, and the protective social infrastructure is both inadequate and unevenly accessible. This research aims to explore the risks researchers working on sensitive topics and/or in vulnerable communities experience. It maps the ways in which these experiences shift their engagement with the research material and participants they are working with, identifying the consequent risks of harm to both researchers and their participants. Furthermore, this research aims to highlight a need for more nuanced theory for teaching research methods and social engagement with vulnerable groups in community psychology, allowing researchers to be prepared for, and supported through, the complex ethical challenges of engagement with sensitive topics and vulnerable communities.

This paper draws on the experiences of several researchers, facilitators and support workers (hereafter referred to as researchers) working on community-based projects in South Africa, in order to explore a commonly-shared problem of traumatic exposure in this work. It is argued that there are three key ways in which these researchers encounter trauma in their work, namely: primary trauma, vicarious trauma (VT), and traumatic helplessness (stemming from an inability to fully protect project participants). This paper aims to highlight a critical and complex dialect in the nature of critical community intervention work - the tension between needing to create safe spaces for participants to explore and share their lived experiences; and the inherent risk of (re)traumatisation for all those involved in this process. More specifically, this paper maps the ways in which traumatic exposure shifts researchers’ engagement with the research material and participants they are working with, and identifies the consequent risks of harm to both researchers and their participants. It further highlights the complex ethical challenges of engagement with sensitive topics and vulnerable communities, and a need for more ethically refined conceptualisation of research methods in community psychology to ensure that researchers are prepared for, and supported through, emotionally risky engagement processes.

**Defining Vicarious Trauma**

Over two decades of research has made it abundantly clear that experiences of distress around traumatic events are by no means restricted to primary victims. VT refers to the stress reaction experienced by those who have not directly (personally) experienced a traumatic event, but have...
exposure to a traumatic incident through the accounts of others. “Bearing witness to an event, having to listen to explicit accounts of a traumatic event or even having explicit knowledge of an event have been shown to cause serious, prolonged anxiety in varying degrees” (Lerias & Byrne, 2003, p. 129). People suffering from VT have been indirectly exposed to a very threatening situation (or in this work, typically many situations) which has caused a shift in the way that they experience themselves and the world (Pearlman, & Mac Ian, 1995; Sui & Padmanabhanunni, 2016). This shift causes them to experience the world as an overwhelmingly harmful and dangerous place, and to experience others as threatening and untrustworthy (Schauben & Frazier, 1995). These effects appear to be “cumulative across time and helping relationships” (Pearlman, & Mac Ian, 1995, p. 558).

VT is related to a number of similar constructs including Secondary Traumatic Stress, Compassion Fatigue, and Burnout (Du Plessis, Visagie, & Mji, 2014; Hill, 2011; Lerias & Byrne, 2003). Although VT, itself, is not officially listed in the Diagnostic and Statistical Manual of Mental Disorders, the current edition (DSM-5, published in 2013) does include vicarious experiences of trauma, namely “learning that a relative or close friend was exposed to a trauma” or “indirect exposure to aversive details of the trauma, usually in the course of professional duties” (American Psychiatric Association, 2013), in the diagnostic criteria for Post-Traumatic Stress Disorder.

Vicarious Trauma beyond Psychotherapy: Outlining the Research Context

Vicarious Trauma is a commonly recognised experience of practising psychotherapists. There is a well-developed literature exploring the necessity of recognising and managing the negative effects of VT on practitioners and the resulting risks for clients (Brady, Guy, Poelstra & Brokaw, 1999; Dalenberg, 2000; Sui & Padmanabhanunni, 2016; Wastell, 2005). Yet the experience of VT is not limited to counsellors working with survivors of violence or catastrophic natural events. VT is a common experience of people working in social work (Goelitz, & Stewart-Kahn, 2013), palliative medicine (O’Mahony, Gerhart, Grosse, Abrams, & Levy, 2016), nursing homes (Mandiracioglu & Cam, 2006), hospice homes (Capretto, 2015; Sinclair & Hamill, 2007) and the police service (Carlier, Lamberts & Gersons, 2000; Leigh Wills, & Schuldberg, 2016), as well as amongst firefighters (Beaton, Murphy, Johnson, Pike, & Corneil, 1999; Sun, Hu, Yu, Jiang, & Lou, 2016), paramedics (Beaton, Murphy, Johnson, Pike, & Corneil, 1998), journalists (Pyevich, Newman, & Daleiden, 2003; Weidmann, Fehm, & Fydrich, 2008) and educators teaching on sensitive topics (Collins, 2013a). Relatively little research explores the parallel experiences of researchers working on community-based projects or with vulnerable communities.

For many social science researchers, data collection involves interviewing individuals or conducting focus group discussions, which includes talking to people about their lived experiences (Kvale, 1996). In South Africa where there is amongst the most extreme inequality in the world, and very high prevalence of poverty, violence and chronic illness (Atwoli et al., 2013; Demombynesa & Özl, 2005; Hunter, 2010; Klasen, 1997), these narratives are often extremely distressing. This is exacerbated by the need for research and community projects to address the most serious social problems and vulnerable communities. These factors create a high risk of VT for both researchers and those project participants engaged in collective activities and sharing of experiences.

More specifically, this paper stems from preliminary research which explores the experiences of ten social science researchers and community activists working on “sensitive topics” in the South African context. Non-probability, purposive and snowball sampling techniques (Neuman, 2011) were used to deliberately select individuals who were engaged in “high risk” research areas/community projects – in other
words, projects that asked people to share their experiences that, or discuss issues that, are emotionally distressing, extremely personal, or socially taboo (Dickson-Swift, James & Liamputtong, 2008). This is consistent with Lee and Renzetti’s (1993) definition of “sensitive research” which includes research which may be considered threatening by “intrud[ing] into the private sphere or delv[ing] into some deeply personal experience” or “where the research deals with things that are sacred to those being studied that they do not wish profaned” (Renzetti & Lee, 1993, p. 6).

Examples of some of the research or community-engagement projects that these participants were engaged in include the organisation of a large anti-rape and sexual violence awareness campaign, developing and implementing a training programme for lay counsellors dealing with intimate partner violence, and designing and facilitating university courses, discussion forums and support interventions relating to a range of vulnerability and forms of violence including sexual violence, xenophobia, homophobia and violence against children. In addition, the participants in this research personally identified the research process and/or activism as challenging, complex and/or overwhelming.

Data was collected using semi-structured individual interviews, conducted by the authors. Although none of the researchers’ participants were directly sampled in this study, many of the researchers discussed and actively reflected on concerns about how their research, or engagement more broadly, may have negatively affected their participants.

**Understanding the Symptoms of Vicarious Trauma**

Research suggests that the process of Vicarious Trauma is very similar to that of survivors who have experienced trauma directly (Pearlman & Mac Ian, 1995). This includes the experience of many of the symptoms specified within the criteria stipulated for Post-Traumatic Stress Disorder (Lerias & Byrne 2003; Sui & Padmanabhanunni, 2016). Herman (1992) offers a seminal clarification of these symptoms by conceptualizing PTSD as having three core symptom clusters: Intrusion, Constriction and Hyperarousal.

*Hyperarousal* refers to the cluster of symptoms that highlight a traumatised individual’s tendency to perpetually anticipate danger, or the state of permanent alertness in which these individuals remain, as a means of self-preservation. The main symptoms in this cluster involve intensified physiological arousal such as heightened startle responses, exaggerated irritability or aggressive responses to relatively minor provocations and hypervigilant scanning of one’s surroundings for signs of danger. In addition, hyperarousal tends to cause nightmares, lack of sleep, intense anxiety and psychosomatic complaints (Herman 1992).

Several researchers working on community-based projects spoke to a number of these different symptoms. One described how her nightly bedtime routine changed dramatically after she began her research. She could no longer go to sleep without repeatedly checking that all the doors were locked and windows were closed. She also reported persistent difficulty falling asleep, as she listened for footsteps or any possible sounds of threat, and waking consistently during the night due to frightening dreams. Another participant similarly described the onset of dramatically increased alertness and hypervigilance corresponding with her involvement in a community-based project. She recalled her fear of driving alone at night. When this was unavoidable she drove with an intense focus on her surroundings, often surveying them incessantly for possible approaching danger. Many of the researchers noted a considerably heightened sense of emotional agitation which was most often experienced as intense emotional responses such as anxiety, sadness, anger and irritability. Several identified the emergence of irritability and emotional outbursts in their intimate and family relationships. Additionally, experiences most commonly included physical complaints, constantly feeling ill, body pain and headaches and intense exhaustion. This included repeated
headaches after conducting focus groups, and overwhelming exhaustion after running support workshops.

The second cardinal cluster of symptoms that Herman (1992) identifies is called intrusion: “the indelible imprint of the traumatic moment” (Herman 1992: 35). Intrusion refers to the various different ways that traumatised individuals continue to relive or re-experience moments of terror from the past, as if they were recurring in present time. “The traumatic moment becomes encoded in an abnormal form of memory, which breaks spontaneously into consciousness” (Herman, 1992, p. 37).

People may experience this as flashbacks when they are awake, as terrifying nightmares when they are asleep, or through their actions in the form of re-enactments. Re-enactment refers to the process whereby trauma survivors “feel impelled to re-create the moment of terror, either in literal or in disguised form” (Herman, 1992, p. 39).

Returning traumatic memories are often triggered by seemingly innocuous cues in the individual’s environment. These intrusive memories are often accompanied by intense emotional distress, most commonly in the form of terror and rage, and as a result people make extreme efforts to defend themselves against this process.

Although this symptom cluster usually presents more intensely amongst those who have, themselves, been directly victimised, it is still common for those with VT to also re-experience aspects of the trauma. Most often, hearing explicit descriptions of the trauma seems to create mental visualizations which tend to be repeatedly triggered by reminders of the victims or events (Herman, 1992; Sui & Padmanabhanunni, 2016). Furthermore, when people deeply empathise with another’s experience, they are likely to develop similar emotional responses as the victim. One of the researchers recalled an example of re-enactment. She and her partner were having a minor disagreement at home and during their discussion, her partner touched her, gently, and she angered immediately, saying “Don’t you lay your hands on me!” with unnecessary hostility, repeating a traumatic narrative she had heard from her participants. Another researcher described her experiences of obsessively thinking about the stories she had been told, and continually replaying the scenarios in her mind. Several researchers also recalled experiencing trauma-related nightmares. Perhaps most notable, again, was the intensity of the emotional responses with which these all occurred (Wastell, 2005).

The final cardinal symptom cluster that Herman (1992) refers to is constriction. Constriction, commonly referred to as numbing, tends to be a direct response to the overwhelming emotions triggered by intrusion, where a person feels entirely powerless and, as a result, falls into a “state of surrender” (Herman, 1992. p. 42). In contrast to the intense fear and rage associated with intrusive symptoms, constriction includes an unusually detached sense of calm and/or profound passivity. “The helpless person escapes from her situation not by action in the real world but rather by altering her state of consciousness” (Herman, 1992, p. 42).

Although this altered state of consciousness, referred to as dissociation, can be an adaptive response during moments of danger, it severely hinders recovery once the individual is safe. Dissociative responses ensure that traumatic memories, and their associated emotions, are kept split or sealed off from conscious awareness, only appearing in painful splintered fragments (intrusive symptoms). This splitting denies the person the opportunity to understand, process and re-integrate the traumatic experience and also tends to impair an individual’s ability to experience a full range of human emotion and relationships, leaving them blunted and withdrawn. Furthermore, the “constrictive symptoms of the traumatic neurosis apply not only to thought, memory, and states of consciousness but also to the entire field of purposeful action and initiative” (Herman, 1992, p. 46). In other words, people with PTSD tend to restrict or confine their lives as a means of establishing a perceived degree of safety and control, and managing their persistent terror. This tends to include
avoiding all possible reminders of the trauma, intimacy, and previously enjoyable activities, and is often accompanied by social withdrawal and reduced interest in one’s future.

Constrictive symptoms were extremely common amongst researchers. Many reported withdrawal from loved ones, social activities and society in general. The woman who developed a fear of driving at night went to great lengths to avoid it. When she had no option, she began treating traffic lights as four way stops: she stopped only briefly, frantically checking for traffic, before hurriedly driving on. Another researcher recalls how she began avoiding the site where her interviews had taken place, saying she often chose to walk a considerably longer distance than to walk past those buildings. Other examples include no longer attending church, a reluctance to “look pretty” by a researcher who worked with sexual violence, and reduced enthusiasm and patience with spouses and children. A recurring theme of helplessness emerged in working with survivors and vulnerable groups, as a growing insight into, and empathy with, these situations was accompanied by loss of optimism in being able to provide effective support. This played out as emotional disconnection from the work, difficulty in completing projects, and/or a pervasive sense of despair.

Expanding Ethics in Social Science Research

Ethics in the social sciences tends to be strongly focused on not harming participants. In most research courses, students are taught at length about the well-developed conceptualisation of procedural and practical ethics aimed at upholding the rights of participants. This has historical roots in the medical sciences and the principle of not causing physical harm (*primum nil nocere*), and has subsequently been expanded in the social sciences to include avoiding emotional harm (Hugman, Pittaway & Bartolomei, 2011). Although procedural ethics, as established by the ethics committee and policies and principles they assert, are essential in all studies in order to protect the rights of all research participants, it can be argued that this focus is insufficient as it is too rigid and therefore does not always account for the vast array of experiences and situations that researchers will encounter once they commence research in the field (Guillemin & Gillam, 2004). This is particularly relevant in qualitative research, where the researcher is closely involved with research participants, and the participants themselves are regarded as an integral part of knowledge production (Willig, 2008).

One of the most challenging aspects of qualitative research is ensuring that one maintains a non-exploitative pattern of interaction with all participants while at the same time fulfilling the purpose and role of researcher (Guillemin & Gillam, 2004). In order to move beyond procedural ethics and produce critically ethical work, researchers need to acknowledge the ways in which theory, research and action can all be both emancipatory and oppressive in nature and, therefore, to actively adopt values, assumptions and practices which foster the liberatory effects of knowledge production (Prilleltensky & Nelson, 2002). Here the shift in emphasis is both away from simply avoiding harm and towards actively striving towards positive outcomes, and towards expanding the understanding of the kinds of harm that are possible. This is particularly relevant in a South African multicultural context. With a history of racial and gender based inequality and a severe disparity in economic wealth distribution, there is a broad scope for abuse of power and entrenchment of oppressive practices of which researchers need to be critically aware.

Guillemin and Gillam (2004) highlight that this requires competence in recognising ethical issues when they arise, as well as the ability to consider all the possible courses of action and respond most appropriately. This process is greatly facilitated by critical reflexivity. In other words, one of the most crucial elements of research which is pragmatically ethical involves paying great attention to one’s own role in the research process and critically reflecting on the process as a whole. Here Freire’s (1993)
work on “critical consciousness” is essential for understanding and managing the power imbalances (Straubhaar, 2015). For example, some of the researchers working with victim-survivors of intimate-partner violence came to realize that by simply asking questions about the context in which violence had occurred, they were re-victimising participants, as the received meaning of the questions was framed by the existing victim-blaming culture in which victim-survivors where implicitly or explicitly judged for remaining in potentially dangerous relationship, and/or have failed in their ‘feminine duty’ of de-escalating conflict. Even neutral questions were understood within this dominant system of persecutory meaning, and thus a combined socially critical and personally empathic style had to be adopted to prevent re-traumatising participants.

Despite this increasingly more nuanced and thoughtful consideration of ethics in qualitative work, some lingering problems need further attention. More specifically, in social science research methodology courses in South Africa, ways of protecting oneself as a researcher are often insufficiently covered or simply overlooked altogether. While attention may be given to the physical safety of the researcher, emotional vulnerability in the research process tends to be overlooked. There is also inconsistency and great variability between disciplines and institutions in terms of how they deal with these issues. Significantly, what is often neglected in this research methodology teaching is the way in which a “protected” researcher is fundamental if the rights of participants are to be satisfactorily upheld. This is explored in more depth in the following section.

In addition, much more thought could (and should) be given to the ways in which the processes of reflexivity and critical consciousness, previously shown to be essential to conducting practically ethical research, require the researcher not only to cognitively reflect on their subject positions, but to unpack their emotional responses to various aspects of their work (Fook & Askeland, 2007). Several authors have begun to explore this area in different ways. Dickson-Swift, James, Kippen and Liamputtong (2009), for example, discuss the “emotional labour” involved in conducting qualitative research, and Finlay (2002) provides a detailed articulation of reflexivity, including an exploration of the importance of emotions in this process. This is a psychologically complex and emotionally taxing process that requires much more attention, specifically within the South African context.

**Linking Vicarious Trauma and Research Roles**

In qualitative enquiry, the researcher is frequently the main “instrument” in the research process. To a large extent, the “success” or “failure” of qualitative research relies on her involvement during the entire research process (Holliday, 2002). Firstly, gathering in-depth and detailed qualitative data requires her to have the ability to engage with participants in an open and empathetic way. The researcher is responsible for creating a safe and trustworthy space where participants feel comfortable enough to share their experiences. Researchers need to be consistently present within these spaces, listening actively and responding in ways that both affirm participants’ experiences and encourage them to share further. Secondly, once these accounts have been gathered, the analysis of qualitative data requires spending considerable amounts of time immersing oneself in detailed descriptions of participants’ experiences (Holliday, 2002). Where these experiences and accounts are deeply distressing, this ongoing constant exposure increases the researchers’ risk of experiencing VT.

Vicarious Trauma appears to have a troubling double effect for qualitative researchers. Firstly, VT is an emotionally painful and potentially overwhelming experience. As mentioned earlier, the symptoms strongly resemble primary PTSD, yet with no overt incident of a personal trauma the symptoms may be ignored or misinterpreted. This is exacerbated by the professional role of “researcher” and the
burdens with which that self-definition is laden. Researchers can feel as though the role requires them to be “superhuman” - any signs of vulnerability or emotionality are perceived as weakness, inadequacy or incompetence (Dickson-Swift et al., 2009; Howlett & Collins, 2014). These ideas are closely linked to, and further reinforced by, the ideals of objectivity, neutrality and critical distance traditionally valued in traditional research and still commonly revered today, despite an attempt to move toward the inclusion of researcher subjectivity in qualitative methodologies (Willig, 2008). A dangerous dichotomy is created between the researcher/researched or the helper/helped. This prevents one from seeking assistance when one feels overwhelmed or distressed (Dalenberg, 2000; Wastell, 2005).

Most of the interviewed researchers revealed that they did not recognise or attach meaning and significance to their presenting symptoms at the time, and often required another person to point these out. Researchers who were able to identify concerning responses at the time reported being reluctant to discuss their difficulties with others, specifically with supervisors, colleagues or their organisation, as they feared appearing incompetent and were concerned about the intensity of their emotional responses. This was similarly discussed in Fook and Askeland’s (2007) work on critical reflection. They found that “participants may feel an unwanted pressure to disclose incompetence… [and] participants also express the desire to ‘protect’ others from strong feelings” (Fook & Askeland, 2007, p. 2). This led to one of the most significant problems that researchers experiencing VT evidenced: failure to complete projects, and withdrawal from community engagement work. Many researchers experiencing symptoms of VT found themselves uninterested or frustrated with their projects, were unable to continue conducting interviews, or abandoned their analyses before they could complete their work. Not only is this personally problematic for the researchers themselves, but it is also ethically questionable as they are “abandoning” project participants to whom they had made a commitment to provide assistance and support.

An important aspect of VT to consider here is the subtle but significant shift of worldview that occurs from persistent exposure to distressing narratives. Janoff-Bulman (1985, 2010) asserts that people live by a set of core positive assumptions about the world, how it operates and the people in it, including the self. In particular, they see the world to be benevolent, meaningful and predictable: people are viewed as generally good and kind; and they have a positive and worthy sense of self. These positive assumptions are also closely linked to early childhood experiences where we learn that we are safe, secure, protected and not vulnerable. A person experiencing VT has been faced with a much darker and malevolent account of humanity and the world which directly challenges, disrupts, or “shatters”, these previously held positive assumptions (Janoff-Bulman, 2010).

This process is particularly relevant to researchers working on sensitive topics. More often than not, the researcher occupies a more privileged position in society, and has therefore been able to take their assumption of safely relatively more for granted than the vulnerable project participants. When they encounter the participants’ greater experience of vulnerability, these firmly held assumptions of worldly safety and human decency are seriously challenged. This can lead to a significant, but not always immediately obvious, shift in the emotional and cognitive outlook of the researcher. This shift toward a pessimistic worldview and a negative view of self can produce an overwhelming sense of helplessness and cynicism, or a feeling of futility, for those researchers suffering from VT (Janoff-Bulman, 2010; Wastell, 2005). This, in turn has a significant influence on the ways in which the researcher responds to participants they are working with, and specifically, tends to produce a number of countertransference reactions (Dalenberg, 2000), discussed in more detail below.
Secondly, VT has serious consequences for project participants. As previously discussed, VT is experienced as a series of complex and contradictory symptoms, with intense and conflicting emotional responses. These primarily negative emotions make it very difficult for researchers to interact ethically with participants for a number of reasons. Herman (1992) describes various stages of recovery through which the survivor needs to mend the different capacities that were damaged during the trauma: “trust, autonomy, initiative, competence, identity and intimacy” (p. 133). If community-engaged researchers are to be helpful rather than detrimental to this process, it requires them to be consistently present, reliable, empathetic and accepting. This is also often required for the projects themselves to be successful. Unfortunately, VT makes these key responsibilities much more difficult.

The problematic responses of the researcher detailed above can be framed, and more fully understood, by the concept of countertransference. According to Bouchard, Normandin and Seguin (1995), countertransference can be described as “the entirety of the analyst’s emotional reactions to the patient within the treatment situation” (p. 719) or, as Wilson and Lindy (1994) define, “the reciprocal impact that the patient and the therapist have on each other during the course of psychotherapy” (p. 9). The critical element tends to be the negative reactions that are triggered in the therapist by the clients’ experiences. Dalenberg (2000) highlights key characteristics of countertransference of therapists treating traumatised patients, including both a feeling of strong attachment toward the patient as well as “conflict-based responses” that the therapist has in relation to the patient and the “trauma related material” (p. 11). Wilson and Lindy (1994) conceptualise countertransference as consisting of two key dimensions. The first dimension refers to “the degree to which the therapist either over-identifies or the therapist avoids identification with their client” (Wastell, 2005, p. 134). Both of these responses appear particularly relevant to researchers experiencing VT.

Recovery from trauma requires a healing relationship (Herman, 1992). Survivors need to recover from the alienation and isolation of traumatic events and form new connections with people. Ideally, community-engaged work should share these common aims. For this to occur, researchers and activists must be consistently empathetically attuned. This, however, becomes very difficult if the researcher is experiencing VT as the need to “invoke (voluntarily or not) defences in order to contain and bind their own distress” (Wastell, 2005, p. 119) becomes overwhelming. The increased anxiety and arousal, and the avoidance symptoms associated with VT, often leave people numb, detached, irritable or angry. These negative emotions make it very difficult for researchers to have consistent empathy and caring attunement to the person or communities they are trying to assist, which then severely undermines the ability to form a safe and trusting bond with them (Trippany, White Kress & Wilcoxon, 2004). Furthermore, Dalenberg (2000) adds that the countertransference responses of withdrawal, avoidance or irritation may also undermine a survivor’s “sense of reality” (p. 92) as they may be interpreted as disbelief, judgement or blame. In these circumstances researcher distance and neutrality begin to be experienced less as professional objectivity and more as insensitivity and victim blaming (Wastell, 2005).

In addition, survivors, and marginalised groups in general, need to experience (re)empowerment. Taking charge of their recovery is the first step to re-establishing control over their lives. Herman states “others may offer advice, support, assistance, affection and care, but not cure” (p. 133). People experiencing VT are often inclined to manage their own emotional vulnerability by trying to “fix” those they are supporting. Anxiety and feelings of being helpless and overwhelmed can make them desperate to solve others’ problems as a way of alleviating their own distress. In these
cases, people feel compelled to act well beyond their jurisdiction, often adopting the role of the “rescuer” (Wastell, 2005). This countertransference response commonly involves over-identification with the survivor and “empathetic enmeshment (over involvement)” with their shared experience (Dalenberg, 2000, p. 74). This “if you feel better, I feel better” dynamic often leaves survivors feeling at best misunderstood, and at worst, re-traumatised by re-experiencing a lack of control similar to that of their traumatic experience(s) (Herman, 1992).

Allowing survivors to re-establish a sense of autonomy in their lives, and to independently redevelop the personal competencies they need to achieve this, requires a degree of emotional consistency, attunement and ‘boundary-maintenance’ that VT hinders in those that experience it. This is particularly difficult in community-engagement settings, where the balance of power is already skewed in favour of the “professional” coming to “fix” a community’s problems (Fook & Askeland, 2007). Experiencing Primary Traumatisation in Community-Based Work

Although experiences of VT proved challenging for community-based researchers, it was not the only trauma-related issue they faced. When discussing their experiences of hearing others’ distressing narratives, another key issue was raised: What happens when participants’ ideas and actions, not just their accounts of their experiences, cause distress? Two examples to frame this question include a self-identifying gay researcher facilitating a group in which a participant stated that “all people deserve equality, except the gays, that’s just wrong”, or an African immigrant researcher being told “but foreigners are cockroaches who steal our jobs, you are an example”. The deeply threatening nature of these comments is to be understood in an environment where homophobic assaults (Ferim, 2016; Msibi, 2009; Reid & Dirusweit, 2002) and xenophobic murders (Harris, 2002; Mutanda, 2017; Neocosmos, 2008) are regular occurrences.

These examples are taken from community-based violence reduction interventions where facilitating a shift in ideas or understandings about the world and one’s self is a central goal. This is a complex and challenging task that requires repeatedly deconstructing firmly held beliefs (which are often negative, stereotypical, prejudiced) about other people and the world more broadly. Before these ideas can be deconstructed they are often shared as “fact”, common sense or “just” one’s personal opinion. People “merely” sharing their opinions/ideas often involves the negation of particular participants and groups, including the facilitators themselves. In this sense, many people, at least initially, appear to display an “anti-social” or hostile attitude toward positive social change as this involves relinquishing ideas or beliefs that either serve them socially, or act as a defence mechanism protecting them from anxiety or fear (Festinger, 1962). As Fook and Askeland (2007) argue:

The challenge of confronting more culturally embedded ideas constitutes one of the major challenges of critical reflection. We have termed it a challenge because we see it as a ‘double-edged sword’: it can be a very potent way of confronting ‘sticking points’ or previously unresolvable dilemmas; but its effectiveness may be limited because of the misunderstanding, resistance and anxiety which can result when deep-seated assumptions are questioned (p. 2).

Consider the previous example of a participant supporting the xenophobic slur that all foreign African nationals are criminals. Alternate narratives which directly challenge this belief construct the participant’s view as not only as factually incorrect, but also as hurtful and contributing to ongoing systems of violence. But being open to new narratives can produce feelings of shame and guilt regarding one’s past thoughts, feelings and behaviours toward other people, and could directly undermine
the positive sense of self that is protected by the original narrative (Gilligan, 1996). Thus the gratifying sense of superiority given by the good citizen/criminal foreigner dichotomy is replaced by a shameful acknowledgement of oneself as an agent of xenophobic prejudice that is both irrational and harmful to others.

Furthermore, firmly held beliefs may be developed as a response to threatening and overwhelming personal experiences of violence. In these cases, individuals adopt the beliefs, values and behaviours of those who are threatening or attacking them as a means of protecting themselves from the traumatic acknowledgement of their own vulnerability and suffering. In psychodynamic terms this is referred to as “identification with the aggressor” (Adorno et al., 1950; Miller, 1990) or in certain instances as Stockholm Syndrome (Herman, 1992). To prevent a sense of emotional annihilation, individuals may repress from awareness the “experience of being an overwhelmed victim, and instead imagining oneself to be in the position of the threatening aggressor” (Collins, 2013, p. 78).

Any challenge to these firmly held beliefs then runs the risk of exposing this traumatic vulnerability. From this perspective it can be understood that these disclosures are no longer simply pieces of data that the researcher can gather and interpret - they are complex and risky social encounters that have both emotional and intellectual impact, and produce significant identity effects. An added layer of complexity is linked to the group nature of this work. Community-based projects, as their name suggests, tend to be interested in exploring issues amongst particular groups of people. This often requires the facilitation of focus group discussions or participatory discussions where people are encouraged to share and discuss their ideas and experiences together. In these cases, not only the researcher but the other participants in the group are potentially at risk of traumatisation through the offensive and potentially hateful ideas disclosed by participants. An example of this was revealed by a researcher who grappled to come to terms with her experience of a man arguing that all women, including his own sister, deserve to be raped if they are ‘dressed provocatively’. This statement was not only threatening for the researcher as a woman, it was expressed in a group that included self-identifying female survivors of sexual assault.

In scenarios similar to these, researchers encounter a third extremely distressing experience: a sense of traumatic helplessness from being unable to effectively protect the participants in their care. In this sense researchers tended to experience themselves as being channelled into the position of a bystander (Herman, 1992), observing harmful events without being able to fully challenge or control them. Thus the well-intentioned and seemingly positively ethical attempt to produce more respectful social relationships can itself become differently traumatic for all of the participants, including the facilitators.

This highlights a critical dialect that exists between openness and safety within these projects. Openness is the primary requirement for transformative engagement but, at the same time, the more open and participatory we make spaces, the greater the risk that participants will be (usually inadvertently) harmful toward others. In other words, the more democratic and open our engagement practice is, the more it allows the risk of reproducing elements of the violent power relations of the external world within the activities. This raises an important question: how do we keep these spaces both safe and open when openness comes at the cost of safety and safety comes at the cost of openness?

Our conclusion, in highlighting and exploring the problems of vicarious trauma, is not that it is simply a risk to be avoided, as research approval committees might be inclined to assume. On the contrary, it is a risk that increases precisely to the extent that social engagement and research is empathic, attuned, participatory, and open – all primary values of socially committed community psychology work. The point is rather that it is a risk to be recognised and managed as
effectively as possible. This requires integrating a clear understanding of vicarious trauma into research and community engagement training. The minimum elements here would entail being able to identify potential risks and emerging reactions, being trained in appropriate self-care techniques, and ensuring that social and organisational support processes and relationships are in place. The specifics of these have already been mapped within psychotherapeutic frameworks – the challenge is to effectively transfer these insights and skills into community engagement and research settings.

References


**Address for correspondence**
plugsn@gmail.com

**Acknowledgements**
This research was supported by Research Incentive Funding from the National Research Foundation, South Africa.

**Author biographies**
Simône Plüg is lecturer at the International Centre of Non-Violence at Durban University of Technology (South Africa) and a PhD fellow in Media Studies at the University currently known as Rhodes (South Africa). Her research interests include gender, identity, and consumer culture, violence, trauma and neglect, and transformative pedagogies. Her research involves critical theorisation by locating social issues within discursive constructions, and aims to defamiliarise common sense ideas in order to promote consciousness raising and provide the space for negotiation of less oppressive and destructive identities and social practices.

Anthony Collins is a theorist/activist working on violence reduction and survivor support. His primary interest is in developing a framework for interrupting the ongoing cycles of violence in all aspects of South African social life. He works with a variety of organisations dealing with intimate partner violence and gender-based violence. He is Professor of Media, Language and Communication at the Durban University of Technology, and Visiting Professor in Psychology at Rhodes University and LaTrobe University, Melbourne. His academic work can be found online at https://rhodesza.academia.edu/AnthonyCollins and https://www.researchgate.net/profile/Anthony_Collins3/