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Vicarious Traumatization: Secondary Traumatic Stress Levels in Claims Workers in the Short-Term Insurance Industry in South Africa

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Abstract

This exploratory study aimed to determine the effects of working conditions, including dealing with traumatised clients and distressing materials, on claims workers in the short-term insurance industry. Stress-related illness and lowered productivity has become one of the most serious and pressing workplace health issues and this study sheds light on a particular group of workers who have largely been overlooked in the anthology of vicarious trauma.

Vicarious trauma was measured in the study group of claims workers along the dimensions of secondary traumatic stress, compassion satisfaction and burnout. Particular emphasis was placed on secondary traumatic stress as this is the actual measure of vicarious traumatization. Self-esteem and optimism/pessimism were also investigated to further broaden the understanding of the effect on the study group by their working conditions.

These constructs were measured using the ProQOL-RIII, the Mehrabian MSE and MOP Scales, and the scores determined on a scale of low, moderate or high. Scores on the study variables were generally found to be moderate except in the case of secondary traumatic stress, where scores were found to be high.

The findings suggest that vicarious traumatization took place in the study group and that it is a clear and present threat to the population of workers under investigation.

Key words: vicarious trauma, secondary traumatic stress, burnout, compassion satisfaction, self-esteem, optimism, pessimism, posttraumatic stress disorder, claims workers, short-term insurance industry.

JEL Classification: M0.

Introduction

In the past three years, 57,162 people have been murdered and 380,173 people have been victims of robbery with aggravating circumstances (IOL, 2007). Each year, myriads of people are affected by some kind of traumatic event, ranging from accidents, encounters with criminals, violence, natural disasters to abuse and neglect. Exposure to such trauma frequently results in serious and persistent emotional and behavioural problems (Perry, 2003). However, it is not only crime that exposes people to trauma; it may be through certain work situations (Anderson, 2004; Goldenberg, 2002; Hesse, 2002), or indirectly, through exposure to those having directly been traumatised, such as medical staff. When individuals experience trauma in an indirect manner, it is referred to as *indirect traumatization*, *secondary traumatization* or *vicarious trauma*. This study focuses on vicarious trauma encountered in the work-place of claims workers in the short-term insurance industry.

It has been proposed that stress has become one of the most serious and pressing health issues of our time (Lu, 1999; Perry, 2003). Assuming this to be the case, it is incumbent on employers to identify workers exposed to specific stressful situations and take steps to lessen the impact of such situations where possible. It is equally important to identify work-related stressors and to be vigilant in alleviating any associated effects. Numerous studies on vicarious trauma have demonstrated that it causes stress related effects across a wide spectrum of professions (Levin & Greisberg, 2003; Linley & Joseph, 2004; Stamm, 1997).

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Most of the published work on vicarious trauma relates to health and mental health workers (Jordan, 2001; Sexton, 1999; Steed & Downing, 1998). There are, however, many other less obvious populations at risk that have largely been overlooked in the conceptual anthology of vicarious reactions. One such a population, at the centre of this study, is that of claims workers operating within the short-term insurance industry. Some studies have indicated that insurance workers in general are at risk for experiencing high levels of occupational stress (Chan, Lai, Ko & Boey, 2000; Coetzer & Rothmann, 2006). However, an extensive literature search revealed a dearth of published material specifically relating to vicarious trauma in claims workers in the short-term insurance industry.

Studies that have identified specific stressors posing a threat to insurance workers as a whole (Chan *et al.*, 2000; Coetzer & Rothmann, 2006) emanate from dealing with difficult or demanding clients as well as from their unique work demands. Other authors have pointed out the serious ramifications of being exposed to traumatised individuals and traumatic materials on an ongoing basis (Sabin-Farrell & Turpin, 2003; Sexton, 1999; Steed & Downing, 1998). However, recent studies (Chan *et al.*, 2000; Coetzer & Rothmann, 2006) have not focused specifically on claims workers in the short-term insurance industry, nor on the prevalence of vicarious trauma within this population.

The present study shares the same goals as the aforementioned authors in that the identification of sources of work-related stress can benefit both employers and employees. Employing strategies to reduce stress can significantly augment productivity (O'Reilly, 2006). It can also aid in the development of efficient interventions that could reduce the harmful effects of work-related stress (Coetzer & Rothmann, 2006). This exploratory study sought to establish whether vicarious trauma should be included as such a source of stress and whether intervention is necessary.

Trauma

Trauma has been the focus of many research studies over the past decade (Harrison & Kinner, 1998; Van der Kolk, McFarlane & Weisaeth, 1996; Van Dijk, Schoutrop & Spinhoven, 2003). Both physiological and psychological experiences and changes following traumatic events have been recorded and investigated (Barlow & Durand, 2001; McNally, 2003; Sue, Sue & Sue, 1994). The dual meaning for the term "trauma" makes provision for injury on a physical or a psychological level, and includes the notion of an external event leading to an inner subjective response (Becker, Daley, Gadpaille & Green, 2003).

A wide array of events can lead to emotional trauma, of which the most severe is believed to be in the aftermath of war (Barlow & Durand, 2001). Other triggers include severe accidents, natural disasters, the loss of a loved one, physical assaults (Barlow & Durand, 2001; Becker *et al.*, 2003), and even from less apparently severe causes such as the break-up of a significant relationship, a humiliating or disappointing experience, the discovery of a severe illness or disabling condition, amongst others (Centre for Healthy Ageing, 2005).

In the domain of the present study, direct trauma is incurred on an ongoing basis, not by the study group, but by the insurance client. Events such as property loss, vandalism or accidents may be accompanied by physical or emotional trauma. According to the South African Police statistics, more than 2.5 million South Africans have become victims of violent crimes over the past three years (IOL, 2007). Statistics such as these have labelled South Africa as the crime capital of the world as violence is so commonplace (IOL, 2007). It is in the nature of the work conducted by claims workers to continuously negotiate indemnity with traumatised clients following losses, which is the reason they are the subject of this study.

The "traumatic materials" referred to in this study are the potentially traumatising materials obtained by claims workers when qualifying claims. For example, personal accident claims may necessitate post mortem reports, medical records and death certificates for settlement. Moreover, these claims are usually accompanied by a copy of the person's identity document, bearing a pho-

tograph of the deceased/injured client. In other cases, the scene of a crime is often photographed displaying signs of forced entry to property in order to attest these claims. Similarly, the scene of accidents or the salvage (car wrecks) are also frequently photographed. When people are killed or seriously injured in these collisions, photographs of the wrecks or the scene can be graphic and unsettling. Inevitably, claims workers need to extract detailed recollections of traumatic events, bear witness to clients' trauma or are exposed to traumatic materials in order to compile claims records.

Vicarious trauma

Since the mid 90's, there has been mounting research evidence that traumatic events do not necessarily have to be experienced directly for traumatisation to occur (Lev-Wiesel & Amir, 2001; Linley & Joseph, 2004; Pieper, 1999). The phenomenon of vicarious traumatisation has been described as a cumulative process of continued exposure to traumatic materials or images (Linley & Joseph, 2004). It ultimately leads to lasting cognitive changes, whereby inner experiences such as thoughts, perceptions and interpretations are negatively transformed (McCann and Pearlman, 1990). Verbal exposure to traumatic materials theoretically also has the ability to change cognitive schemas as well as memory systems (Rae Jenkins & Baird, 2002).

These alterations can potentially become disruptive to the person's psychological or interpersonal functioning (McCann and Pearlman, 1990), manifesting as flashbacks, nightmares or intrusive thoughts (Rae Jenkins & Baird, 2002). Some believe that the latter constitutes the hallmark of posttraumatic stress disorder or PTSD (Barlow & Durand, 2001; McNally, 2003).

In addition to these altered cognitive processes, other psychological symptoms associated with vicarious trauma are cited (Annschuetz, 1999; Pieper, 1999; Varner, 2004). The first set of reactions reported is similar to that of direct traumatisation, being the initial feelings of horror, intense fear, helplessness, shock and disbelief. The resultant set of symptoms is equated with those of PTSD, such as sleep disturbance, hopelessness, helplessness, flashbacks, anxiety, depression, hypersensitivity, apathy, anger, feelings of being trapped and emotional numbness. Hesse (2002) goes as far as to suggest that severe secondary traumatic stress and PTSD are synonymous, and that those exposed frequently to traumatic situations may experience similar symptoms to those of their clients (Lev-Wiesel & Amir, 2001). The only difference in the case of STS is that exposure is indirect, whereas PTSD is a result of direct experiences of trauma (Hesse, 2002; Linley & Joseph, 2004).

Other important study variables

Associated with vicarious trauma are other frequently used terms, such as **secondary traumatic stress (STS)**, **compassion fatigue** and **burnout** (Annschuetz, 1999; Bell, Kulkarni & Dalton, 2003; Hesse, 2002; Stamm, 2003). Although STS is the actual measure of vicarious trauma, compassion fatigue and burnout are closely related concepts.

According to Linley and Joseph (2004), the term **secondary traumatic stress** or **STS** originally referred to the emotional duress experienced as a result of dealing with traumatised clients. This term is key to the present study, as claims workers are in constant contact with such clients. Symptoms of STS generally include re-experiencing of the witnessed event, avoidance of recollections of the event, numbing in affect and function, and continual arousal (Levin & Greisberg, 2003). STS was later renamed **compassion fatigue**, as it was believed to be less stigmatising (Linley & Joseph, 2004). These terms can be used interchangeably but, for the purpose of the study, the term STS is used, as claims workers are not in a care-giving profession *per se*.

Burnout, in contrast, can apply to any client-centred profession, especially when working with any difficult population (McCann & Pearlman, 1990). The insurance industry is such a problem-laden, client-centred industry. Burnout can be defined as "...a state of physical, emotional and mental exhaustion caused by long-term involvement in emotionally demanding situations" (Pines & Aronson, 1988, cited in Hesse, 2002, p. 297). It is understood as the body's way of responding to continuous occupational exposure to psychologically taxing interpersonal situations, including continuously

conveying empathy to clients in emotional pain (Annschuetz, 1999). The definition of burnout describes feelings of exhaustion, reduced feelings of accomplishment and depersonalisation (Hesse, 2002; Sabin-Farrell & Turpin, 2003; Sexton, 1999). Symptoms reported by McCann and Pearlman (1990) also include depression, cynicism, boredom, loss of compassion and discouragement.

The concept of **self-esteem**, for the purpose of this study, can be defined as a generalised positive or negative attitude toward oneself and the level of confidence about one's mental and physical abilities (Mehrabian, 1998). In the context of claims workers, self-esteem typically refers to their regard for themselves, the level of confidence in their skills and their self-assessed ability to cope with stressful events. Several studies have indicated that exposure to trauma can encroach on one's self-esteem (AtHealth, 2003; PTSD Alliance, 2003; Sierra Pacific Network, 2001). Low self-esteem is not only a result of PTSD, but can also predispose one to PTSD. The converse has also been found to apply, in that high self-esteem acts as a protecting factor (Tracy, 2002).

A secondary effect often associated with trauma is the adoption of a **pessimistic** orientation (Dheer, Jaiprakash, Sharma & Singh, 2003). A sense of gloom and feelings of a foreshortened future following trauma, which signifies pessimism, are also described by the DSM-IV (Barlow & Durand, 2001). Constant exposure to negative events such as trauma change peoples' beliefs about the world, which can be perceived as out-of control, dangerous and meaningless, gravitating individuals towards seeing their life circumstances and future in an increasingly pessimistic light (Mehrabian, 1998; Sabin-Farrell & Turpin, 2003). **Optimism**, on the other hand is the emotional and cognitive gravitation towards feeling that the good things in life outweigh the bad (Mehrabian, 1998). The ongoing exposure of claims workers to traumatic materials and events may compromise their self-esteem and levels of optimism.

Aims of this study

The study aimed to ascertain whether dealing with traumatised clients and traumatic materials are harmful to claims workers in the short-term insurance industry. It is therefore essentially exploratory and takes a multidimensional look at vicarious traumatisation. The research was conducted on the basis of considering the concept in terms of three important related aspects. These are: compassion satisfaction, burnout and secondary traumatic stress. Measures of these aforementioned variables are synthesised to create an overall view of vicarious trauma. To add further richness to the analysis, self-esteem and levels of optimism/pessimism were also measured.

Method

Research design

An exploratory assessment design was used to achieve the objectives of this study. Concepts of interest were formulated into distinct study variables prior to data collection. These were then measured systematically in a naturally occurring sample by the use of pre-existing instruments, being the ProQOL-RIII Scales (Stamm, 2003) and the MSE and MOP scales (Mehrabian, 1998). This observational method yielded numerical data in the form of test scores. These were interpreted and juxtaposed to construct a picture of how claims workers are affected by their dealings with traumatised clients and traumatic materials.

Participants

A total of 44 claims workers were sourced to complete the measures from the three most prominent short-term insurers in Gauteng Province, South Africa. Descriptive information of the sample is provided in Table 1.

Descriptive Statistics: Biographic Variables

		Claims workers (n=44)	
	VARIABLE	FREQUENCY	PERCENT
Gender	Male	13	29.55
	Female	31	70.45
Age	25-30 years	17	38.64
	31-35 years	11	25.00
	36-40 years	3	6.82
	41-45 years	13	29.55
Years of Service	2-4 years	15	34.09
	5-8 years	17	38.64
	9-12 years	5	11.36
	13-16 years	2	4.55
	17+ years	5	11.36

Participating insurance managers confirmed that the sample was very representative of their claims worker corps. The sample consisted mainly of young females with less than ten years experience. Possible reasons for this demographically skewed sample were put forward by the insurers, who concurred that the unique characteristics were related to high staff turn-over rates and ongoing restructuring efforts which mainly affected middle-aged workers.

Instruments

Biographic data of the sample were collected through use of a questionnaire and are presented in Table 1.

The *ProQOL-R/III Scales* (Stamm, 2003) were used to obtain an objective measure of the level of vicarious traumatisation along the dimensions of compassion satisfaction, burnout and secondary traumatic stress. The use of the three subscales is believed to be more fitting to the complex nature of vicarious trauma (Stamm, 2003). Each subscale can be viewed both on its own and also in relation to the others to generate a more comprehensive picture of vicarious trauma. The self-report Likert-type scale consists of 30 items that are scored from 0 (*never*) to 5 (*very often*), and takes approximately 10 minutes to complete. It is designed to tap into any traumatising aspects of one's work.

Stamm (2003) reports that this test is mainly for *screening* purposes and has been applied effectively in more than 30 countries across a wide array of professions. Unfortunately, these scales are not standardised for use in the South African workforce, and the psychometric properties remain uncertain. Participating insurers concurred that time was of the essence which led to the choice of these exceptionally short scales. The reported reliability coefficients are .87 in terms of compassion satisfaction, .72 in terms of burnout and .80 in respect of secondary traumatic stress (Stamm, 2003). Cronbach alphas were calculated for the present study and the subscales achieved sound reliability. In terms of the compassion satisfaction scale, the calculated alpha was .87. Regarding burnout, the alpha obtained for the study sample was .70 and for secondary traumatic stress, the alpha obtained was .85. With each of the subscales, the item-total correlation for each individual item was $>.20$, therefore no items needed to be omitted from the study.

Score cut-points, percentiles and norms provided by the test manual were *not* utilised in the study because the population under investigation was not included in the standardisation. Scale definitions, however, were referred to for interpretation only. This information was used for the sole purpose of establishing whether an individual or aggregate score represented low, moderate or high levels of the variable. Given that norms were not used during any analyses, it was deemed appropriate to draw upon the information in this limited way. Finally, Stamm (2003) reported that the psychometric information collected and obtained from multivariate analysis of variance did not provide any evidence of differences based on country, type of work or gender.

The *Mehrabian Self-Esteem Scale or MSE* and the *Mehrabian Optimism/Pessimism or MOP Scales* (1998) were also completed. It is argued that vicarious trauma could lead to low self-esteem (PTSD Alliance, 2003; Tracy, 2002) as well as a pessimistic position (Barlow & Durand, 2001; Dheer *et al.*, 2003). These two separate self-report scales consist of 11 and 8 items respectively and are scored according to +4 (*very strong agreement*) to -4 (*very strong disagreement*) with 0 indicating *neither agreement nor disagreement*. These scales took approximately five minutes each to complete. The minimum requirements to utilise the scales posed by Mehrabian (1998) were exceeded by the minimum job requirements in the insurance industry.

These scales are also not standardised for use in the South African workforce. Again, time constraints necessitated the use of very short scales. An internal consistency coefficient alpha of .86 is reported for both the MSE- and MOP Scales by the test manual (Mehrabian, 1998). These scales achieved good reliability in the present study. An alpha of .74 was obtained for the MSE scale and an alpha of .71 for the MOP scale. The item-total correlation in terms of each of the items for both scales were >.20, and as a result, no items needed to be omitted from the study.

The percentiles and cut-scores provided by the manual were also *not* used. Instead, simple descriptive statistics were used to establish the level of each variable expressed by the study group. This was done by examining the score ranges, means and standard deviations. Finally, the MSE/MOP manual (Mehrabian, 1998) confirms that the genders do not significantly differ in terms of any of the scale variables and interpretations made again equally apply to men and women.

Data analysis

In terms of the biographic variables, frequency tables were used in order to describe the sample. Cronbach alpha coefficients were calculated to gauge the internal consistency of each scale. It was primarily an exploratory study without any inter-group comparisons. Instead, descriptive statistics were used to examine a naturally occurring sample. Distribution frequencies were carried out on each study variable to examine normality, skewness and kurtosis. Descriptive statistics were used to further describe the data (means and standard deviations). The level of each variable (low, moderate and high) was determined by either drawing upon scale definitions, or by using descriptive statistics.

Results

As mentioned earlier, vicarious trauma was measured along the dimensions of compassion satisfaction, burnout and secondary traumatic stress. The mean scores on each of the study variables, including self-esteem and optimism or pessimism are reported in Table 2.

To give meaning to the test scores acquired, the level of each variable expressed by the claims workers was determined. In order to establish if a mean score was low, average/moderate or high, scores were interpreted by comparison with the scale definitions in the ProQOL-RIII manual (Stamm, 2003).

Table 2

Descriptive Statistics: ProQOL-RIII Subscales; MSE Scale and MOP Scale

DEPENDENT VARIABLE	N	MEAN	SD	MINIMUM	MAXIMUM
PROQOL-RIII SUBSCALES:					
Compassion Satisfaction	44	36.59	7.55	12	50
Burnout	44	19.64	5.39	8	32
Secondary Traumatic Stress	44	16.52	8.79	2	43
MSE SCALE					
Self-Esteem	44	5.95	8.24	-7	27
MOP SCALE					
Optimism/Pessimism	44	9.61	8.45	-11	29

The average score for compassion satisfaction described by the scale definition, which simultaneously indicates moderate levels, is 37 (*SD* 7; alpha scale reliability .87). Those with a score above 41 experienced high levels of compassion satisfaction and derived considerable compassion and professional satisfaction from their positions. On the other hand, a score below 32 indicates low levels of the variable. This signifies some problems within a position and suggests that not much compassion or professional satisfaction is forthcoming from doing that type of work. In the case of the claims workers, the mean score was 36.59. This mean is slightly below the scale definition average of 37, which nonetheless indicates *average* or *moderate* levels of compassion and professional job satisfaction.

In terms of the burnout scale, the scale definition average is 23 (*SD* 6.0; alpha scale reliability .72), which again indicates a moderate level of the variable. A score above 28 represents high levels of burnout, which point towards difficulties in dealing with job demands and workload. Scores below 19 indicate positive feelings about one's job and general efficiency in meeting job demands. The claims workers scored 19.64, which falls on the conceptual borderline of the more positive extremity of the scale. These relatively low burnout scores indicate some positive feelings and that claims workers are generally meeting some job demands efficiently.

Finally, regarding secondary traumatic stress or STS, the study group exhibited *high levels* when interpreted from the scale definition. An average score for STS is 13 (*SD* 6.0; alpha reliability .80) which also indicates moderate levels of the variable. A score below 8 usually signifies low levels of STS and suggests that persons are not traumatised by their work. A score of 17 or above indicates high levels of STS. The mean score for claims workers was 16.52, which falls approximately on the conceptual borderline for high levels of the variable. This elevated mean score indicated that there are aspects of the claims workers positions that they find traumatic.

The Mehrabian MSE/MOP manual, however, does not provide similar scale definitions for determining the levels of self-esteem or optimism/pessimism. In order to pinpoint the expressed levels of these variables, the mean scores were calculated. Firstly, in terms of the self-esteem scale, scores could theoretically range from -44 (being the lowest achievable score) to 44 (being the highest achievable score). In the case of both scales, zero is the midmost or fixed central point. The calculated *M* for self-esteem was 5.95, with a *SD* of 8.24. This score is less than one standard deviation above the fixed point of the scale, which indicates an *M* close to zero. This result signifies that the group mean is *moderate*, and that the levels of self-esteem exhibited is neither high nor low. When looking at the optimism/pessimism scale, scores could theoretically range from -32 (being the lowest achievable score) to 32 (being the highest achievable score). The claims workers obtained *M*=9.61, with an *SD* of 8.45. This mean is approximately one *SD* above zero which indicates that optimism/pessimism scores were *moderate*. The claims workers were neither noticeably optimistic nor palpably pessimistic, but rather remained neutral in their appraisals.

Discussion

At first glance the scores for the claims workers looked unexceptional and encouraging. Self-esteem, optimism/pessimism and compassion satisfaction scores were moderate with low incidences of burnout. The only scores that were high enough to raise concern were the secondary traumatic stress (STS) scores. This is an important finding as the main aim of the study was to establish whether exposure to traumatised clients and traumatic materials could be traumatising to claims workers. These elevated scores confirm that the nature of interactions with clients possess certain characteristics that are conducive to vicarious traumatisation.

Stamm (2003) recommends that, if a score on STS is 17 or above, the individual should identify the source of trauma and consider debriefing with a colleague, supervisor or, ideally, a healthcare professional. Up to 43% of the sample expressed disturbing levels of STS, which were largely obscured by the amalgamated scores. Out of the 44 participants, 19 scored 17 and above. Six participants scored between 17 and 19; nine participants scored between 20 and 29 and four partici-

pants scored between 30 and 36. The highest score was 43, indicating a severely traumatised individual in need of urgent psychological assistance.

Those with elevated STS scores could be suffering from PTSD, since an association has been established. This is so because the STS items of the ProQOL-R-III Scales were each carefully formulated around the core symptoms of PTSD as described by the DSM-IV (Stamm, 2003). These include avoidance behaviours, sleep disturbance, exaggerated startle responses, preoccupation with the traumatic events, withdrawal, feelings of being disconnected from others, sudden intrusive thoughts and feelings of helplessness (Barlow & Durand, 2001). High scoring individuals would then, naturally, be exhibiting many of the trait symptoms of PTSD.

The high STS scores coupled with the moderate compassion satisfaction, self-esteem and optimism/pessimism scores, further point to PTSD. Aggregate scores on these variables indicate that claims workers were in general neither passionate, excited and in high spirits, nor excessively dependent, unhappy or overly apathetic. They tended towards a more, neutral and unresponsive position, which one might consider to be more desirable than an overall negative one.

However, the ubiquitous neutrality they exhibited could quite possibly indicate the onset of emotional detachment and flattened affect that are closely associated with PTSD (Barlow & Durand, 2001). This unenthusiastic position or propensity towards neutrality could be indicative of disinterest, indifference and a loss of passion rather than a sign of invulnerability. Although this is not indisputable evidence of PTSD, it is nonetheless an important point to consider, seeing that such a large portion of the sample exhibited disquieting levels of STS. It can therefore be concluded that some individuals might be experiencing PTSD. To answer this question more firmly would, however, require more specific screening. At this point, drawing conclusions from the information at hand, one can only hypothesize that PTSD could be present.

Victor Frankl (1963, cited in Joseph, Williams & Yule, 1993) posited decades ago that our need for finding meaning is a fundamental human motivation. The underlying premise to the Cognitive Constructivist Development Theory is that all humans construct their own personal realities by developing complex cognitive structures (McCann & Pearlman, 1990). From these we interpret all events in our continuous, innate pursuit of meaning (McCann & Pearlman, 1990). These structures encompass our beliefs, assumptions and expectations, not only about ourselves, but also about what happens in the world. Continuously attempting to assimilate an increased influx of negative information has the capability of negatively transforming one's core beliefs (McCann & Pearlman, 1990). Schemas become increasingly negative and hinder the development of adaptive schemas by rather promoting maladaptive ones (Pyeich, Newman Daleiden, 2003). To this, Falsetti, Resick and Davis (2003) add that the development of PTSD is usually symptomatic of a conflicted belief system that is brought into being by augmented negative information about the world in general.

A daily reality overflowing with traumatic experiences and losses described by clients, could indeed be described as predominantly negative input. Constant exposure to client's testimonies of breached trust, human cruelties, powerlessness, ever present dangers and of how unfair life can be, may well result in similar changes to the claims worker's schemas. Our lives are fragile in the face of life's events, accidents and disasters. A human life means very little to those who want to seize our belongings. Claims workers need to continuously attempt to find meaning amidst incessant reports from clients of how people are maltreated by life, and more so by criminals. Such testimonies accentuate personal fragility, insignificance and the little value that lives hold. This could be instilling burgeoning feelings of worthlessness, helplessness and hopelessness in claims workers and ultimately compromise their self-esteem and optimism.

The neutrality exhibited in terms of self-esteem implies that many participants do not have a particularly high regard for themselves. This also means that they are possibly experiencing some decline in their belief in themselves and their capabilities to withstand life's challenges and further trauma (Sierra Pacific Network, 2001). Although claims workers are not overwhelmingly pessimistic, their neutrality and unresponsiveness seem to suggest a lack of passion, enthusiasm and joviality. The resultant altered schemas are carried with the person into every life situation and the

effects therefore extend into every domain of existence. This includes clinical functioning, interpersonal relationships, social functioning and working life (McCann & Pearlman, 1990). As a result, the world is typically viewed and filtered through lenses coloured by trauma.

When looking at individual responses to certain ProQOL-RIII scale items, 12 of the highest scoring secondary traumatic stress or STS participants expressed clear difficulty in separating their work life from their private lives. This result clearly ties in with the notion that trauma and vicarious trauma permeates into all aspects of one's existence (Barlow & Durand, 2001). It also suggests that the effects of the traumatising and distressing aspects of their work spiral out into their personal lives and continue to affect some claims workers in non-work situations.

It is important to point out that the vicarious traumatisation of these workers is inevitable but unintentional on the part of their employers. Claims workers are not all affected in the same way, as confirmed by the fact that the majority of participants (57% of the sample) had low STS scores. Despite ongoing problem-laden interactions that could lead to vicarious traumatisation, there were many well adjusted, happy individuals who derive pleasure, self-esteem and satisfaction from their work. It should be noted that the majority of claims are unremarkable and mundane, and that it is relatively few incidents that impact negatively on some participants, as indicated by their disquieting STS scores.

According to Stamm (2003) there are also more and least desirable combinations of high scores. The most concerning combination is that of high STS coupled with high burnout scores (Stamm, 2003). These individuals are at greatest risk for negative outcomes, including poor professional judgement, increased errors, poor administration and overall unsatisfactory work performance. Of the sample, four individuals (9%) exhibited such a combination of scores. These individuals could be risking job loss due to bad judgement or poor performance. They also run the greatest risk of developing depression and/or PTSD (Stamm, 2003). Although this percentage is not high, it is disturbing that there are individuals facing these high work-related risks.

There may be apparently resilient claims workers who could become overwhelmed should they be exposed to additional work or personal pressures or a diminution of their support systems (Jordan, 2001). Claims workers are not in a helping profession *per se*, and therefore do not have the same support structures that are available to helping professions, so may be more vulnerable.

More importantly, individuals are *particularly* at risk of negative outcomes if the trauma they are exposed to is ongoing and continuous (Jordan, 2001). The vicarious trauma and traumatic materials encountered in the short-term insurance industry are probably quite different and possibly less intense to those encountered by health and mental health workers. However, the vicarious traumatisation befalling claims workers is continuous, recurrent and inextricably part of their realities, posing a constant threat to their wellbeing. Even though the human body is able to withstand substantial levels and periods of stress, when the stress is prolonged, the body will inevitably sustain some form of damage through ongoing exposure to raised levels of glucocorticoids (The Field Foundation, 2005).

Since the STS scores were relatively high, it was surprising that self-esteem and levels of pessimism, burnout and compassion satisfaction were not affected more drastically. One could argue, in such cases, that the levels of STS experienced were not sufficient to induce low self-esteem, compassion satisfaction as well as full-blown pessimism and burnout. Alternatively, they might have possessed healthier, more desirable levels of these variables prior to their employment in the insurance industry. Constant exposure to vicarious trauma might have diminished these variables to more moderate levels.

Another explanation might be that suggested by Tracy (2002), who specifically identified high self-esteem to be a protecting factor against traumatic effects. The effects of vicarious trauma in these workers might initially have been substantially buffered by healthier levels of self-esteem. Constant and ongoing exposure to traumatised clients might nonetheless have reduced their self-esteem over time. Similarly, these workers could have been more optimistic and sanguine and might have experienced greater levels of compassion satisfaction which might also have been compromised over time.

Although the results were not as dramatic and unequivocal as has been found in the helping professions, the study nevertheless raised several points regarding a population of workers that is largely un-researched. It firstly supported existing studies in acknowledging and confirming the potentially deleterious nature of engaging with traumatised clients. It also created an awareness of the quandary of these workers and placed this previously overlooked population at the forefront of an investigation.

It is important for the industry to take heed of the toll vicarious trauma is taking on its workers and the information generated can serve as a springboard for further study. It can be concluded from this study that claims workers in the short-term insurance industry are vulnerable to vicarious traumatisation and that it is taking place. As many as 43% of the sample presented with disquieting levels of STS.

The study, however, had a number of limitations. Sample size was a concern but a convenience sample was used. The study also coincided with one of the busiest times of the year for the industry, which hampered participation. Also, the measuring instruments utilised were chosen for their limited length. The aim was not to occupy too much of the participants' already over-extended time, but using such short instruments had certain drawbacks. It is believed that there is a direct correlation between the number of scale items and its sensitivity, which would lead to a more comprehensive construct measurement (Foxcroft & Roodt, 2001; Neuman, 1997). The chosen instruments were also not standardised for South African use which rendered the psychometric properties uncertain. However, since this was an exploratory study and no norms were used during any analyses, the instruments were deemed appropriate. However, psychometric instruments validated for the South African context could have yielded more accurate and reliable information.

Recommendations

While the impact on claims workers is inevitable and unintentional, it still needs to be ameliorated by identifying, developing and eventually putting proactive strategies into operation. The amalgamated scores from this study generally indicate that these workers are at moderate risk of developing complications and difficulties.

However, preventing STS from reaching more serious levels by intervening earlier would be less demanding and more successful. Searching for curative measures only once the levels of vicarious trauma are severe is both perilous to workers, and presents a more complex and exigent task. Also, the present study merely began to explore this rather complex query into vicarious trauma. Further research, both qualitative and quantitative, is essential in order to begin to understand this phenomenon and precisely how it affects these identified workers.

Short-term insurers stand to gain greatly from being brought into contact with the rich diversity of existing strategies and interventions developed and employed by other groups affected by vicarious trauma. It would be of great value if one could determine, through future research activities, which measures are most effective for short-term insurers and to disseminate proven measures to the benefit of all in the industry.

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