



# **SUMMATIVE AND FORMATIVE EVALUATION OF THE TEDDY BEAR CLINIC**

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# CONTENTS

<b>Contents</b>	<b>1</b>
<b>List of figures</b>	<b>2</b>
<b>List of tables</b>	<b>2</b>
<b>Background</b>	<b>3</b>
Context	3
Brief History of the Teddy Bear Clinic	4
<b>Methodology</b>	<b>5</b>
Evaluation Aims	5
Initial consultation with stakeholders	5
Sources of information	5
Ethical considerations	6
Sampling of case records	6
Internal Interviews	7
External Interviews	8
Direct Observation	8
Psychometric evaluation	8
<b>Results of the Case File Analysis</b>	<b>9</b>
Volume of work recorded in the Teddy Bear Clinic files	9
Geographical distribution	9
Gender, age and race	10
Primary Caregivers	11
Nature of the crime	11
Discovery of abuse	13
To whom disclosed	14
Alleged perpetrator	15
Referral network	15
Internal Referral between services	16
Referral to external agencies	17
Summary and recommendations arising from the analysis of case files	17
<b>Analysis of Internal Interviews</b>	<b>18</b>
Well-being of personnel	18
Stressors in the workplace	19
Summary and recommendations arising from the internal interviews	24
<b>Analysis of External Interviews</b>	<b>24</b>
Quality of service	24
Relationships with other service providers	25
What would you like to see from the clinic in future?	26
Summary and Recommendations arising from external interviews	27
<b>Psychometric data</b>	<b>28</b>
<b>Observational Data</b>	<b>29</b>
<b>Organisational Growth</b>	<b>30</b>
<b>Consolidation and System Integration</b>	<b>32</b>
Strategic planning cycle	32
Funding cycle	35
Monitoring	35
Record keeping and reporting	36
Performance management	38
Research and reporting	38

<b>Work with volunteers</b>	<b>38</b>
<b>Care of personnel</b>	<b>39</b>
<b>SWOT analysis</b>	<b>41</b>
<b>Recommended future directions</b>	<b>42</b>
<b>Conclusions</b>	<b>44</b>
<b>Appendix A: Case file data capture forms</b>	<b>45</b>
<b>Appendix B: Internal interview schedule</b>	<b>47</b>
<b>Appendix C: External interview schedule</b>	<b>50</b>
<b>Appendix D: Compassion fatigue and satisfaction self test</b>	<b>53</b>

## **LIST OF FIGURES**

Figure 1	Client age distribution	10
Figure 2	Client racial breakdown	11
Figure 3	Alleged offence by gender	12
Figure 4	Alleged offence by race	13
Figure 5	Means of discovery by gender	14
Figure 6	Means of discovery by race	14
Figure 7	Distribution of compassion fatigue scores	28
Figure 8	Organisational growth chart	31
Figure 9	System integration diagram	32
Figure 10	Action-research paradigm	33
Figure 11	Logical framework diagram	34

## **LIST OF TABLES**

Table 1	Sample breakdown by centre	7
Table 2	Sample breakdown by year	7
Table 3	Sample breakdown by project	7
Table 4	Client distribution by area	9
Table 5	Client distribution by primary caregiver	11
Table 6	Client distribution by alleged offence	12
Table 7	Client distribution by means of discovery	13
Table 8	Client distribution by person disclosed to	15
Table 9	Client distribution by alleged offender	15
Table 10	Client distribution by referring agency	15
Table 11	Aggregated secondary traumatic stress results	28

## BACKGROUND

Every evaluation, in fact every research study, is conducted within an historical, social, economic and political context. Researchers ignore this context at their peril. Several important contextual factors are important to consider with respect to this evaluation study of the *Teddy Bear Clinic*.

*Context:*

1. The clinic has been operating for approximately 15 years. As such it has a substantial organisational history, having come through many changes over its life-span. Although it is not the purpose of this report to document this entire history it is important to note that the clinic has weathered many changes in the past and will continue to adapt to new challenges in the future.
2. Over the past three years in particular the clinic has grown enormously, in terms of the number of children being assisted, the number of sites at which children are assisted, the geographical area from which the client population is drawn, as well as the variety of services offered. While growth and development are essential in a healthy organisation, with stagnation being an indicator of likely future decline, too rapid growth destabilises an organisation. Ideally, growth occurs according to a carefully thought out strategic plan complete with staff development, systems development and a clear sustainability plan.
3. Violence against children is an incredibly daunting challenge for South African society. Many experts believe that the incidence of child abuse and related crimes is on the increase. Certainly the number of reported cases is increasing substantially every year.
4. Resources for child protection and care are extremely limited, and it is imperative that services are as cost effective as possible. While the clinic has a substantial capacity with respect to staffing and physical resources, such capacity is unlikely to be sufficient to meet the need in the short to medium term. Thus the clinic is forced to achieve as much as possible within limited resources.
5. When the *Teddy Bear Clinic* first came into being, child abuse did not enjoy the kind of media attention and public profile that it does today. In fact, the current high level public debate around child protection is only a few years old, despite the hard work of child activists before that time.
6. These high levels of public and media attention bring both opportunities and threats. The key opportunity is that with the public and media focus on child abuse and child protection issues, decision-makers both within and outside of government are forced to take these issues very seriously. The long history of work at the *Teddy Bear Clinic* means that the clinic is ideally placed to influence policy and benefit from public pressure to improve South Africa's child protection indicators.
7. A potential threat arising from high public profile, is that it drives rapid growth. At times there have been strong calls for poorly thought out policies and action from both public lobby groups and government bodies. Stated differently, a danger exists that public demand will overwhelm the wisdom and experience contained within the *Teddy Bear Clinic*, and that scarce resources will be squandered on ill advised intervention strategies.

8. A second threat due in part to high public profile, is that public and government bodies become so critical of the shortcomings of existing services to children, that they irreparably damage what services are available. Recent media coverage and reports on the functioning of child protection services generally are considered by many to be more damaging than helpful, even when they are pointing out the well known weaknesses and problems in the system.

In short, this evaluation takes place at an interesting and important time in the struggle against child abuse in South Africa. The *Teddy Bear Clinic* is an important part of that struggle and it is hoped that this research will assist the organisation to make an even greater contribution in future.

#### *Brief History of the Teddy Bear Clinic*

In the mid-1980s, years of advocacy and lobbying work by a wide range of people concerned about child abuse in South Africa paid off and decision-makers began to pay some attention to the problem. Organisations such as the various Child Welfares and the South African Society for the Prevention of Child Abuse and Neglect (SASPCAN) were instrumental in this process. Before the end of the decade several new organisations emerged with the explicit goals of protecting children from abuse, and assisting children who had been victimised. Among these organisations were the Child Protection Unit (CPU) of the South African Police Services (SAPS), Childline, and the Child Abuse Clinic attached to Johannesburg Hospital and the Department of Paediatrics of the University of the Witwatersrand. This clinic later became known as the *Teddy Bear Clinic* and for the next decade continued to operate with only a handful of staff carrying out medico-legal examinations on sexually and physically abused children, and providing expert reports and testimony to the courts. As the number of children receiving assistance at the clinic grew it became necessary to offer a broader range of services and to expand their reach.

Since 1997, the *Teddy Bear Clinic* has seen a great deal of growth, both in terms of the breadth of services offered and the number of sites from which those services are offered. In terms of the range of services, to the original medico-legal work has been added therapeutic services for both children and parents, court preparation through the Kids Court Support programme, a diversion programme for youthful offenders called the Support Programme for Abuse Reactive Children (SPARC), and most recently the addition of pre- and post-test counselling for HIV. In addition the clinic serves as a training, research and development site for a variety of medical practitioners, and contributes greatly to awareness raising, lobbying, policy debates and training around child abuse in the country.

From the perspective of location of the various services, although services were originally offered exclusively from the Parktown offices, abused children and their families are now being served through sites at the Johannesburg court as well as in Krugersdorp and Soweto. With four sites, the accessibility of the services available through the *Teddy Bear Clinic* is greatly increased. Recently the *Teddy Bear Clinic* has made some important structural changes including separating itself from the *University of the Witwatersrand* and establishing itself as a separate Section 21 Company and a registered welfare organisation. Although a positive and inevitable step in the growth of the clinic, these changes mean that the clinic will have to take care of more of its own administrative functions than it had to in the past.

Thus, at the time of this evaluation the *Teddy Bear Clinic* offers a very comprehensive range of services to abused children and their families and has established itself as a leader in the field in South Africa.

Currently there is some pressure on the clinic to get involved in new and exciting projects. These include:

1. Starting a victim empowerment style service for the Family, Child and Sexual offences unit (FCS) of the SAPS in Vereeniging. The plan is to partner with the Vaal Alpha Trauma Centre who had been given premises by the SAPS and the clinic has assisted with equipping the office.
2. Expanding SPARC with support from the Provincial Department of Social Services. The plan is to only expand to the centres where the clinic already has infrastructure and build the capacity of existing organisations in areas in which it does not currently operate. There are no additional structural needs, and the clinic has applied for additional staffing and finances as it was the Department of Social Services who requested the expansion in line with the increased demands of the pending Youth Justice Bill.
3. Continue to develop the HIV programme which is supported primarily by Provincial Health. The programme offers Post Exposure Prophylaxis and VCT for paediatric sexual assault cases. The work is the ongoing community project of our fourth year social work student at the clinic.

These and other current and future initiatives should be kept in mind in reading this report.

## **METHODOLOGY**

### *Evaluation Aims:*

The aims of the study are to provide a summative and formative evaluation of the current work of the *Teddy Bear Clinic* thereby providing a strong basis for future growth and development. As such the evaluation should take into account the rapid growth through which the clinic has come, and the opportunities that are available to the clinic in the near future.

### *Initial Consultation with Stakeholders:*

Meetings were held with the appropriate representatives of the *Teddy Bear Clinic* and the *Open Society Foundation* in order to explore in more depth the crucial issues emerging in the work of the clinic. These meetings provided two slightly different sets of priorities.

#### *Teddy Bear Clinic priorities:*

Summative account of the existing work of the clinic, recommendations for taking the clinic into the future with respect to personnel, funding, administration and support systems, management and organisational structure, as well as intervention.

#### *Open Society Foundation priorities:*

Documentation of the successes of the clinic as a model for service providers in other parts of the country. Particularly important is to document the different styles of operating between major urban centres and less developed areas.

### *Sources of information:*

Fundamental to evaluation methodology is the need to cross validate findings by accessing information from different sources and perspectives. For this reason this evaluation proceeded by means of an analysis of case records; interviews with people internal to the clinic including staff and volunteers; interviews with people outside of the clinic including police and court personnel, other specialists in child abuse and protection employed in other organisations, and adult beneficiaries of the clinic's services; observation of the clinic and various programmes as appropriate; and a psychometric test of secondary traumatic stress among the staff.

### *Ethical considerations:*

Research that involves children and traumatic stress throws up many ethical challenges. In taking data from case files the names of clients were not entered into the database in order to preserve anonymity, and no case files were removed from the clinic premises. People who contributed to the evaluation through the interview process were assured of confidentiality and every effort has been made to include their comments while protecting their identity. Individual results for the psychometric testing were made available to participants if they were requested as well as basic information about how to deal with any personal risk factors identified. Further, it is difficult to ensure informed consent with children and when parents are not available the researcher is in a difficult position. Finally, discussions of abuse may be traumatising for children and their parents and thus should be avoided by researchers where possible. For this reason the evaluation methodology was very circumspect in its approach to child victims of abuse and their parents.

### *Sampling of case records:*

Comprehensive record keeping is essential to professional case management, particularly when forensic and legal processes are involved. The *Teddy Bear Clinic* has an extensive set of records, divided up between the three centres and the various projects run from those centres. Data collected included the suburb of origin, age, race<sup>1</sup> and gender of the child, nature of the alleged crime, relationship to the offender (if any), method of discovery, and if disclosed, who the disclosure was to. In addition the nature of the services utilized was captured as well as referral information both to and from the clinic. The data capture form is attached under appendix A.

The major weakness of this form of analysis is that it relies heavily on the record keeping practices of the organisation. Where these practices are not highly reliable the work of the organisation may be unfairly judged because the data is not available. The sampling of case files revealed a very high level of variability in the level of case recording. While some files had been meticulously kept, with the necessary information in the correct place, other files were far from adequate. Within the small sample that the evaluators looked at were several files which consisted of single scraps of paper with a child's name and contact number. No other information was included, not even the reason for the scarceness of data. In other cases we found files that erroneously included data from two different children, one of whose records must have been misfiled. It is important to note that the staff and management of the *Teddy*

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<sup>1</sup> Children's ethnic background presented a difficult problem to the researchers. While the *Teddy Bear Clinic*, like many other organisations, sees no reason to document a child's skin colour according to the broad racial classifications laid down by the apartheid government, many donors and decision-makers are likely to be interested to see whether the clinic has managed to make itself accessible to the broadest section of the country's population. Since race is not recorded in the case files, an approximation was made for the purposes of the analysis based on a combination of the language of the child's name, and the area in which the child is living. Although not a comfortable method it does allow us to show the ethnic diversity of the clinic's client base.

*Bear Clinic* have been working on their case record system and that it is certainly more effective than it was in 1999.

*Sample*

A random sample of clinic records was taken between the dates 1 January 2001 and 30 June 2002 using an interval sampling method. Since records are numbered progressively and ordered by the date on which a child was first brought to the clinic, this technique produces a spread of cases, over the 19 month period. It was decided that since the Soweto and Krugersdorp sites were still in the process of establishing themselves, greater emphasis should be placed on the record keeping in the Johannesburg site. For this reason, a sample of 20% of case files was drawn at the Johannesburg clinic, and samples of 10% of case files were drawn from the Soweto and Krugersdorp clinics. This procedure produced a total sample of 306 cases broken down as follows:

**CENTRE**

	<b>Frequency</b>	<b>Percent</b>
Parktown/Johannesburg	245	80.1
Soweto	28	9.2
Krugersdorp	33	10.8
<b>Total</b>	<b>306</b>	<b>100.0</b>

Table 1

**YEAR**

	<b>Frequency</b>	<b>Percent</b>
2001	201	65.7
January to June 2002	105	34.3
<b>Total</b>	<b>306</b>	<b>100.0</b>

Table 2

**PROJECT**

	<b>Frequency</b>	<b>Percent</b>
Counselling/Therapy	105	34.3
Medical	131	42.8
Kids Court Support	70	22.9
<b>Total</b>	<b>306</b>	<b>100.0</b>

Table 3

A set of files from SPARC were also analysed although the sample in this case is too small to include in the overall analysis. Also since the SPARC cases are minors who have been referred by the courts following an offence, it is misleading to confound data from this group with child victims of abuse.

*Statistical treatment:*

All case data was captured and analysed using the *Statistical Package for the Social Sciences (SPSS), Version 10*. Because the client base at the clinic is in no way randomly sampled the number of cases in many cells is low and distributions are seldom normal. For these reasons non-parametric statistical methods are used. Since the details of the statistical analysis are not fundamental to this research report and because many readers find statistical notation alienating, the statistical results are presented as footnotes which can easily be glossed over by readers who are not interested in them.

### *Internal Interviews:*

Thirteen semi-structured interviews were conducted with people who are intimately involved with the workings of the *Teddy Bear Clinic*. The purpose of these interviews were to gain insight into the inner workings of the clinic, to gauge the feelings of people working in the clinic, to find out from the people who know best what the clinic's chief challenges and strengths are. The interview schedule is included as appendix B.

### *External Interviews:*

Ten semi-structured interviews were conducted with people who have had substantial contact with the *Teddy Bear Clinic* of one kind or another, but who are not part of the clinic. This form of evaluation is often referred to as a "reputability study". The purpose of these interviews is to gauge the quality of the services provided by the *Teddy Bear Clinic* from its reputation among informed outsiders. Given the ethical impossibility of sitting in on medical examinations and therapy, and the lack of expertise of the evaluators to be able to judge the quality of that work through direct observation, it is more appropriate to ask people who are more specialised for their opinions. The experts in this case included parents who have an expert understanding of the experience of their children at the clinic, legal personnel who are experts in the strength of evidence coming from the clinic and the ability of children to testify following court preparation, police officers working on child abuse cases, as well as other child abuse specialists who interact with the clinic as part of a referral network and on other platforms. The interview schedule is included as appendix C.

### *Direct Observation:*

The researchers spent time in the various offices of the *Teddy Bear Clinic* and were able to observe the interaction of staff and volunteers, and the ways in which clients coming to the clinic are cared for (excluding actual examinations, counselling etc.). Researchers attended two court preparation days, sitting in on the parents' groups as well as four groups for children of different ages. Where it was possible to observe from behind one way glass observation rooms were used, but in most cases researchers joined the groups. Since this was clearly disruptive of the groups and both the facilitators and the participants (particularly the older children) felt uncomfortable, time in the groups was kept to a minimum.

### *Psychometric evaluation:*

Psychometric assessments are not a common part of evaluations but they were included in this case due to the particular nature of exposure to traumatic stress. The field of secondary traumatic stress is a relatively new psychological field which deals with the effects of high exposure to traumatized people on helpers. Secondary traumatic stress reduces helpers' capacity to form effective relationships with their clients, and has serious negative consequences on workers' emotional health. The compassion fatigue self-test developed by Figley and Stamm (1995), is designed for self use by helpers<sup>2</sup>.

The test produces three scores: compassion satisfaction, compassion fatigue and burnout. Compassion satisfaction is a measure of how much personal pleasure and sense of meaning that helpers get from assisting others. People with high compassion satisfaction are well suited to emergency work because the pleasure derived from doing the work protects them against the

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<sup>2</sup> The Compassion Fatigue Self-test can be downloaded free of charge from the internet at Beth Stamm's personal website (<http://www.isu.edu/~bhstamm/tests.htm>) as long as it is not used for commercial purposes.

stress of the work. Compassion fatigue is a measure of how much the emotional stress of caring for others is exhausting a person. All people who work with emergency situations are in danger of developing compassion fatigue if they do not look after themselves properly. People with low compassion fatigue scores are managing to cope well with the amount of exposure involved in their work. Burnout is a measure of the extent to which the volume of work, the level of responsibility and the day to day annoyances of our lives are impacting upon our emotional state. People with low burnout scores are managing to cope with the challenges that their lives present and should monitor their emotional state and maintain it. People with high burnout scores should urgently seek ways to manage the stress in their lives better. Burnout takes much of the pleasure out of life, prevents us from negotiating relationships successfully, and from doing our work well. A copy of the test is included in appendix D.

## RESULTS OF THE CASE FILE ANALYSIS

### Volume of work recorded in the Teddy bear Clinic files:

Working across the various programmes and sites, the *Teddy bear Clinic* is currently assisting in excess of 100 new families per month. More specific figures taken from the organisation's annual report for 2001 record 376 medical examinations, 584 play therapy clients, and 1201 children in the Kids Court Support programme. This represents an enormous amount of work for a relatively small organisation. This section of the evaluation provides greater detail of the client base and service usage patterns.

### Geographical distribution:

Greater Johannesburg is divided into several municipal areas. The clients of the *Teddy Bear Clinic* come from virtually all these areas as the following table reveals.

Area	% clients	Area	% clients
Alberton	1.5	Midrand	1
Greater Benoni	4	Northern MLC	10.5
Eastern MLC	19	Southern MLC	40
Greater Germiston	4	Western MLC	9
Kempton Park / Thembisa	1	Westonaria	1.5
Krugersdorp	4	Outside Gauteng	5

Table 4

Clients that came from outside the Greater Johannesburg area included children from Bloemfontein, Cartonville, Delmas, Kinross, Klerksdorp, Potchefstroom, Sasolburg, Secunda, Thabazimbi, and Vereeniging.

The fact that 40% of cases come from one municipal region of Johannesburg demands closer attention. What we discover is that there are two distinct areas within that region. The first area comprises the suburbs directly south of the central business district of Johannesburg including South Hills, Rosettenville, Booysens, Glenesk and Turffontein. According to clinic managers, the high case load from this area reflects the work of both the local police stations and the child protection unit in the area. The police in these areas are working exceptionally hard and refer a large number of cases to the clinic. Why so many child abuse cases are being reported in these suburbs is worrying, and at present unclear. The children who came from these suburbs accessed services through the Parktown offices. The second region comprises the suburbs of Soweto including Protea, Protea Glen, Chiawelo, Naledi, Dobsonville and Mofolo. Children from these areas accessed services through the Soweto office.

**Gender:**

The majority of children receiving services from the *Teddy Bear Clinic* are female (85%). There is no difference in the gender split of black and white children<sup>3</sup>.

**Age:**

The age of clients attending the *Teddy Bear Clinic* is extremely broad, ranging from less than one year to as old as 19. The average age is 8 years and 9 months (with a standard deviation of 4 years and 3 months). The following chart shows the distribution of age.

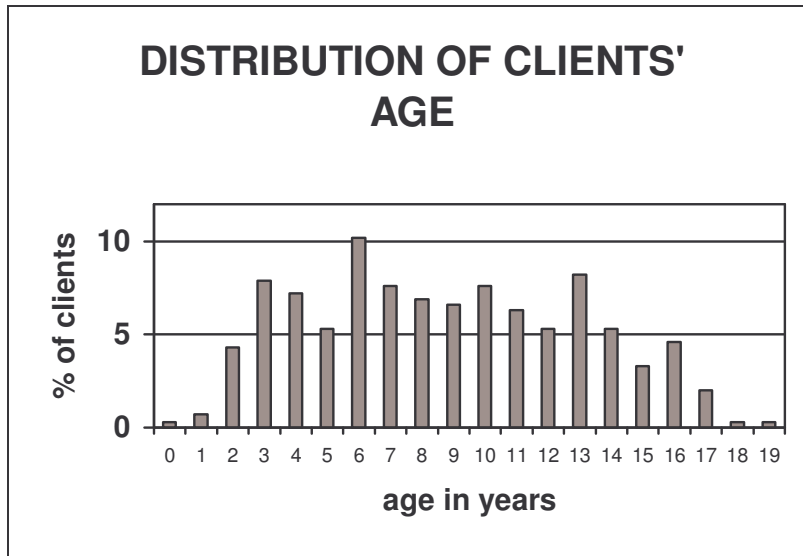


Figure 1

There is no significant difference between the mean ages of male (9 years 2 months) and female children (8 years 8 months)<sup>4</sup>. This conflicts with findings that in Southern Johannesburg roughly equal numbers of girls and boys up to the age of 14 report being the victims of both rape and beatings, but that the incidence of these crimes increases more rapidly for adolescent girls than boys after 14 years of age<sup>5</sup>. Similarly there is no significant age difference between black (8 years 5 months) and white children (9 years 0 months)<sup>6</sup>.

**Race:**

This country's history is characterized by large differentials in the services available to people of different skin colour. Although analyses by "race" are distasteful to many South Africans, it is essential that services are able to show that they are accessible to a diverse section of the population. The following chart shows how roughly equal numbers of black and white children attend the clinic. Although this split does not reflect the proportions of the general population of Greater Johannesburg, it is a far cry from the early days of the clinic where the client base was almost exclusively white. As things currently stand the *Teddy Bear Clinic* is the only specialist service for survivors of child abuse which sees a substantial proportion of white

<sup>3</sup>  $\chi^2=0.738$ ,  $df=1$ ,  $p=0.39$ .

<sup>4</sup> Mann-Whitney  $U=5543.5$ ,  $z=-0.818$ ,  $p=0.413$ .

<sup>5</sup> CIET Africa (2000). *Beyond Victims and Villains: The Culture of Sexual Violence in South Johannesburg*, unpublished research report.

<sup>6</sup> Mann-Whitney  $U=8862.5$ ,  $z=-1.197$ ,  $p=0.231$ .

children. The Rainbow clinic at Coronation hospital, Zamakuhle Clinic and Nthabaseng in Baragwanath Hospital are all situated in areas that have virtually no white inhabitants and so it is not surprising that a large portion of the *Teddy Bear Clinic's* clients are white. What is clear is that the services of the clinic are available to whomever wishes to avail themselves of them, regardless of skin colour.

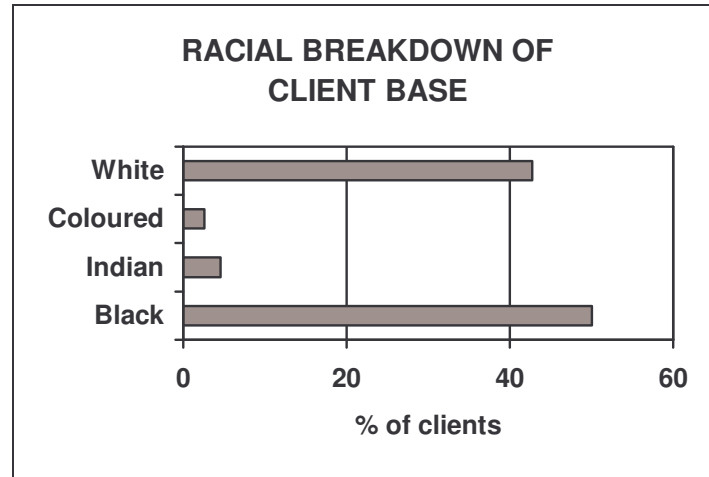


Figure 2

### Primary Caregivers:

The following table shows the breakdown of primary caregivers for the sample of children who have received services from the *Teddy Bear Clinic*. Nearly 80% are cared for by one or both biological parents, with the next most common being children who are cared for by members of their extended family (11.3%).

Primary Caregiver	% Clients
Biological Parent	79.2
Extended Family	11.3
Institutional Care	6.8
Other	1.4
Child minder	.9
Sibling	.5

Table 5

Primary caregiver was not significantly related to either the child's age<sup>7</sup>, gender<sup>8</sup> or race<sup>9</sup>. In virtually all cases the primary caregiver brought the child to the *Teddy Bear Clinic*, although sometimes accompanied by a person from the referring agency.

### Nature of the crime:

The nature of crimes perpetrated against children attending the *Teddy Bear Clinic* was also analysed. While the records often only report the "most serious" crime, it is well documented that in most cases multiple forms of abuse appear concurrently. Furthermore, the "indecent assault/unclear sexual abuse" category is likely to contain a broad spectrum of offences which neither the child's testimony nor the medical evidence elucidated.

<sup>7</sup> Kruskal Wallis  $\chi^2=5.86$ ,  $df=2$ ,  $p=0.053$ .

<sup>8</sup>  $\chi^2=1.096$ ,  $df=2$ ,  $p=0.578$ .

<sup>9</sup>  $\chi^2=3.457$ ,  $df=2$ ,  $p=0.178$ .

Alleged Offence	% Clients
Vaginal penetration	34.4
Fondling / digital penetration	23.5
Indecent assault / unclear sexual abuse	21.3
Anal penetration	11.8
Physical Abuse	4.1
Oral Penetration	3.6
Non-contact sexual abuse	.9
Other	.5

Table 6

Virtually the entire case load (more than 95%) seen at the *Teddy Bear Clinic* relate to some form of sexual abuse. This figure does not match the distribution of kinds of abuse that are reported to the police which suggests that the clinic is known particularly for its work in sexual abuse. It is worth noting that, due to the acute nature of physical abuse many of these cases are referred directly to paediatric services in hospitals. Not surprisingly the nature of the crime is strongly related to both the gender and the race of the child, as illustrated in the following charts.

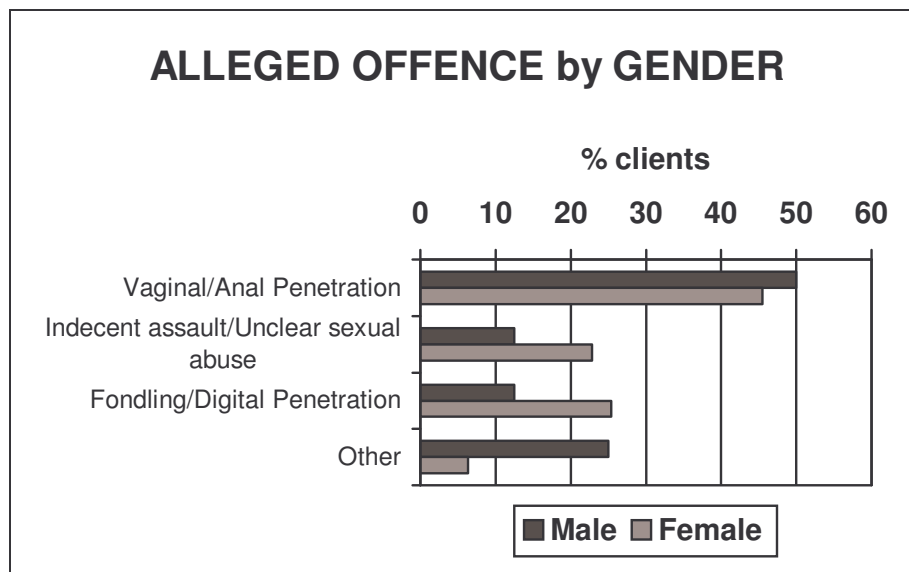


Figure 3

This chart demonstrates that although boys reporting to the *Teddy Bear Clinic* are significantly more likely to have experienced penetration than girls, the other sexual crimes are more likely in the girls than boys<sup>10</sup>. A likely explanation for this finding is that in boy children a great deal of “less serious” crimes such as fondling and indecent assault are less commonly reported.

<sup>10</sup>  $\chi^2=13.93$ ,  $df=3$ ,  $p=0.003$ .

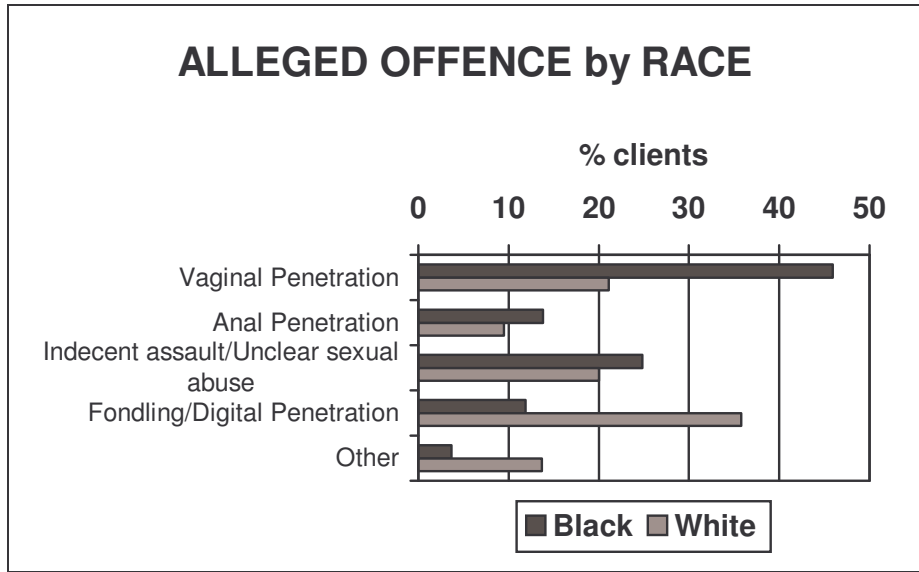


Figure 4

Black girl children reporting to the clinic are roughly twice as likely to have been penetrated than white girls. In contrast a much higher proportion of the white children are likely to have experienced fondling and digital penetration<sup>11</sup>. It is likely that deeper analysis of the social norms and taboos of various South African cultures and the effects of poverty, displacement, and family fragmentation will explain a great deal of this finding.

Finally the nature of the offence is also significantly related to the child's age. Children who have experienced either vaginal or anal penetration (average age of 9 years 6 months) tend to be older than children who have not (average age of 7 years 4 months)<sup>12</sup>.

### Discovery of abuse

The route by which the abuse came to light was also investigated. As is clear from the following table, the majority of cases first came to light after disclosure by the child.

Discovery of abuse	% Clients
Disclosure by child	58.6
Observation (behavior/injuries/illness)	18.1
Suspected, undisclosed	12.9
Witnessed and reported	5.7
Reported by another victim	4.3
Offender Confession	.5

Table 7

Girl children proved more likely to disclose the abuse than boys<sup>13</sup>, and white children are more likely to disclose than black children<sup>14</sup>. These points are illustrated in the following charts.

<sup>11</sup>  $\chi^2=29.07$ ,  $df=4$ ,  $p=0.0000$ .

<sup>12</sup> Kruskal Wallis  $\chi^2=25.69$ ,  $df=4$ ,  $p=0.0000$ .

<sup>13</sup>  $\chi^2=9.701$ ,  $df=3$ ,  $p=0.021$ .

<sup>14</sup>  $\chi^2=10.115$ ,  $df=3$ ,  $p=0.018$ .

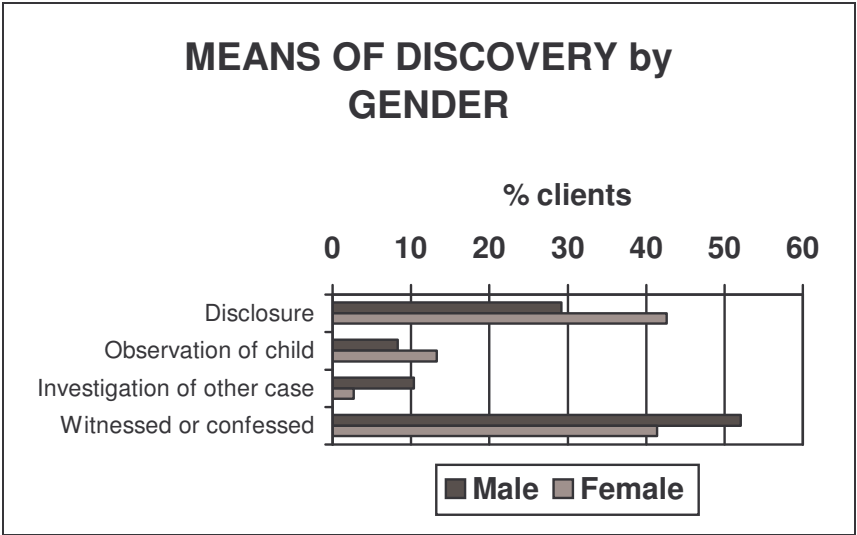


Figure 5

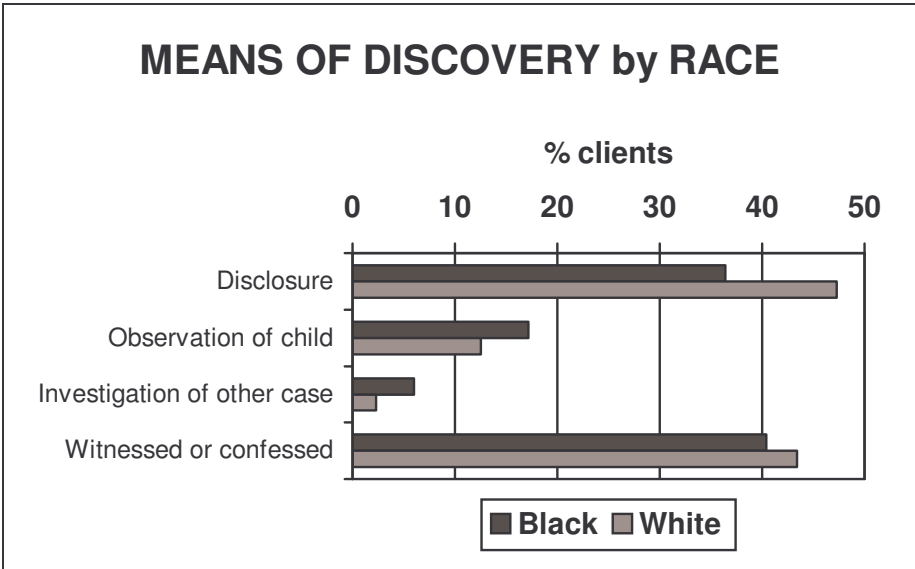


Figure 6

These findings demonstrate clearly how strongly the identification of child sexual abuse depends upon disclosure and how disclosure depends so strongly upon gender and cultural norms. A likely explanation is that the stigma for boys reporting sexual abuse at the hands of another male is greater than for girls, and that the socialization of children in different social groups informs the likelihood of disclosure.

**To whom disclosed:**

When discovery of the abuse did happen primarily through disclosure it is interesting to examine who the child informed. Unsurprisingly the majority (77%) of children disclosed to members of their families, most commonly the biological mother.

<b>Person disclosed to</b>	<b>% Clients</b>
Biological parent	64.2
Extended family member	13.1
Peer	7.3
Police	3.6
School Personnel	2.9
Sibling	2.2
Social Worker	2.2
Unrelated Adult	1.5
Other	1.5
Teddy Bear Clinic	.7
Child minder	.7

Table 8

### **Alleged Perpetrator:**

The alleged perpetrator was also coded in the data and produced the following results.

<b>Alleged Offender</b>	<b>% Clients</b>
Adult Acquaintance	27.3
Minor Acquaintance	13.4
Biological Father	12.5
Mother's Partner	12.0
Adult Relative	9.7
Unknown	7.9
Stranger	6.0
Older Sibling	4.6
Minor Relative	2.3
Mother	1.9
Teacher	1.9
Foster parent/institution caregiver	.5

Table 9

It is worth noting that in approximately 20% of cases the alleged perpetrator was a minor (acquaintances, siblings and other relatives), and in 25% of cases the alleged perpetrator was the biological mother's partner (biological father, and mother's partner).

### **Referral Network:**

The *Teddy Bear Clinic* also draws its cases from a broad spectrum of sources as is demonstrated by the following table.

<b>Referring agency</b>	<b>% Clients</b>
Criminal Justice System / SAPS	50.3
Social Work Services	13.6
Health Services	13.1
Self Referred	9.5
Mental Health Services	4.5
Educational Personnel	3.5
Child Abuse NGOs	3.0
Legal NGOs	2.0
Faith Organisations	.5

Table 10

Just over half the cases seen at the clinic are referred by the police, in most cases specialist child and family units, and the courts. Unsurprisingly the next major referral resources come from social work services (typically the various child welfare societies) and from health

services (mostly clinics and hospitals). Almost 10% of the client base have referred themselves directly to the clinic which is an important demonstration of the significant public awareness that has been built around the *Teddy Bear Clinic*.

### **Internal referral between services offered by *Teddy Bear Clinic***

One of the key benefits of offering related services under the same roof is that it becomes possible to refer clients from one programme to another within the clinic, thereby reducing the need for the client to interact with multiple service providers, and hopefully reducing the number of cases that “fall between the cracks”. The problem of cases being “lost” to the system between perpetration and judgment is an important one. For example, working with the crime of adult rape, a recent study in Southern Johannesburg shows how 394 rapes ends up in only a single conviction as cases are removed from the system along the way<sup>15</sup>. The identical process occurs with child abuse cases and it is imperative that as few cases as possible are lost at the *Teddy Bear Clinic*.

Sadly, the case file data does not show a high level of referral between services. Of the 131 medical files analysed only 15 cases (11%) are linked to a counselling file. Similarly, of the 105 counselling files analysed only 8 cases (8%) are linked to a medical file. Finally, only 6 (5%) of the medical files are linked to Kids Court Support files. Given that in 33% of cases the medical assessment confirmed that abuse had taken place, and in a further 14% the results of the assessment were consistent with the child’s testimony, one would have expected in the region of 45% linkage between the medical and counselling files.

There are several possible explanations for this finding:

1. Many clients who are referred between services at the clinic do not take up the offer of the other services. Counselling and therapy are foreign, threatening, and viewed as potentially stigmatizing to many clients, and that these clients do not return after medical assessments. The fact that many parents work and find it difficult to bring children to the clinic, as well as the costs of transport also contribute to this problem.
2. This finding might also be a result of poor record keeping and therefore be an inaccurate reflection on what is actually happening within the clinic. As noted above there are still some weaknesses in the record keeping processes of the *Teddy Bear Clinic*. It may be that case files are not being updated from one service to another, or that the links between counselling, Kids Court Support and medical files for the same children are not being adequately maintained.
3. Initial appointments often serve as screening sessions after which children are referred on to other service providers including private practitioners. However, recorded referral figures to external agencies are also low as discussed in the next section.

It is likely that the very low internal referral figures are due to a combination of these factors although it is impossible to tell the relative extents. Clinic management feel that these figures do not accurately reflect the degree of internal referral that is in fact happening within the clinic. It is very likely that referral letters and information are missing from the files, and the lack of a shared case number between different services makes it almost impossible to make an

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<sup>15</sup> CIET Africa (2000). *Beyond Victims and Villains: The Culture of Sexual Violence in South Johannesburg*, unpublished research report.

accurate measure of internal referral. This is something that should be rectified in future record keeping systems. Certainly low compliance by clients is also an important problem for most service providers working with people from very poor communities. Two possible avenues of response exist for the problem.

Firstly, the *Teddy Bear Clinic* can continue to make services more easily accessible to a wider range of clients. The moves to open satellites in Krugersdorp and Soweto are important steps in this regard. However, the implication is that in opening any future offices the clinic target areas from which they already receive cases but where the follow up is poor, rather than opening up the service to whole new client bases. Offering indigent clients transport money in the hope that this will enable them to better utilize this service is a strategy that the clinic is already using and should continue to use. In order to be successful such schemes must be very carefully controlled. Finally, having to find their way between different services can be alienating and confusing to some clients. Other clinics try to assist clients by physically introducing them to other staff and setting up appointments directly. A referral procedure which involves giving a client a name and telephone number to make an appointment is less likely to encourage compliance. Again the clinic is already helping clients through referrals in this way and should continue to do so.

The second avenue of response is to accept that client follow up is low, and develop a counselling model that is aimed at achieving the maximum benefit in the first session. In these kinds of models the first counselling session is less about establishing a trusting relationship with the client, but more about providing practical assistance relating to specific problems. These models often use appropriate printed material for clients to take away with them so that if clients do not return for a second appointment, they still have the material to refer to for assistance. In the clinic's line of work this would entail spending a greater amount of time with caregivers, and less with the child in the first session.

### **Referral to external agencies**

Because the *Teddy Bear Clinic* provides a specialist level service it is to be expected that there will be far more referral *to* the clinic, than *from* the clinic. Nevertheless, resources at the clinic are limited and it is unavoidable that some cases will need to be referred elsewhere. Of the 306 cases analysed only 15 cases (less than 5%) mention referrals to outside services. Of these, eight were referred to private therapists, four were referred to trauma counselling services, two were referred to hospitals and one was referred to the Child Protection Unit.

A five per cent referral rate seems low even for a specialist service. The reasons for this low figure might once again be that children are very seldom being referred, or that when they are referred, this information is not consistently recorded in the case files. In discussion with clinic management and examination of the case discussion book suggests that once again these figures are not an accurate reflection and arise largely from inconsistent record keeping. As mentioned above, questions of how referrals are made and recorded in future need attention.

### **Summary and recommendations arising from the analysis of case files**

1. The *Teddy Bear Clinic* is currently assisting a very large number of new families every month, thereby making a significant contribution to child protection in the Greater Johannesburg area.
2. The existing structures are working at maximum capacity and any attempt to increase the client loads will put great stress on staff and organisational structures, to the long

term detriment of the clinic. Increasing the capacity of the clinic from this point depends upon increased income to support the salaries of further staff.

3. Families come to the clinic from all over the region and beyond, and from all parts of the population.
4. The vast majority of cases relate to sexual abuse. Although a significant form of abuse it is by no means the only form of abuse. It is recommended that this pattern be discussed with the major referring agencies, particular the SAPS, in order that children who have suffered a wider range of abuse can also benefit from the clinic's expertise.
5. The establishment of satellites closer to areas from which many clients are being referred is an appropriate response to increasing follow up and compliance by clients. The value of increasing the compliance of the existing client base must be valued against the value of opening up services in entirely new areas.
6. It is recommended that the clinic also explore counselling models aimed to deal with the problems of limited follow up. This has been achieved with other populations in South Africa, and is an area in which the clinic could make an important contribution to technologies of caring for abused children in South Africa.
7. Recording of case information is not yet at the same standard as the rest of the clinic's work. More attention is given to this topic later in the report.
8. Greater attention can be given to the way case files from different parts of the clinic's work are linked together. Once again, this is looked at in more detail later.

## **ANALYSIS OF INTERNAL INTERVIEWS**

### **Well-being of personnel**

All the personnel interviewed in the course of the evaluation expressed their enjoyment at working for the *Teddy Bear Clinic*. Not a single person said that they were unhappy or wished to leave the clinic. All remarked that the rewards of working at the clinic outweighed the stressors. The most commonly and strongly repeated reward for working at the clinic was the fact that the work is extremely meaningful to the staff. The following quotations are illustrative of responses to the query about what people gained from their work:

From the clinical staff with reference to clients:

*... making a difference ... taking away that stressful look or just easing their life a bit.*

*... just to know that you are making a little difference ... it can't just be fixed on that morning, but to know you have made a bit of a difference.*

And from a member of the support staff with reference to the clinical staff:

*Seeing the clinic running smoothly ... that whatever they need, they get.*

Other important rewards mentioned included personnel development through skills training, the chance to work with wonderful people, and the interaction with children.

When asked about their plans for the future, staff were all committed to continuing to work at the clinic although different people had different aims. Some wished to expand their skills in order to contribute more to the organisation, others wished to change the focus of their work.

### **Stressors in the workplace**

Despite their expressed happiness in the workplace staff produced a substantial list of stressors

*Emotional impact of the work:*

Everyone working at the *Teddy Bear Clinic* expressed concern about the effects that ongoing exposure to child abuse was having on themselves and their colleagues. The following quotes illustrate this.

*You see the looks on their faces ... you know what's happened to them ... and you think, I'm really not in the mood for this today ... you get tired of the sadness of the job.*

*One day I wanted to kill a lady here ... its something that worried me that I got so angry with her.*

When asked what assisted them to cope with the emotional impact of their work, staff made the following comments:

*The challenging side of this work is to actually sit back and look and nurture oneself.*

The need to actively nurture oneself and others is a crucial aspect of working in a field like child abuse. The common response used by emergency workers, police, journalists and other people in high exposure professions is to tune out the pain and distress of the people with whom one is working. Although when applied unskillfully as it often is, this approach has serious negative consequences for other arenas of the person's life, it does help people to survive. Unfortunately, for those people who must engage intimately with the traumatized person in order to assist them (such as therapists), these possibilities are negated. Nevertheless the temptation is there, as is expressed in the next quotation.

*...you can't ever become desensitized but you have to remain focused.*

Secondary traumatic stress and burnout are serious concerns for any organisation working with high exposure to traumatic events and traumatised people. For this reason a substantial section on care for workers is included later in this report.

### *Workload:*

Most of the personnel felt that their workload was too great. This is a significant problem for any service organisation working to provide a service where the problem is virtually limitless, but the available resources are not. There will always be more work than can be done. The following quotes are taken from staff's discussion of their workload:

*I take a lot of admin. work home ... I am not able to manage it at work.*

*I just stop counting overtime, because there just isn't time to take the overtime.*

While it is not unreasonable to expect people to work extra hours from time to time, it becomes problematic when it becomes the organisational norm. The challenge of fixing clear performance expectations is one that needs to be dealt with formally and explicitly, so that personnel do not find themselves trying to handle more cases, larger groups, and longer hours than is sustainable. When the workload is not limited, the dangers of burnout are greater and involve enormous cost to both individuals and the clinic.

### *Administrative Burdens:*

One aspect of the high workload that was repeatedly mentioned by staff was the burden of having to do a great deal of administrative work.

*You have to document everything ... what happens is I am not able to do it on a daily basis.*

There are several points to be made about this. The first is that many people in the "helping professions" consider administrative work to be a bothersome footnote to the real work of providing care and assisting clients. When people do this they commonly end up putting off the administrative side of their work indefinitely. The consequences of this practice is poor record keeping since by the time the work gets done the person is having to catch up a large amount of administrative work under time pressure and has forgotten some of the detail. It is important to work towards an organisational culture that views record keeping and administrative work as an integral part of helping work. A large part of the clinic's administrative functions cannot be handled by administrative/support staff alone since they do not have the requisite medical, psychological and forensic backgrounds.

At the same time, everything must be done to insure that the administrative functions, just like every other function, are organised as efficiently as possible. Poorly designed record keeping and reporting systems can add to the energy and time required by staff to keep their work up to date. The larger an organisation gets the greater becomes the cost of inefficient support systems, ultimately leading to the paralysis that can be observed in so many large organisations in South Africa today. These problems are dealt with in more detail in a later section.

Finally, it is worth noting that most service providers struggle with good record keeping and that it is only when supervisors play a strong and active role in ensuring that record keeping is of professional standards that these problems are resolved.

*Unnecessary bureaucracy:*

A couple of the personnel interviewed felt that some of the systems by which the *Teddy Bear Clinic* runs were unnecessarily bureaucratic, and cumbersome.

*The most stress in this clinic is ... a lot of red tape, bureaucracy .. forms that keep getting changed, job descriptions that don't allow people to do certain things.*

The argument that the “system” is cumbersome is a common response to the abovementioned problems of staff not giving sufficient priority to administrative work. Nevertheless, it is important that systems be as streamlined as possible, so that the maximum time and effort can be put into direct work with abused children.

*Role clarity:*

A common stressor in workplaces and one which is present to some extent in the *Teddy Bear Clinic* is the question of role clarity and clear job descriptions. In two interviews the comment was made that people were unclear exactly what was required of them. The following quote illustrates this:

*[I find it] difficult to sort out what is my job and what isn't ...*

*The various roles ... everyone is calling on you.*

There are several possible ways of responding to this concern. Although it may be argued that staff who are unsure of their job description should either decide for themselves or ask a supervisor, it is not always that simple. These problems seem to be specifically related to emergencies and unplanned for events.

*As much as I structure my diary there's always other demands ... everybody has urgent requests and demands.*

*You are in crisis a lot ... stuff gets put on your plate at the last minute because someone else can't make it.*

The problem is not so much one of not knowing what is expected, but of not knowing how to choose between competing demands. Despite the additional stress that this places on staff, role confusions also create fertile ground for conflict within the organisation, something which is dealt with in more detail below.

This problem can be approached from three complementary perspectives. Firstly, it is important that explicit and detailed job descriptions and performance criteria are established for every position. Such documents often differentiate between core functions and secondary functions, in this way assisting in the prioritisation of tasks. Secondly, job descriptions must be designed so as to allow space for emergencies and unplanned for events. Thus for example, it is not wise to set performance criteria for a therapist of 30 therapy sessions a week, since this does not allow the flexibility needed to travel to see a client in hospital, or give evidence in court on short notice. Finally, proactive supervision and coaching is important. Very often stretched organisations develop a culture where managerial roles become “problem solving” rather than developmental. In this culture managers are constantly being asked to resolve priority issues but do not have sufficient opportunity to develop the capacity to solve these

problems in other staff members. In contrast, where a proactive coaching model is in place whereby supervisors meet regularly with staff (either alone or in small groups), future problems can be predicted and planned for. In this model staff develop the capacity to resolve role confusion for themselves.

*Communication between “head office” and satellites:*

Staff working in both the Krugersdorp and Soweto offices had concerns about the nature of communication from head office. Interestingly their concerns were different. On the one hand it was argued that staff and volunteers in the satellites are often left out, or excluded from key processes happening at head office. It was argued that this disadvantaged the staff in those offices. Particular mention was made of conference and training announcements. On the other hand, it was argued that there should be a list of functions which are exclusively the concern of head office, and that involving satellite staff in all those processes reduced their capacity to establish the satellites. In other words, that the satellites were being include too much in head office affairs.

Both arguments have some merit. An efficient organisation operates with clear and mutually agreed mandates, allowing particular individuals or groups of individuals to make decisions and create policy on behalf of the organisation as a whole. It is important that only those people who need to be part of any particular process are involved in it. However, it is also important that everybody in the organisation has access to information. With the obvious exception of confidential information (including staff records, salaries, etc.), all staff and volunteers need to be kept informed of all the aspects of the organisation’s functioning. In an organisation the size of the *Teddy Bear Clinic* this does not require a great deal of effort. A weekly one-page bulletin updating people achieves this. Furthermore, a bulletin of this nature reduces the need to spend time discussing issues which are not important to everyone at staff meetings.

*Interpersonal conflict:*

Interpersonal conflict was mentioned by a couple of people only, for example:

*Dynamics between people in the organisation will threaten to bring it down ... there’s not all the trust there should be ... people feel abused or they are abusing each other ... this is the nature of what happens in these organisations.*

The fact that there are few mentions of interpersonal conflict suggests that a few isolated confrontations are behind the comments, rather than a systemic problem within the *Teddy Bear Clinic*. However, this information has been included because small interpersonal conflicts which are not quickly resolved are often early warnings of deeper problems within the organisation. When people become stretched their interpersonal skills diminish, and anger and frustration may be inappropriately expressed towards colleagues. Frustration was linked to lack of support and supervision from managers, lack of role clarity and being let down by volunteers.

*Leadership style:*

It is very clear from all the internal interviews how much the volunteers and staff of the *Teddy Bear Clinic* value and admire the clinic’s leadership. The following quotes illustrate this strongly.

*... is an absolute pillar ... kind of fills the gaps and is good at having an overview and knowing what needs to happen ... a solid person who deals with issues frontally.*

*... has got a lot of strengths, a lot of energy, a lot of drive, ... makes things happen, ... thinks big ... incredibly well connected.*

*... is keen for staff to develop themselves, even when its not exactly job related.*

*People who go the extra mile.*

*I think there is quite strong management ... that it is cohesive.*

There were however several remarks made about management at the clinic which show that things could be better. It is important to note that many of these remarks came from the managers themselves.

*Some people are having to do stuff that is not necessarily their strength.*

*There are some things that I think are never going to change.*

*There have been issues with ... [management] style and this translates into the processes you create ... for instance communication channels, and who makes decisions about what ... some of these things weren't clarified and there wasn't consistency around that.*

*It leaves staff feeling a little uncontained and not knowing what to do.*

*[One of the most challenging parts of my job are] things I'm not trained to do, which is true management tasks ... I'm trained to manage children's behaviour, not people and money.*

Clearly, although the individuals concerned are greatly admired and respected, there is a problem around management, but not leadership, at the *Teddy Bear Clinic*. This is discussed in more detail in a later section.

#### *Office Equipment:*

Although dependent upon funding, office equipment was an issue repeatedly raised by staff. Certainly an organisation the size of the *Teddy Bear Clinic* can justify having a small computer network in the head office and a decent computer in each satellite with electronic mail facilities. Things like vacuum cleaners in the satellite offices are small expenses to the clinic but make a great deal of difference to the people working in those offices. There is a danger that smaller service organisations class this kind of equipment as “luxuries” and so agree to do without them, underestimating the impact that working without a computer/vacuum cleaner/fax machine has on staff productivity and happiness in the work place. A relatively small capital outlay can provide much greater benefits. In addition, many companies are prepared to donate equipment that they manufacture when they are not prepared to donate money for salaries and other project expenses.

### *Setting up the satellites:*

The interviews with staff in the satellite offices clearly demonstrated that the establishment of a satellite happens along different lines to that of the establishing the head office. Although it is undoubted that the satellites benefited greatly from the use of the name “Teddy Bear Clinic”, their project success is due largely to a very small number of significant local relationships with SAPS, court and welfare personnel. Sometimes these relationships have taken a significant amount of perseverance to develop. For instance the relationship with prosecutors at one of the courts has taken the satellite co-ordinator more than a year to build but today the relationship is a strong one which benefits both the work of both organisations significantly.

One of the difficulties of setting up satellites is the emergence of issues around the sharing of financial resources between the various service sites. It is unavoidable that satellites will often be supported by different donors and that these donors will provide funds for different aspects of any particular satellites work. It is very difficult to provide every satellite with identical resources, and the more satellites that open the more difficult this problem becomes. The only option for addressing this problem is by keeping the budgeting, fund-raising, and fund allocation processes as inclusive and transparent as possible. If co-ordinators are part of these processes at every step they are in a much better position to understand and accept the inevitable differences that will arise.

### **Summary and recommendations arising from the analysis of internal interviews:**

1. Staff at the clinic achieve a high sense of personal satisfaction from their work and are happy in their jobs. This is an important positive indicator for the long term success of the clinic.
2. Many staff feel the emotional strain of working with abused children on a daily basis and this is something that must be monitored continually.
3. It is recommended that attention be given to the development of clearer job descriptions and performance criteria for all positions. These should prioritise particular core functions, set limits on the amount of work expected from the staff, leave sufficient room for unplanned for events, and allow for administrative functions. Performance criteria should be monitored and reviewed on a six monthly basis.
4. The functions of head office and the satellites needs to be further negotiated and clarified.
5. It is recommended that the organisation consider a regular short news bulletin to keep people informed of developments. This should help to keep people better informed and save time at meetings.
6. Some attention needs to be given to existing administrative systems in order that any opportunities to streamline them may be taken advantage of.
7. To the existing powerful leadership needs to be added powerful management skills. Clear expectations, instructions, policies, and systems foster a sense of security within the organisation. In particular it is important that management starts to develop a coaching, rather than problem solving style.

8. Record keeping is an area of weakness in the clinic and management need to monitor this function more closely until confident that it is being handled as professionally as the other aspects of the clinic's work.
9. Although the satellites have taken some time to become more established this has proved a successful exercise and a significant number of clients are seen at both new offices. The monitoring, support and communication with satellites is an important managerial issue. It is imperative that the satellites are closely managed by head office or have stronger management capacity on site. At the moment the latter is not practical and so it is important that senior people from head office spend substantial amounts of time (one day per week) in each satellite offices.

## **ANALYSIS OF EXTERNAL INTERVIEWS:**

### **Quality of service:**

The vast majority of responses to the quality of service of the *Teddy Bear Clinic* were extremely positive. This is true for all the services offered by the clinic as is illustrated by these quotes:

*Its not fancy ... but it serves its purpose - its child friendly. When we tell them [children] they have to go for a medical examination there are extremely tense and once they get there [Teddy Bear Clinic] they just seem to calm down ... They are very happy once they are there.*

*The service is quite unique. They offer a lot of services under one roof that you don't get anywhere else.*

*They do proper medical examinations. In fact I wish they could train the doctors here.*

*The assessments are of a very, very high standard ... that's not my opinion. That's the opinion of the courts.*

*The medical evidence presented in court is accepted ...very competent doctors.*

*[Following court preparation the children are] much more relaxed. They are not afraid to come to court any more. Its easier to talk. They are not afraid to give all the details.*

Thus in addition to the high volume of work conducted at the clinic, many people who working the field find the quality to be very high too. However, among the flood of positive evaluations of the *Teddy Bear Clinic* there were some more critical remarks.

*Documentation from the clinic is sometimes not sufficiently detailed, especially for statutory work that is referred to [us]. Volunteers are often not clear what documentation is necessary.*

*[Kids Court Support Programme] is not as tight as it used to be.*

*There are cases that have come to us [after Kids Court Support] who have no idea of what is happening ... they don't know who their prosecutor is and they are confused in terms of the system.*

On the whole the positive comments relating to the work of the *Teddy Bear Clinic* far outweigh the negative remarks. Furthermore, the negative remarks do not consistently refer to any area of weakness in the overall functioning of the clinic which can be pinpointed and improved. Rather the criticisms refer to particular cases or negative experiences where the standards expected by other role players have not been met. On the whole the response is laudatory.

### **Relationships with other service providers:**

Given the questions raised by the referral patterns from the clinic it is important to look at how others feel about the relationships between the clinic and other service providers. Again, most of the people who the researchers spoke to felt that the *Teddy Bear Clinic*, and particularly specific senior individuals employed at the clinic, are particularly good at networking.

*They're good at networking. They work well with multiple organizations around.*

*Teddy Bear Clinic [is] willing to help other organisations get established. I find that quite an achievement.*

Clients also notice the networking relationships. This comment from a relative of a child who was assisted at the clinic.

*They worked hand in hand. It was like a puzzle that each one fitted into ... we call it a team. There is a very close bond between them. If they hit a snag they contact the others and put their heads together to solve this problem.*

Clearly the relationships between the child protection unit and the clinic is very important. The following comment illustrates this.

*The word is spreading that they are giving a good service and its spreading through the CPU.*

However, more than one respondent mentioned one area of danger. The following quotes illustrate this:

*It is important not only to focus networking on the people you work with, but also to focus on other role-players. Sometimes [other service agencies] feel that Teddy Bear Clinic has not consulted with them and so there is a doubling of services.*

*They must be careful. They can't be everything to everybody! Focus on what you do well and stick to that.*

*They are over ambitious to the point of annihilating the good work of others.*

Anxiety and hostilities between service providers in under-resourced sectors is a common finding. Although organisations work hard to co-operate, competition for resources is often

divisive. To some extent, it is possible to read in these criticisms an underlying competition between the clinic and other service providers. Clearly, arguments about duplication of services must be read critically. Where it happens that a particular family is getting the same services from several providers (as does happen), we can realistically talk about duplication of services. However, when clinics such as the *Teddy Bear Clinic* are working with substantial waiting lists, the fact that similar services exist within the same city, is not a solid argument of redundancy.

At the same time, this is an important point for the *Teddy Bear Clinic* to consider when planning for the future. Moves to expand the range of services offered must proceed with the support of other service providers, if the good reputation of the clinic is to be maintained and advanced.

### **What would you like to see from the clinic in future?**

External experts were also asked what they would like to see the clinic doing in the future. For the most part people responded that they would like to see the clinic continuing to do its good work.

*Just keep doing what you do!*

A few respondents did have some suggestions

*It would be good if they could do more training ... so doctors would have no excuse for bad medical examinations.*

*You don't have constant people who stay and get more specialized. They need to train volunteers more so that they can testify in court.*

*I would like to see them moving into adults as well because we have a big population of adults getting raped that doesn't get much support.*

*If they could move into the HIV area, give training ... and be able to support emotionally with counseling and therapy for HIV patients, especially children who contract HIV through rape.*

Clearly, some respondents, who greatly admire the staff and work of the *Teddy Bear Clinic*, would like to see the clinic expanding its services. As mentioned earlier for a successful organisation working in the field of child abuse in South Africa today, there will always be more demands and opportunities than the organisation is able to handle.

### **Summary and recommendations arising from the analysis of external interviews:**

1. The most important finding to emerge from the external interviews is the high regard that the *Teddy Bear Clinic* enjoys among experts in the field. This is a very important indicator of the quality of work done at the clinic, and the organisation should be proud of their reputation.
2. The question of co-operation and collaboration with other service providers is also important. Although on the whole the clinic enjoys a good reputation as being responsible in this regard, other local organisations are clearly feeling threatened by the clinic's rapid and continuing expansion.

3. It is recommended that the clinic work ever harder to build relationships with other structures working in the field of child protection and ensure the support of other agencies as the range of services offered by the clinic is increased. The clinic's existing work building the capacity of other organisations is particularly important in this regard and should be developed.
4. Clearly many people would like to see the work of the clinic expanding into other areas. This is potentially very dangerous for the clinic as it can lead to a focus which in the end overstretches the expertise of the staff, produces poor quality work over a broad range of services and damages the clinic's reputation. The clinic provides a specialist service and should work to protect this position.

A quote taken from the internal interviews reflects this danger with respect to HIV infection and voluntary counselling and testing (VCT).

*I see this counselling changing the focus of the clinic ...*

5. One of the weaknesses of working with volunteers is that they do not stay with the organisation long enough to develop into experts in the field. A great of the work of the clinic depends upon highly specialized input. Although more content about volunteer management is included later in the report, the need to constantly develop the skills of volunteers is apparent from some of the comments made by external respondents.

## PSYCHOMETRIC DATA

The results of the Compassion Fatigue Self-test are included in this section. As described above the test produces three scores, namely compassion satisfaction, compassion fatigue and burnout. (See pages 8-9 for a description of what these scales measure). In a healthy organisation one would expect to see high scores for compassion satisfaction, and low scores for compassion fatigue and burnout. The following table contains descriptive statistics of the aggregated scores obtained from the *Teddy Bear Clinic*.

Scale	Average	Std dev.	Min	Max	Category
Compassion Satisfaction	101	10.2	87	114	High Potential
Compassion Fatigue	29	15.3	16	52	Low Risk
Burnout	24.8	6.7	19	37	Extremely Low Risk

Table 11

These figures suggest that despite the evident distress expressed by many personnel in the internal interviews, the staff are coping well with the stress of working on a daily basis with abused children. An important part of this is the high level of compassion satisfaction experienced by many people at the clinic. The belief in the importance of what one is doing, and the magnitude of assisting even one child is the most important component in the sustenance of staff doing this work.

Although on the whole these figures are extremely positive they do mask some important detail in the compassion fatigue scale. The distribution of the scores of the eight people who agreed to complete the scale are presented in the following table.

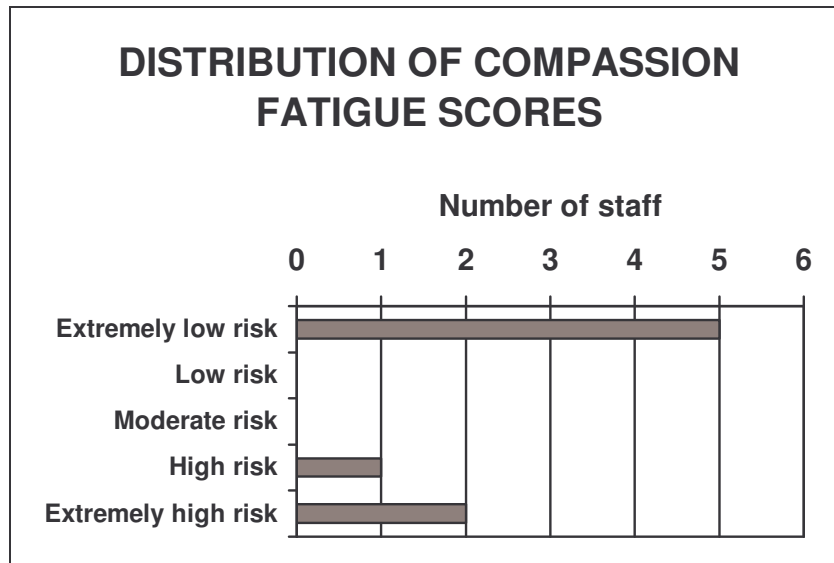


Figure 7

This chart shows clearly that the low risk recorded by the average score is a result of the presence of a small number of people who are in danger of compassion fatigue being masked by the majority who are not.

Compassion fatigue is a serious problem and not as easily resolved as other forms of stress and burnout. Compassion fatigue changes the beliefs that care workers hold about themselves, other people and the world. People who score high on compassion fatigue are likely to experience a fair amount of distress as a result of their work, and although they may be sustained for a long period by the satisfaction that they get from their occupations, will eventually have to leave in order to restore their mental health. It is significant to note that the three people with the highest compassion fatigue scores, also had the lowest compassion satisfaction scores. Compassion fatigue gradually erodes the sense of personal satisfaction and meaning that care workers get from their work, thereby leaving them vulnerable to burnout, secondary traumatic stress and depression.

It is important that the clinic continue to pay attention to problems of secondary traumatic stress in the workplace. As mentioned above self-care is very important and one member of the team mentioned the power of prayer. More about ways of caring for people suffering from compassion fatigue are discussed in a later section.

## OBSERVATIONAL DATA

Direct observation of the functioning of the clinic supported many of the findings coming out of the case files, psychometrics, and interviews.

*Day to day running of the clinic:* Of particular interest to the researchers was observation of the clinic staff when the clinic was busy, since it is at these times that working relationships are tested. Several of the days that the researchers spent in the clinic were extremely busy. At no time during these days did clinic staff become frustrated or impatient with clients. Only once was there a small amount of tension between staff members. This supports the feelings expressed in the interviews that virtually all staff members enjoy working with the other people at the clinic. Many people have had experience of service providers where clients are not treated respectfully because of the pressure on personnel.

*Kids Court Support Days:* The two Kids Court Support Days where the researchers were present were very well attended by both children and caregivers. The caregivers' group that was attended was too large to be handled by a single facilitator. This meant a very long and difficult session for the facilitator which was handled as well as can be expected. Unfortunately it meant that when one or two caregivers became emotionally overwhelmed by their experiences it was almost impossible for the facilitator to offer the appropriate containment and support. In discussion with the facilitator afterwards it became clear that the turnout on this particular day had been exceptional and that plans were already underway to split the caregivers into two more manageable groups in future.

At the caregiver group each person had an opportunity to explain how far their particular case had progressed and to discuss their concerns with the facilitator. The facilitator gave well informed responses to all the questions and fielded a great deal of anger which would more appropriately have been directed towards the court system. The challenges of a difficult process were handled most skilfully. Discussions with caregivers following the meeting revealed clearly how much had been gained from the process.

The children's groups were much smaller and handled very effectively by the various facilitators. In two situations where children became visibly distressed the facilitators provided the necessary containment and distraction which allowed the educational process to continue while at the same time assisting the child to contain the traumatic experiences. Clearly the children who had been present at previous days had learned something from their past exposure since they were readily able to answer questions about court procedure and had been coached in asking to take a break, to repeat questions and so forth.

The courtroom simulation was less successful. The explanation of the courtroom was done for all the children in multiple languages. With all the children in one room there was no time for interaction and the children became restless having to listen to languages they did not understand. The adolescents played all the roles in the mock courtroom and many of them were clearly not interested in doing the exercise and had to be cajoled into participating. The younger children were supposed to be watching the simulation but most of them did not pay attention.

Observation of medical examinations and therapy were not considered appropriate or ethical, and data on these services was obtained instead through the interview processes discussed above.

#### **Summary and recommendations arising from direct observation:**

1. The observations support the findings from the external interviews of the high quality of service provided at the *Teddy Bear Clinic*.
2. The clinic has achieved a high degree of child friendliness.
3. The court simulation part of the Kids Court Support programme might need some development in order that younger children have a better chance to interact with the court process in the court room, and are not required to be spectators.
4. The size of groups should be monitored as closely as possible. The nature of the work means that large groups are less effective and extremely stressful for the facilitators.

## ORGANISATIONAL GROWTH

Organisational growth is characterized by periods of rapid expansion following periods of consolidation in which much less growth happens. Proper consolidation allows for further sustainable growth. This pattern is represented in the following diagram.

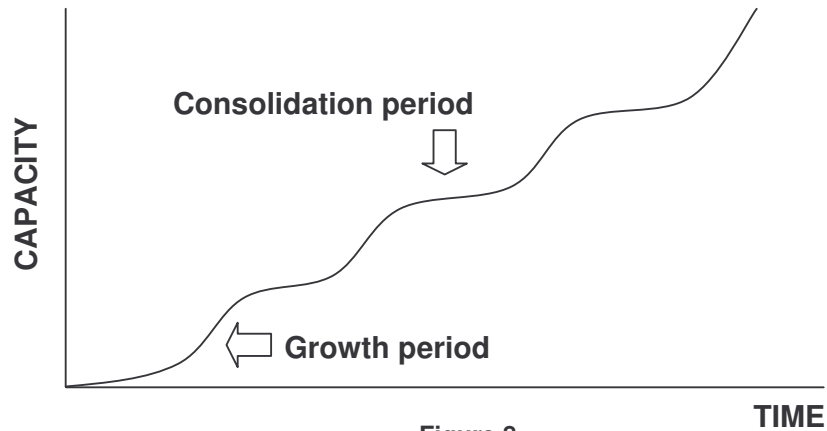


Figure 8

The implication of this well established pattern of organisational development is that following every period of rapid expansion must come a period of consolidation if the organisation is to remain healthy. The question arises as to what happens if there is no period of consolidation and the organisation continues to expand. There are several possible scenarios:

- a) With very strong leadership and management the organisation can survive and continue to grow, but this will be at great personal expense to the staff of the organisation. It is likely that the standard of work will drop for a while as staff try to take on more than can realistically be accomplished.
- b) The organisation can fail structurally with important deadlines not being met, turn over of staff increasing dramatically, programmes and projects closing down, and the reputation of the organisation being severely damaged.
- c) The organisation can fragment with particular programmes breaking away from the parent organisation and re-establishing themselves on firmer organisational footing. While this can be a positive step for an organisation it is often not. The proliferation and poor co-ordination of non-governmental service providers in South Africa is in part a symptom of the pressure to deliver that has been placed on this sector during the past several decades.

Many people at the *Teddy Bear Clinic* appreciate that the organisation has come through a major expansion period and needs to continue the process of consolidation before further significant expansion.

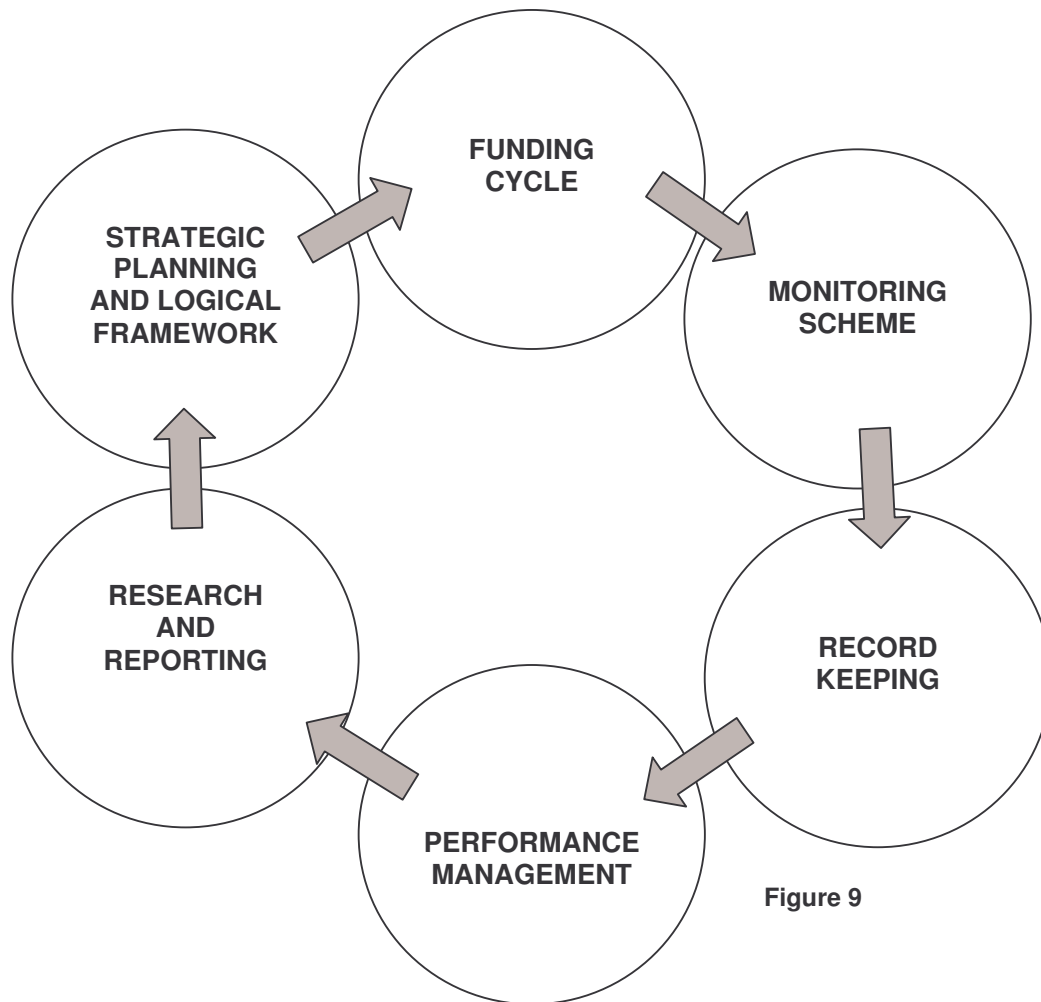
*I think the clinic is in a point in time when it needs to begin consolidating.*

*Constant transformation makes management difficult, the system hasn't caught up.*

The following sections look more closely at what goes into organisational consolidation.

## CONSOLIDATION AND SYSTEM INTEGRATION

In the same way that it is essential that the organisation's various services be deeply and explicitly integrated, it is important that the processes and systems that support those services are integrated. These internal processes and systems include strategic planning, fundraising, monitoring, record keeping, as well as research and reporting. This section of the report focusses on these systems and their integration.



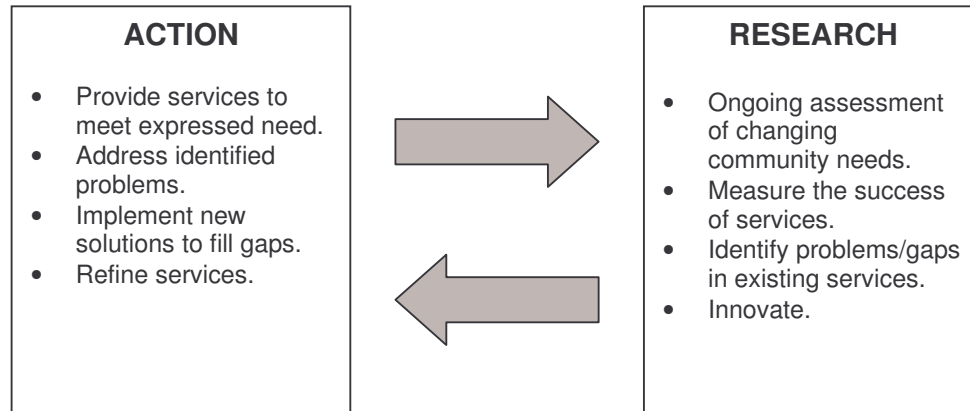
### Strategic Planning Cycle:

The *Teddy Bear Clinic* is in the exciting but challenging position of being in many respects a pioneer of service provision in the field of child protection in South Africa. As a result, the organization is continually faced with new problems and obstacles, as well as new opportunities. Both organizational structure and process should be refined to reflect the optimum response to the pioneering nature of the work. The strategic planning process which the *Teddy Bear Clinic* already uses is an essential part of this process. It is recommended that the existing strategic planning process be further refined, and fed directly into funding, monitoring, record keeping, and performance management.

Although strategic planning should happen on an annual basis, it is very useful to encourage ongoing critical reflection and refining action on the part of the staff.

*Encouraging ongoing critical reflection:*

A useful conceptual model to guide the organization in this, is the action-research model. The *Teddy Bear Clinic* can be conceived of as a substantial and ongoing action-research project, with the dialectic between action and research conceptualized as follows.



**Figure 10**

Conceptualizing the organization and its work in this way has some far-reaching implications for the processes and climate of the organization. Central to the action-research formulation is the strategic planning and critical reflection. It is important that a thorough and explicit strategic planning process happens on a regular basis. Although an annual process is common, it is helpful to encourage critical reflection at all times. Other organizations of comparable size and structure have found the following system effective for their needs.

All projects are run by teams under a team leader. Team leaders are responsible for providing short reports on a quarterly basis to the executive team. These reports are designed to answer the following questions:

- a) Has the project met its targets for the quarter?
- b) How have the needs of the community changed, if at all, since the last report?
- c) What new opportunities and threats have emerged in the environment since the last report?
- d) What changes will be made to the way the project runs in the next quarter?
- e) What are the targets for next quarter?

These questions are designed to reduce the amount of work team leaders are required to do in reporting and to compel them to think critically about their work and not become complacent. An effective team leader can complete the report very quickly by making a couple of succinct points in response to each question.

Finally, the accumulated reports over the year form a strong basis for the next strategic planning cycle which in turn translates into annual and donor reports, as well as fundraising proposals.

One of the criticisms often leveled against strategic planning processes is that they become “talk shops”, that is, people come up with grand plans but never put them into action. The reasons for this are several, but often start with the planning process itself. Too often strategic planning ends with plans which overloaded operational staff find almost impossible to put into

action. For this reason, strategic planning needs to continue until the details of changes to the work plan have been carefully worked out. One of the ways of doing this is to develop a detailed logical framework analysis for all the work carried out by the organization. Such a framework highlights the logic which links the inputs and activities of the organisation to the intended impact upon the community.

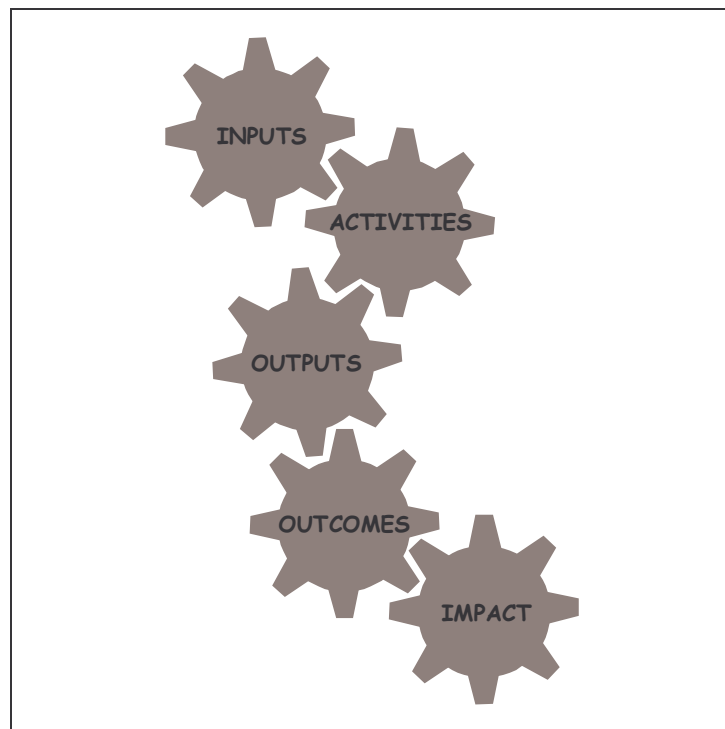
*Logical Framework Analysis:*

Although many donors do not require detailed logical framework analyses, this technique, if thoughtfully applied, provides a powerful tool for managing complex programmes such as those offered at the *Teddy Bear Clinic*. It is advisable for managers to develop a comprehensive logical frame work of the organisation’s work which in turn feeds directly into ongoing monitoring, administration and reporting as well as staff performance management.

The service plans for the various branches submitted to the *Department of Social Services and Population Development*, contain the beginnings of logical frameworks including outputs, activities, performance indicators, and inputs. In the case of the *Teddy Bear Clinic* it seems that the contents of these service plans have been pulled together in response to demands from the department, and not from the independent planning processes of the organisation. It is recommended that, when an appropriate time for strategic planning comes around again, the entire personnel of the clinic be involved in the development of a detailed logical framework that encompasses the entire work of the organisation, including both service delivery and support functions.

Logical framework analysis assists organisations to explicitly map out the pathway between the resources used in the work and activities on which time and energy are spent, with the eventual impact that the organisation wishes to have on the community. This is illustrated in the following diagram.

**Figure 11**



In order to create a certain *impact* - in this case, a healthier community where children are safer - certain *inputs* must be present. These inputs include the financial and material support provided by donors and structures within the community, as well as the training and experience of personnel. Inputs are utilized through a range of *activities* (the things that the personnel do on a day to day basis), to achieve certain *outputs* (so many forensic assessments, so many therapy sessions with so many children, etc.) These *outputs* in turn lead to particular *outcomes*, such as children recovering more completely from their experiences of abuse, being less frightened when confronted with the workings of the criminal justice system, and offenders being convicted. Such outcomes impact more broadly on the surrounding community, for example, increased awareness of the prevalence of child abuse in our society, changes to the processes of the criminal justice system, and so on. It is important to note that while *outputs* are directly under the control of the organisation and its staff, *outcomes* and *impact* are not, and yet it is really these that are most important to clinic staff, donors and other stakeholders. Indeed, our inputs and activities might produce a range of impacts (both helpful and harmful) which we had not planned for, but for which we must take responsibility.

Thus the completed logical framework must specify each of these five components for all the various projects undertaken by the clinic. Once this framework has been finalized, the inputs drive the process of fund-raising and staff development, activities and outputs drive the performance management processes, and outputs, outcomes and impact determine the organisations indicators and drive the record keeping, monitoring and reporting processes.

### **Funding Cycle:**

One of the key functions of the clinic's management is to maintain relationships with donors and sustain an ongoing cycle of funding reports and proposals. Different donors have somewhat different expectations with respect to both proposals and reporting. However, when a detailed logical framework has been established for all the work of the clinic, it is a relatively simple operation to lift the appropriate aspect of the framework into a funding proposal to a particular donor. Thus although the work of drawing up the logical framework is substantial it streamlines work throughout the rest of the year. Perhaps more importantly it helps organisations become clearer about what they wish to achieve within any particular year and less likely to be swayed by the particular pressures applied by the donor community.

### **Monitoring:**

The logical framework also provides the basis for the monitoring and thus record keeping and performance management systems. Monitoring entails the ongoing data collection of key *indicators* which enable all stakeholders to constantly measure the progress of the clinic. Detailed indicators need to be established for the activities, outputs, outcomes and impact of each programme run through the clinic. Such indicators may be quantitative or qualitative in nature and should take into account existing data courses, methods of data collections, methods of data analysis, the time scale on which the data is to be recorded and analysed, and who is responsible for data collection, recording, aggregation and analysis. To a large extent the monitoring is already in place through the existing record keeping practices of the clinic, at least for activities and outputs. It is a relatively simple matter for the clinic to calculate how many therapy sessions have been offered and how many children have participated in the Kids Court Support Programme. However, indicators at the level of outcomes and impact do not seem to have been fully developed. For example, the eventual outcomes of therapeutic processes are not clearly specified and we left speculating as to whether clients never returned to follow up, or were dissatisfied with the service, or made full recoveries.

## **Record keeping and Reporting:**

The management of information is a chronic problem within the entire child abuse sector, and allegations of corruption and negligence are not uncommon. It is certainly clear that many violent offenders have escaped justice due to the inadequate record keeping and case management of service providers. Perhaps more importantly is the fact that we know that many abused children “fall out” of the system without receiving adequate care, and that their cases are not followed up by the caring professions.

Well kept records are also the most important instrument in monitoring the quality and quantity of work done by a clinic. One of the objectives of this evaluation is to develop a usable and comprehensive monitoring system, and case records form an inevitable part of this system. For all these reason and others, accurate and comprehensive case records are an essential part of an organisation such as the *Teddy Bear Clinic*.

The record keeping system and practices at *Teddy Bear Clinic* must be given some attention in order for the clinic to meet the highest standards of professional practice. This is most important, since if this work is to be extended into other centres, it is likely that the problems will be greater, not less, in the newer centres. Other service providers within the sector have developed reputations for being unable to manage information professionally, and we must prevent this from happening here before the model is replicated.

*What are the reasons for poor record keeping?*

In our assessment the reasons for the problems in the record keeping in the *Teddy Bear Clinic* are multiple:

1. The existing information management system is somewhat cumbersome and might be more efficiently designed.
2. The existing information management system has no built in checks that data has been correctly entered.
3. The fact that work happens at multiple sites around Gauteng also contributes greatly to the confusion in record keeping.
4. Administrative functions are not given sufficient priority in the job profiles of medical and counselling staff.
5. Management has not been sufficiently vigilant in ensuring that records are properly kept.

As much as the causes of the problem are multifaceted, so must the solution be.

*Development of a more effective information management system*

An information management system that is integrated across multiple sites, and across multiple areas of work is indispensable to the *Teddy Bear Clinic* at this point in its development. This information management system should strive to meet the following objectives.

1. An integrated system is required so that each child assisted by the clinic is identified by a single case number (automatically assigned), and that through this case number it is possible to access the child’s demographic and contact details, any forensic assessment that is conducted, any psychological assessments that are conducted, as well as therapy and court preparation records.

2. Satellites should be able to upload their new records to the database over the internet. An administrative person within each satellite office should be made responsible for uploading new records on a daily basis.
3. The system must be appropriately secure to protect the privacy of clients.
4. This system must facilitate data entry so as to reduce data input time to a minimum, thus assisting personnel to spend more time on the work of caring for children.
5. Job functions must be structured in such a way as to allow time for administrative functions. 10% of time is not uncommon, which amounts to a full morning per week of a normal working week. Unless time is allocated to record keeping it will never be managed adequately.
6. The system must be managed by a single well-skilled person in the central office. This person's responsibilities must include checking that data is being entered comprehensively, assisting personnel who are struggling to use the system, and informing management of problems in the records. This is a time consuming function, and once again must be given adequate recognition within an administrative person's job function. Weekly back ups of the data base should also be the responsibility of this person.
7. Managers must make record keeping one of their priority concerns (at least for a period) and ensure that personnel are keeping and recording the necessary information.
8. Finally, other institutions working with abused children around the country are working towards a standardized reporting format in order that more accurate statistics can be collected. The *Teddy Bear Clinic* should try to ensure that their information system is congruent with national endeavours.

*Bringing in a new system:*

It is always difficult for organisations to move from one record keeping system to another. For this reason it is important that the following are kept in mind in making the change.

1. Establish "buy-in" from personnel. Management need to meet with all personnel as a group and discuss the current record keeping problems, and the reasons why record keeping is considered so important. The group should discuss the various options available (including the electronic option described above) and come to a mutually satisfying solution.
2. Change must be led by the most senior people in the organisation, who through example, high expectations, and immediate corrective action can overcome a great deal of the inevitable resistance to the new information management system.
3. If the choice is for an electronic database as recommended above, it is important to employ an individual or company who are highly skilled in this work, and who will be able to provide support into the future. There is some cost attached to this, although some firms will assist service agencies at highly reduced rate or without charging.

4. It is important that all personnel who will be using the system are adequately trained in its use. Poor training makes the work of entering data and managing the system that much more frustrating and time consuming.
5. Introduce the new system gradually. Starting with the system administrators to make sure that the database is robust and that all functions are operating smoothly. Secondly, have the administrators enter data from paper records (as are currently being kept) for the medical and counselling staff. Thirdly, have the administrators enter data with the medical and counselling staff to assist them with the work. Finally, all personnel should be able to access the database and update records without assistance.

### **Performance Management:**

The indicators described above also feed directly in a performance management system which states very clearly what is expected of each member of the team. The process of determining target is a collaborative one between staff and supervisors and should be made as concrete as possible. Quarterly or six monthly review of performance indicators enables supervisors and staff to pinpoint areas in which the organisation is not meeting its goals and to take strategic action to rectify the situation.

A performance management system of this kind moves the organisation a long way towards changing the management style of the clinic. Where staff are working within a clear supervision framework the emphasis falls on meeting longer term goals, rather than in constantly responding to the latest urgent request and sacrificing the longer term, and perhaps more important strategy.

### **Research and report**

Finally, an organisation of the clinic's stature should be starting to develop a stronger policy and research presence. An enormous amount of important information and expertise exists within the clinic structures, which are seldom given the exposure they deserve because of the low priority afforded these functions within the organisational climate. Having data collection and management happening as a matter of course within the organisation provides a strong basis for relatively effortless and swift report writing.

## **WORK WITH VOLUNTEERS**

Work with abused children straddles the divide between activities performed out of love and those performed for pay. These often competing interests arise from the fact that this work comprises both "visible" and "invisible" components. On the one, hand the contribution that volunteers make can be measured in terms of the number of children who receive care, the nature and quality of the services that they receive, as well as the multiple skills that volunteers bring to the job. All these are the visible components of the clinic's work. Yet this work also depends upon empathy and deep ideological and emotional investment in the well-being of children that workers bring to their work. These are the invisible components.

Volunteerism is an essential part of services to children in South Africa and will be into the foreseeable future. However, it is important that we think critically about volunteers, especially where the volunteer core has created a great deal of frustration for some of the staff at the clinic. People volunteer their services for a variety of different motives, and it is erroneous to assume that all volunteers are working out of a desire to contribute to the lives of people around them. Many people, especially people with few marketable skills and little or no

income, volunteer in care organisations in the hope that they will gain skills, experience, some financial compensation for their work, and perhaps even employment. When these hopes are not met, many people, who might otherwise have made important contributions, gradually withdraw from the organisation.

It is important that the clinic offers something fairly tangible to volunteers for their contribution to the organisation. The most obvious reward is a monetary donation but this is not usually a useful response. In other organizations such “stipends” have come to be regarded as wages (although well below the legal minimum wage) and can become abusive or workers. More useful is to offer volunteers the opportunity of gaining a meaningful qualification through work at the clinic. With the current changes taking place within the South African skills development world, there are many opportunities to start “learnerships”, in this case under the Health and Welfare Services SETA, whereby volunteers could emerge from their time at the clinic with a marketable qualification in child care for example. Furthermore, it may be possible to use the skills development fund to pay for the establishment of such learnerships thereby bringing more income into the clinic.

## **CARE OF PERSONNEL**

Caring for victims of abuse, especially children, on a daily basis presents serious emotional challenges to personnel. Unless care personnel pay special attention to their own changing emotional states they are in danger of both secondary traumatic stress and burnout.

Although the problems of secondary traumatic stress and burnout are often discussed somewhat superficially as being part and parcel of the same problem, they are in fact different phenomena, with different underlying causes, emotional content and remedy. For these reasons the distinction is worth making.

### *Secondary Traumatic Stress:*

Secondary traumatic stress (alternatively conceptualised as vicarious trauma or compassion fatigue) results from a caregiver’s witnessing of one or more traumatic events as recounted by people that he or she is attempting to assist. Caregivers are often in great danger of secondary traumatic stress for the following reasons.

Firstly, some helpers engage deeply with the traumatic experiences of many people, thereby increasing their personal exposure. It is misleading to compare the traumatic exposure of a helper with that of the person they are trying to help, since in recounting the episode the trauma survivor has already processed the experience, thereby reducing its impact upon further witnesses. Nevertheless, a trauma counsellor might engage with many similar traumatic stories per day for several days on end. The cumulative effect of such exposure is often very difficult to manage.

Secondly, many helpers mistakenly believe that their role, training and experience makes them somehow immune to the effects of traumatic exposure. In so doing, they forget that the traumatic stress response is in large part a powerful biological response to danger, and that although our theories and models might help us understand our response, they do not prevent that response from happening. The great danger is that because of helpers’ deep assumptions of their own immunity they put themselves at increased risk by continuing to work when they have exhausted their emotional resources. By not caring for themselves adequately when they notice the early signs of secondary traumatic stress, and even by concealing their pain behind

masks of denial and avoidance because they feel that they are failing as helpers if they reveal their own distress, caregivers tend to make the problem worse.

Thirdly, many helpers work hard not to become desensitized to the violence around them and in their work. Clearly, counselors and therapists who are themselves not able to engage empathically with the distress of the people they aim to assist are unlikely to have great success in their work. So it is important that helpers work hard to remain aware, both cognitively and emotionally, of the violence around them. Sadly, this necessity robs many types of helpers of one of the most effective ways that human beings have of tolerating ongoing traumatic exposure.

Finally, helpers' perceived effectiveness is another aspect of their increased vulnerability. The importance of helplessness or powerlessness has been written about at length in the literature on traumatic stress, and its effects should not be forgotten when considering secondary traumatic stress. The emotional consequences of feeling powerless to assist people in need undermines the identity and personal meaning of many helpers. Factors such as the personal histories and cultural backgrounds of the client and the helper, the context within which help is being provided and the nature of the traumatic experience, all play a role in determining how much assistance is possible.

Prevention of secondary traumatic stress involves managing traumatic case loads, close monitoring of emotional health and the creation of opportunities to process the content of trauma cases, especially where those cases involve extreme violence and grotesque imagery. Recovery from secondary traumatic stress often requires intensive therapy from a traumatic stress specialist with a deep understanding of these dynamics.

### *Burnout*

Burnout is an emotional phenomenon that plagues almost every high stress workplace, and is derived from the amount of work that is expected from a person, the severity of penalties when the work is not completed, and the frustration that a person feels in the day to day course of getting their work done.

Although burnout is most often associated with the highly competitive world of commerce in which the struggle to be the best continues day and night, it is in fact a very important problem for service provision organisations as well. It is a simple fact of South African life, that there are more children needing the services of child protection and child care specialists, than there are specialists. This fact is unlikely to change in the foreseeable future. This means that there is always another child for specialists to care for, the work is never over for the day. At an organisational level, there is always another community to extend the service to and there is always another group of victims in need of assistance.

Many people in the care professions define themselves strongly around the nature of their work, and as such it is very difficult to withhold assistance from a person who needs it, especially when that person is a child. The result is that caregivers are typically very bad at protecting themselves from burnout.

Prevention of burnout involves setting and keeping to reasonably challenging work objectives, working a reasonable number of hours per week, and taking leave from work at reasonable intervals. Recovery from burnout requires a lengthy break from the work environment, often coupled with counselling to assist the person to sort out their life's priorities.

### *Creating a Healthy Workplace:*

A great deal can be done at the level of the organisation to protect personnel for both secondary traumatic stress and burnout.

1. Education of personnel about secondary traumatic stress. The key message here is that unless adequately managed, the high level of traumatic exposure experienced by personnel will inevitably result in secondary traumatic stress. Further, secondary traumatic stress is extremely distressing and debilitating, and is more difficult to treat than other forms of traumatic stress.
2. Ensuring that people are never discouraged from expressing their distress. It is important to develop a climate where staff can talk about their feelings without feeling as though it will in any way damage their standing in their colleagues and supervisor's eyes.
3. When staff do not manage their emotions appropriately it is important that this behaviour be corrected in a supportive manner, sensitive to the difficulty of managing feelings in this context.
4. By putting the organisation's health on the agenda of every meeting, an awareness of secondary traumatic stress grows within the agency. In most cases this is an item that is passed over with a "yes, we're all doing fine this week", but at other times asking the question can prevent management overburdening already vulnerable people.

Also important is the question of clear regulations to govern the work of staff members. The staff of the *Teddy Bear Clinic* are deeply emotionally invested with the people with whom they are working and so it is easy for work commitments to intrude upon people's time away from work. Staff do need to be able to leave their work at work sometimes.

## **SWOT ANALYSIS**

Analysis of organizational functioning in terms of strengths, weaknesses, opportunities and threat is a well known, but nevertheless effective technique. Both the internal and external interviewees were asked to conduct a brief 'SWOT' on the *Teddy Bear Clinic*. There was a high degree of conformity between the interviews.

### *Strengths:*

Current Staffing	Strong skills base and multidisciplinary. Highly experienced. High level of commitment to child protection. Very loyal to the <i>Teddy Bear Clinic</i> . Self motivated.
Offer a range of related services	Complementary set of services. Offering medical assessments.
Strong strategic partners	Johannesburg General Hospital – sustainability. University of the Witwatersrand – access to theory and lit. Nelson Mandela Children's Fund - sustainability Others
Network with other providers	Police, particularly CPU and FCS units. Courts in Johannesburg, Krugersdorp and Soweto Government and non-government welfare organizations and other service providers.

*Weaknesses:*

Management	Managers have multiple, often conflicting responsibilities. Insufficient time to meet all responsibilities fully. Often away from the clinic. People become disillusioned and angry.
Head office - satellites	Satellites feel unsupported and poorly managed. People in head-office feel that the satellites are “just doing their own thing”. Lack of accountability.
Difficulties with volunteers	High drop out of volunteers, except at Soweto. High costs in training, quick drop out in beginning. No shows by some volunteers mean staff must pick up extra, unplanned responsibilities. Very few volunteers stay long enough to become experienced.
Low salaries	Salaries are lower at the clinic than people might earn in some other institutions (private and academic). Difficult to recruit high quality professional staff. People eventually move on in search of better pay.
Stress, burnout and secondary traumatic stress	Work is highly emotional and many staff are very stressed. Key people in the organisation are highly stressed and there is fear that they might leave.

*Opportunities:*

Replication of model	Can set up more clinics along the lines of the existing satellites. Can work at “franchising” the <i>Teddy Bear Clinic</i> model for replication in other centres.
Training and dissemination	Many opportunities to train others. High level of skill and experience in the clinic.
Add further services	Adult rape cases. HIV work, specifically therapy for HIV patients who contract the virus through rape.
High public profile of child abuse	Good opportunity for fund-raising and policy work at the moment.
SPARC	First programme of the kind in the country. Strong support from the criminal justice system.

*Threats:*

Financial Sustainability	Ongoing struggle to raise sufficient funds. Have been let down by “proxy fund-raisers” Changing funding policy from existing major donors. Policy changes in department of health. Funding cut backs.
Staff turn-over	A small group of key people are seen as vital to the clinic. There is concern that these key staff will leave due to better offers and high stress.
Interpersonal conflict	Although not mentioned by everyone this factor was mentioned several times.
Becoming too unfocussed	Two people mentioned that the clinic is offering a wider and wider set of services. “Trying to do everything”. Difficult to sustain. May damage relationships with other service providers.

**Recommended future directions:**

*Management Structures:*

The process of consolidation described above will take some of the strain off the organisation’s leaders if it is comprehensively applied. If the burden of responding to crisis is removed and staff develop the capacity to solve more problems without assistance from senior people a good

part of the problem will be solved. However, as the clinic grows the managerial responsibilities are likely to become more and more burdensome, especially to people who would rather spend their time providing services to children directly. With this in mind it is recommended that the *Teddy Bear Clinic* consider employing a senior administrator whose tasks would be to manage all the various interlocking systems described above.

#### *Systems development and integration:*

Systems development and integration is one area in which employing consultants can be extremely efficient and effective. Two possibilities should be considered by the clinic. Firstly, bring in a database design consultant who can set up an integrated data management system for the clinic. Secondly, an organizational development or personnel development consultant who can assist the clinic in developing clearer job descriptions and performance appraisal mechanisms. Although these interventions do require a significant financial outlay, they are an important part of the strengthening of the organisation, a benefit that last for many years.

#### *Replicating the model:*

There has been a great deal of discussion in the *Teddy Bear Clinic* around how the work of the clinic might be expanded to reach other parts of South Africa. There are several different ways in which this might be achieved. Whichever the clinic opts for must be sensitive to the different contexts of various South African communities:

1. Establishment of further satellites which would continue to be support and supervised through national and regional centers. This is the common hierarchical model that many private and government structures use.

The advantages of such a model are that there is strong control over the quality and standardization of services across all the clinics. Training and supervision of staff is supervised, and the models used in the various interventions are identical. The disadvantages of this model is that it requires an extremely powerful set of administrative systems in order to run efficiently. Many organizations structured in this way have become paralyzed by insufficient administrative support. Currently the *Teddy Bear Clinic* is struggling to support three sites adequately. With every additional site the stress on organizational systems will rise exponentially.

2. Providing a clearly manualized model of operation which can then be replicated in other parts of the country. This is the “franchising” model used by many private companies.

The advantages are that once the difficult work of manualizing the model has been achieved and once minimal standards have been set the resource drain on the franchising organisation is more limited. The disadvantages are that the minimum standards have to be carefully monitored and regulated if the originating organisation’s reputation when their work is replicated less skillfully by other parties.

Given the nature of the *Teddy Bear Clinic’s* work this model is not recommended. Quality of service must be the priority.

3. Finally, the option of developing a formal “training and development” center within the clinic should be considered. Many clinic staff are already doing training and development work as part of their day to day activities. Adoption of this approach

would mean formalizing these functions, providing greater time for training and development, and gradually establishing a center for excellence within the clinic.

The advantages of this model is that it provides a clear structure within which programme design and development can take place, and from which high quality training and supervision can be provided on an ongoing basis. The disadvantage is that it is possibly the most expensive as it depends upon salaries for additional staff if the overall service provision capacity of the clinic is to be sustained. Although this is the recommended model for future expansion, it is not recommended that this be achieved by increasing the pressure on the existing staff.

#### *New Programmes:*

Currently the clinic is considering branching out into new areas of work. Although it is true that the clinic has a good reputation for work in the area, the fact that the clinic has a strong need for consolidation and is picking up some resistance from other service providers should be seriously considered. It is not recommended that the clinic embark on new areas of work which will require a great deal of development for highest level specialist service provision.

### **CONCLUSIONS:**

It has been a great honour to work with the caliber of people of people employed at the *Teddy Bear Clinic*. The work is impressive in volume, scope and quality, as are the individuals who give of themselves on a daily basis.

The growth of the past few years has placed the organisation under strain, but this strain will pass as attention is paid to the managerial and systems issues discussed in the body of the report. When the strain passes there will be many more opportunities for growth and expansion and the clinic will be better placed to respond. Sacrificing some opportunities today might be in the best interests of the clinic in the long term.

Most important to the *Teddy Bear Clinic* is its reputation as a specialist service provider. Each new service offered will link to more possibilities for intervention. If the clinic makes the mistake of broadening its services too much it will find it harder and harder to distinguish itself above the sea of other welfare agencies offering services to children and families, and will thus find it more difficult to raise the necessary funds to offer the original services.

At the same time, the clinic contains an enormous amount of expertise which should be reaching the thousands of people around the country who wish to assist children who have been abused, but lack the technical knowledge and experience. The more the clinic can do to support and develop these people, the greater will be its contribution to the struggle against child abuse in South Africa.

It is our sincere wish that this report assists the *Teddy Bear Clinic* to advance from strength to strength in the future, and to continue to offer the impressive services that it does at the moment.

**APPENDIX A**

**CASE FILE DATA CAPTURE FORM**

<i>CASE ANALYSIS: TEDDY BEAR CLINIC</i>	
ID	
<b>Child's Details:</b>	
Age (years at first consultation)	
Gender	
Race	
Suburb of residence	
<b>Caregiver's Details:</b>	
Who brought child to TBC?	
Who cares for child on daily basis?	
<b>Reporting Details:</b>	
How was abuse discovered?	
Initial disclosure to?	
Officially reported to?	
Referred to TBC by?	
<b>Perpetrator Details:</b>	
Relationship to child (if any)	
Nature of crime	
<b>Intervention Details:</b>	
Forensic assessment (yes/no)	
Results	
Psychosocial assessment	
Results	
Number of therapy sessions	
Psychometric assessment	
Results	
Therapy (num sessions)	
Therapy over what time span	
Assessment at termination	
Court preparation (yes/no)	
Assessment of court readiness	
<i>Other Remarks</i>	

**APPENDIX B**

**INTERNAL INTERVIEW SCHEDULE**

SECTION	QUESTIONS	PROBES
Introduction	<p>Introduce yourself by name</p> <p>This study is to assist the Teddy Bear Clinic in its future development and we need your view as an person intimately connected with the org.</p> <p>Participation is entirely voluntary, if at any point you wish to stop or skip sections that make you uncomfortable that is fine.</p> <p>This interview is totally confidential. Data will be aggregated and nothing you say will be traced back to you.</p> <p>If I tape the interview it is easier to listen carefully to what you are saying since I don't need to write. Is it OK if I switch the tape recorder on now?</p>	
Background to interview	<p>How long have you been with the organisation?</p> <p>What is your current job title?</p> <p>What are your current core job functions?</p> <p>What proportion of time do you spend on each of these functions?</p>	<p>Changing job functions</p> <p>child care, assessment, therapy etc.</p> <p>administrative managerial</p>
Job satisfaction	<p>What are the most challenging aspects of your job?</p> <p>What are the most rewarding aspects of your job?</p> <p>Overall, how happy are you at work?</p> <p>What are the core work stressors for you?</p> <p>How do you visualize your career progressing? Or where would you like to be in five years?</p>	<p>Administrative problems</p> <p>Managerial problems</p> <p>Emotional problems</p> <p>Conflict within the team</p> <p>Work environment</p> <p>Administrative problems</p> <p>Managerial problems</p> <p>Emotional problems</p> <p>Conflict within the team</p> <p>Work environment</p> <p>Why?</p> <p>stress vs secondary traumatic stress</p> <p>within the organisation? Externally?</p>
History	<p>You mentioned that you have been with the organisation since ____</p> <p>can you tell me what changes you have noticed since you joined?</p> <p>(structure as a timeline)</p>	<p>structural changes (incl. new centres)</p> <p>management changes</p> <p>administrative changes</p> <p>changes in client base</p> <p>are the changes +ve or -ve, and why?</p>

Future	<p>What do you consider to be the key strengths of this clinic at this point in its history?</p> <p>What do you consider to be the key weaknesses of this clinic at this point in its history?</p> <p>What do you consider to be the key opportunities of this clinic at this point in its history?</p> <p>What do you consider to be the key threats of this clinic at this point in its history?</p> <p>What needs to be done to take this organisation in the future?</p>	<p>structural administrative financial services networks and strategic partners</p> <p>all of the above again</p> <p>all of the above again</p> <p>all of the above again</p> <p>all of the above again</p>
Other	<p>Is there anything else that you would like to discuss with me that would help us understand the clinic better, or make valuable contributions to the clinic's future?</p>	
Close up	<p>Thanks for your time, this has been extremely valuable. If you think of anything that you would like to cover that slipped our minds today, please get in touch with me</p>	

**APPENDIX C**

**EXTERNAL INTERVIEW SCHEDULE**

SECTION	QUESTIONS	PROBES
Introduction	<p>Introduce yourself by name</p> <p>This study is to assist the Teddy Bear Clinic in its future development and we need your view as an person intimately connected with the org.</p> <p>Participation is entirely voluntary, if at any point you wish to stop or skip sections that make you uncomfortable that is fine.</p> <p>This interview is totally confidential. Data will be aggregated and nothing you say will be traced back to you.</p> <p>If I tape the interview it is easier to listen carefully to what you are saying since I don't need to write. Is it OK if I switch the tape recorder on now?</p>	
Background to interview	<p>How long have you worked with the Teddy Bear Clinic?</p> <p>How many hours per month (on average) do you spent working with the TBC?</p> <p>What is the nature of your working relationship with the Clinic?</p>	<p>Take referrals from/referrals to clinic</p> <p>Administrative support</p> <p>Financial support</p> <p>Technical support</p> <p>Other working relationships</p>
Perceptions of TBC	<p>Are you able to comment on the quality of work done by the TBC in the following areas?</p> <p>Are you able to comment on any of the following areas of the functioning of TBC?</p> <p>What general comments would you like to make about the operations of the TBC?</p>	<p>Medical/forensic assessments</p> <p>Psychological assessments</p> <p>Counselling/therapy</p> <p>Court preparation</p> <p>Co-op. with other child prot. agencies</p> <p>Administration</p> <p>Management</p> <p>Personnel training and supervision</p> <p>Support of personnel</p> <p>General work environment</p>

Future	<p>What do you consider to be the key strengths of this clinic at this point in its history?</p> <p>What do you consider to be the key weaknesses of this clinic at this point in its history?</p> <p>What do you consider to be the key opportunities of this clinic at this point in its history?</p> <p>What do you consider to be the key threats of this clinic at this point in its history?</p> <p>What needs to be done to take this organisation in the future?</p> <p>What changes would you suggest to improve the service provision of the TBC?</p>	<p>Structural Administrative Financial Services networks and strategic partners</p> <p>all of the above again</p> <p>all of the above again</p> <p>all of the above again</p> <p>all of the above again</p>
Other	<p>Is there anything else that you would like to discuss with me that would help us understand the clinic better, or make valuable contributions to the clinic's future?</p>	
Close up	<p>Thanks for your time, this has been extremely valuable. If you think of anything that you would like to cover that slipped our minds today, please get in touch with me</p>	

## **APPENDIX D**

# **COMPASSION FATIGUE AND SATISFACTION SELF TEST**

## Compassion Fatigue and Satisfaction Self-Test for Helpers

*Stamm, B. H. (in press). Measuring Compassion Satisfaction as Well as Fatigue: Developmental History of the Compassion Fatigue and Satisfaction Test. In C.R. Figley (Ed.). Treating Compassion Fatigue. New York: Brunner/Mazel. ©© B. Hudnall Stamm, Traumatic Stress Research Group, 1995-1999* <http://www.isu.edu/~bhstamm/rural-care.htm>.

Helping others puts you in direct contact with other people's lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. This self-test helps you estimate your compassion status: How much at risk you are of burnout and compassion fatigue and also the degree of satisfaction with your helping others. Consider each of the following characteristics about you and your **current** situation. Print a copy of this test so that you can fill out the numbers and keep them for your use. Using a pen or pencil, write in the number that honestly reflects how frequently you experienced these characteristics in the last week. Then follow the scoring directions at the end of the self-test.

<b>0=Never</b>	<b>1=Rarely</b>	<b>2=A Few Times</b>	<b>3=Somewhat Often</b>	<b>4=Often</b>	<b>5=Very Often</b>
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### Items About You

- \_\_\_ 1. I am happy.
- \_\_\_ 2. I find my life satisfying.
- \_\_\_ 3. I have beliefs that sustain me.
- \_\_\_ 4. I feel estranged from others.
- \_\_\_ 5. I find that I learn new things from those I care for.
- \_\_\_ 6. I force myself to avoid certain thoughts or feelings that remind me of a frightening experience.
- \_\_\_ 7. I find myself avoiding certain activities or situations because they remind me of a frightening experience.
- \_\_\_ 8. I have gaps in my memory about frightening events.
- \_\_\_ 9. I feel connected to others.
- \_\_\_ 10. I feel calm.
- \_\_\_ 11. I believe that I have a good balance between my work and my free time.
- \_\_\_ 12. I have difficulty falling or staying asleep.
- \_\_\_ 13. I have outburst of anger or irritability with little provocation
- \_\_\_ 14. I am the person I always wanted to be.
- \_\_\_ 15. I startle easily.
- \_\_\_ 16. While working with a victim, I thought about violence against the perpetrator.
- \_\_\_ 17. I am a sensitive person.
- \_\_\_ 18. I have flashbacks connected to those I help.
- \_\_\_ 19. I have good peer support when I need to work through a highly stressful experience.
- \_\_\_ 20. I have had first-hand experience with traumatic events in my adult life.
- \_\_\_ 21. I have had first-hand experience with traumatic events in my childhood.
- \_\_\_ 22. I think that I need to "work through" a traumatic experience in my life.
- \_\_\_ 23. I think that I need more close friends.
- \_\_\_ 24. I think that there is no one to talk with about highly stressful experiences.
- \_\_\_ 25. I have concluded that I work too hard for my own good.
- \_\_\_ 26. Working with those I help brings me a great deal of satisfaction.
- \_\_\_ 27. I feel invigorated after working with those I help.
- \_\_\_ 28. I am frightened of things a person I helped has said or done to me.
- \_\_\_ 29. I experience troubling dreams similar to those I help.

- \_\_\_ 30. I have happy thoughts about those I help and how I could help them.
- \_\_\_ 31. I have experienced intrusive thoughts of times with especially difficult people I helped.
- \_\_\_ 32. I have suddenly and involuntarily recalled a frightening experience while working with a person I helped.
- \_\_\_ 33. I am pre-occupied with more than one person I help.
- \_\_\_ 34. I am losing sleep over a person I help's traumatic experiences.
- \_\_\_ 35. I have joyful feelings about how I can help the victims I work with.
- \_\_\_ 36. I think that I might have been "infected" by the traumatic stress of those I help.
- \_\_\_ 37. I think that I might be positively "inoculated" by the traumatic stress of those I help.
- \_\_\_ 38. I remind myself to be less concerned about the well being of those I help.
- \_\_\_ 39. I have felt trapped by my work as a helper.
- \_\_\_ 40. I have a sense of hopelessness associated with working with those I help.
- \_\_\_ 41. I have felt "on edge" about various things and I attribute this to working with certain people I help.
- \_\_\_ 42. I wish that I could avoid working with some people I help.
- \_\_\_ 43. Some people I help are particularly enjoyable to work with.
- \_\_\_ 44. I have been in danger working with people I help.
- \_\_\_ 45. I feel that some people I help dislike me personally.

### **Items About Being a Helper and Your Helping Environment**

- \_\_\_ 46. I like my work as a helper.
- \_\_\_ 47. I feel like I have the tools and resources that I need to do my work as a helper.
- \_\_\_ 48. I have felt weak, tired, run down as a result of my work as helper.
- \_\_\_ 49. I have felt depressed as a result of my work as a helper.
- \_\_\_ 50. I have thoughts that I am a "success" as a helper.
- \_\_\_ 51. I am unsuccessful at separating helping from personal life.
- \_\_\_ 52. I enjoy my co-workers.
- \_\_\_ 53. I depend on my co-workers to help me when I need it.
- \_\_\_ 54. My co-workers can depend on me for help when they need it.
- \_\_\_ 55. I trust my co-workers.
- \_\_\_ 56. I feel little compassion toward most of my co-workers
- \_\_\_ 57. I am pleased with how I am able to keep up with helping technology.
- \_\_\_ 58. I feel I am working more for the money/prestige than for personal fulfillment.
- \_\_\_ 59. Although I have to do paperwork that I don't like, I still have time to work with those I help.
- \_\_\_ 60. I find it difficult separating my personal life from my helper life.
- \_\_\_ 61. I am pleased with how I am able to keep up with helping techniques and protocols.
- \_\_\_ 62. I have a sense of worthlessness/disillusionment/resentment associated with my role as a helper.
- \_\_\_ 63. I have thoughts that I am a "failure" as a helper.
- \_\_\_ 64. I have thoughts that I am not succeeding at achieving my life goals.
- \_\_\_ 65. I have to deal with bureaucratic, unimportant tasks in my work as a helper.
- \_\_\_ 66. I plan to be a helper for a long time.

**Scoring Instructions:** Please note that research is ongoing on this scale and the following scores should be used as a guide, not confirmatory information. Cut points are theoretically derived and should be used with caution and only for educational purposes.

- 1. Be certain you respond to all items.
- 2. Mark the items for scoring:
  - a. Circle the following 23 items: 4, 6-8, 12, 13, 15, 16, 18, 20-22, 28, 29, 31-34, 36, 38-40, 44.
  - b. Put a check by the following 16 items: 17, 23-25, 41, 42, 45, 48, 49, 51, 56, 58, 60, 62-65.
  - c. Put an x by the following 26 items: 1-3, 5, 9-11, 14, 19, 26-27, 30, 35, 37, 43, 46-47, 50, 52-55, 57, 59, 61, 66.
- 3. Add the numbers you wrote next to the items for each set of items and note:
  - a. *Your potential for Compassion Satisfaction (x)*: 118 and above=extremely high potential; 100-117=high potential; 82-99=good potential; 64-81=modest potential; below 63=low potential.
  - b. *Your risk for Burnout (check)*: 36 or less=extremely low risk; 37-50=moderate risk; 51-75=high risk; 76-85=extremely high risk.
  - c. *Your risk for Compassion Fatigue (circle)*: 26 or less=extremely low risk, 27-30=low risk; 31-35=moderate risk; 36-40=high risk; 41 or more=extremely high risk.

*Adapted with permission from Figley, C.R., (1995). Compassion Fatigue, New York: Brunner/Mazel. ©© B. Hudnall Stamm, Traumatic Stress Research Group, 1995-1999 <http://www.isu.edu/~bhstamm/rural-care.htm>.*